NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

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## Annual Report and Accounts

## 2017-2018

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# Performance Report

## Overview of Performance

### Chief Executive's Statement

On behalf of the Board, I'd like to welcome you to this annual report on the Trust's performance in the year from 1st April 2017 to 31st March 2018.

### Performance

I am pleased to report that the year has again seen ongoing improvements in overall performance. There are, however, some challenging performance areas: particularly with respect to the national A&E performance standard which is reflective of the national picture. Demand for services has continued to be high, particularly in the winter period, and there has been a keen national debate as to how services should respond.

Details of performance during the year can be found at page 10 of the report, setting out the key performance indicators. The Trust has performed well against the majority of the national and local performance standards, and the Board has continued to be focused on close oversight of the performance, including reviewing areas that have not met expectations. The improvements in performance have been supported by the detailed work undertaken through the Board's Committees.

Locally, we have continued to work closely with our partners within the Tameside and Glossop area to drive the provision of better services for our local communities. Both the Trust and our local partners are committed to have as integrated approach as possible, reflecting that the community sees health and social care provision as a continuum that provides care for individuals, and needs to work seamlessly. We have continued to work with Tameside Council to progress the implementation of new service models in order to improve the health and wellbeing in our communities, for example, the 'Digital Health' to support those in a care home environment, to reduce the need to attend acute services such as Accident and Emergency.

We are also actively working at the regional level, with the Greater Manchester Health and Care Partnership, to develop services in partnership with all the providers and commissioners across the region. Greater Manchester operates as the Sustainability and Transformation Partnership for the Greater Manchester area.

### Finance

As in previous years, the Trust has managed to achieve its agreed financial plans in a difficult environment. The Board agreed a financial plan for the year leading to a deficit of £24.347 million for the year ending 31st March 2018, which the Board considered to be a challenging but achievable target for the year. During the year, robust delivery systems were implemented to ensure the efficiency programmes were delivered. As a result of these measures, the Trust ended the year with a deficit of £23.726 million, (including the 'winter monies' from Government) which met the Board's expectations for the year. I would like to publicly thank colleagues for their hard work in identifying and delivering the savings that were necessary for the year.

The financial environment continues to be challenging, with significant political discussion on how the NHS should be funded and the levels of funding that are appropriate. Her Majesty's Government have indicated an intention to bring forward proposals in the autumn of 2018 for a long-term (10 year) funding settlement for the NHS. If those proposals gain the support of Parliament, it would give a more stable basis for NHS organisations to plan.

For 2018-2019, the Board has again set a financial plan with the aim of being challenging but

achievable. After a very detailed process of financial planning, the Board has agreed that the plan for the year leads to a deficit of £25.8 million. This includes making efficiency savings within the Trust's continuing operations of £12.8 million in the year, which represents about 5.3% of continuing turnover and is at the upper end of what is regarded as deliverable in the NHS.

Governance

The governance of the Trust is led by the Board of Directors, with the Council of Governors exercising a representative function and performing some specific functions that Parliament has reserved to it. Regulators have set out required standards of governance, linking across both the Care Quality Commission and NHS Improvement, through the *Well-Led* process and the related Key Lines of Enquiry (KLOE) for CQC inspection processes. Current policy is for all provider trusts to have their governance inspected (through the "Are they well-led?" strand) on an annual basis, and the Trust is awaiting its first inspection on this basis. NHS Improvement requires each provider organisation to undertake a detailed, externally-led review of its governance processes at least every three years; and the Trust is currently undertaking this process.

Governance has continued to be effective during the course of the year, with the Board meeting regularly. Each formal meeting has publicly reviewed a range of performance and quality data, together with strategic developments. The Board has also been supported by a Committee structure that undertakes detailed review of information and proposals, and reports to the Board regarding the assurance levels that are available.

The year has seen some changes to the Board and to those who have directly supported the governance of the Trust. During the year, Paul Connellan and Trisha Kalloo retired as Directors, and on behalf of the Board I'd like to record our thanks for their service and contribution to the Trust. We have been joined by Jane McCall as the new Chair of the Board, and also Peter Noble as a new Non-Executive Director, who are already make a contribution to the Board's work. Details of the Board's membership can be found on page 44 of the report.

On the executive side, Claire Yarwood (Director of Finance) will be leaving us at the end of May 2018 to take up a new role with the Manchester CCG's. I'd like to thank her for an exceptional contribution; and wish her well in the future.

Conclusion

Over the course of the year, we have continued to work hard as a team, both within the organisation and with our local and national partners, and we've continued to deliver well in a difficult environment for the NHS. My congratulations and thanks to all of my colleagues for their hard work in delivering for patients and the community through the year.

Looking forward, for the medium-term it seems likely that the Trust will continue to be operating in a challenging environment. Our strategy to work in a collaborative and integrated way with our partners offers the opportunity to continue to provide the highest quality of care whilst addressing the financial and operational challenges being seen across the system.

Karen James
Chief Executive

## Statement of Purpose and Activities

The Trust exists, as part of the National Health Service, to provide health services to the population of England; and more specifically, mainly to provide them to the residents of the areas of Tameside Metropolitan Borough Council, and the Glossop, Tintwistle and St John's areas of Derbyshire.

We provide a District General Hospital service, including an Accident and Emergency Department, together with community-based and intermediate care services. This range of services enables us, in combination with our partners, to provide care beyond the traditional acute setting.

With a significant part of our area in the Greater Manchester Region, we are closely involved with development of Greater Manchester's health and social care system; and as part of this wider approach, we are continuing to move towards greater integration of the health and social care systems in the Tameside area. These changes would not necessarily apply to the Derbyshire side of our area, but we are seeking to apply them in those areas in association with the relevant CCG.

The Trust's business model is to move, over time, to being a provider of integrated care across both health and social care services. We have already moved forward in this work over the previous few years, with a consolidation of services being provided by the Trust and also other services which the Trust does not provide (such as Primary Care) being co-ordinated through the establishment of Neighbourhoods. The neighbourhood arrangements work to bring together health, social care and other local services in a single location, so that patients and service users have easier and co-ordinated access. With our key partners in the local health economy, we are also working in a linked fashion to better co-ordinate the interface between health provision (NHS) and social care provision (Local Authorities) so that the overall care and experience for patients and their carers is improved. However, it is important to recognise that there are limits to the work that can properly be undertaken by the Trust, given both the division of responsibilities reflected in legislation, and also the requirement that the objective of the Trust is the provision of services for the NHS. During the year, the Board has reviewed and reformulated its strategy, reflecting developing national and Grater Manchester objectives.

The Trust's organisational structure is as a Public Benefit Corporation, incorporated under the provisions of the *National Health Service Act 2006* (as amended, principally by the *Health and Social Care Act 2012*). The Board considers that this remains the most appropriate legal form for the provision of these services, given the legislative requirements.

## History of the Trust

The Trust was authorised as a Foundation Trust in February 2008, the successor to various organisations that have been responsible for the provision of care on the Tameside General Hospital site for many years. The Trust now provides secondary and community healthcare services to the populations of the Tameside Metropolitan Borough area, and the Glossop, Tintwistle and St John's areas of Derbyshire. We are also working closely with our partners across the piece to deliver integrated care through the creation of co-ordinated provision in five neighbourhoods, which bring together primary and secondary health with social care and local voluntary and community services, for the benefit of patients.

The Trust is a Public Benefit Corporation, incorporated under the *National Health Service Act 2006*. As such, it is subject to regulation by Monitor (now part of NHS Improvement), who are responsible for regulating its organisational performance and governance. It is also regulated by the Care Quality Commission, who have primary responsibility for regulating the quality of care provision in the Trust (as with all registered providers of care). The Trust also has regulatory relationships with other statutory regulators including the Human Tissue Authority and the Human Fertilisation and Embryology Authority; and maintains relations with the statutory regulators for its individual members of staff, including the General Medical Council and the Nursing and Midwifery Council.

Key Issues and Risks

The Board recognises that the delivery of the objectives that it has set for the Trust can be affected by a range of issues. There is a policy and process in place to enable the Trust, through the Board, its Committees and management, to identify risk, set out and measure steps to mitigate and manage risk, and to identify the potential impacts if the risk eventuates.

Key external matters affecting the ability of the Trust to deliver its objectives include-

- National policy decisions, including those related to funding, national pay arrangements, and development priorities set out by NHS England through the Standard Contract;
- The expectations of clinical regulators, particularly the Care Quality Commission, and changes to those expectations from time to time;
- The position of the staffing market for key specialist staff, particularly clinical colleagues, who are a key factor in being able to provide high-quality and safe services.

The Board maintains a Board Assurance Framework (BAF) which sets out the strategic risks that the Board has identified as affecting the achievement of the strategic objectives. During the year, the BAF was considered, with suggestions for updates, at each formal meeting of the Board. The Board is considering a change in the way it oversees the BAF, given that the risks are strategic and might be expected to be longer-term in changing and responding to actions to mitigate or manage them.

For the 2017-2018 year, the key strategic risks identified by the Board were-

- The challenges in the recruitment and retention of sufficient staff with the skills and experience to ensure that services are delivered in a safe way and providing a good patient experience;
- Ensuring that the Trust is able to deliver the agreed financial plan (including the challenging efficiency plans) and maintain access to loan support from the Department of Health;
- Ensuring that there are effective partnership arrangements for the Trust's work with partners at the local and regional health economy levels, which will deliver the anticipated benefits from the integrated provision of services by the partners.

Going Concern

Having given careful consideration to all information in their possession, the Directors have concluded that there is a reasonable expectation that Tameside and Glossop Integrated Care NHS Foundation Trust has adequate resources to continue in operational existence for the 12 months following the approval of this statement. For this reason they continue to adopt the going concern basis in preparing the accounts.

In coming to this conclusion, the Directors recognise that there is material uncertainty that affects whether the Trust should adopt this basis. The Directors have had particular regard to the following matters.

The Trust is planning for an income and expenditure deficit of £25.8m in 2018/19. As at the 31st March 2018, the Trust had net liabilities of £2.5m and anticipates this will increase to £28.3m net liabilities by the 31st March 2019, reflecting the planned deficit for 2018/19. In order to deliver the agreed financial plan, the Trust will have to achieve efficiency savings of at least £12.8m within the year.

In order to meet the Trust's liabilities within the year, the Directors anticipate seeking a further £25.8m from the Department of Health (DH) in loan support. This would bring the total Trust loan liability to £101.2m.

The Directors have cause to believe that DH will provide the required loans. as NHS Improvement have indicated that they will approve a final financial plan for the year predicated on those loans becoming available, The Directors have also had regard to the guidance issued by the Secretary of State under Section 42A of the *National Health Service Act 2006*, regarding his policy on granting loan support to NHS provider organisations.

If loan support is not provided, the Trust would not be able to meet its debts as they fell due. The Trust would need to enter discussions with Commissioners and regulators regarding the future of provision, particularly Commissioner-Requested Services under Condition CoS 7 of the Trust's Provider Licence.

The Directors have also considered the following factors in concluding that the Trust is a going concern;

- The level and basis of expected income for 2018/19, supported by fully signed off contracts and agreed activity levels,
- Contractual agreement with its main commissioner (Tameside & Glossop Clinical Commissioning Group) to the Trust's overall service strategy, including full agreement of future commissioning intentions;
- Robust assessment of the impact of the block contract agreed with the main commissioner, specifically for 2018/19 but looking to the medium-term,
- Robust assessment of the impact of Payment by Results tariffs for secondary commissioner contracts, specifically in 2018/19 but looking to the medium-term,
- Full identification of potential risks and opportunities incorporated into the financial plan for 2018/19, including the potential impact of planned demand management initiatives.
- The announced intention of Her Majesty's Government to bring forward a long-term (covering 10 years) financial settlement for the NHS in the autumn of 2018;
- Prior Board agreement to apply to DH for loan funding as required during the course of the 2018-19 year, up to a total of £25.8 million.

The capital expenditure programme for 2018/19, as agreed by the Board, has been risk assessed to reflect the requirements of the Trust to ensure delivery of Commissioner-Requested Services.

# Performance Analysis

Key Performance Measures

The Board recognises the importance of being able to measure performance in order to effectively manage and improve it. The following are the key metrics (KPI's) that were reported to the Board regularly during the course of the year, stated with the agreed target and performance over the course of the year-

| | Target | Actual |
|---|---|---|
| Safe Service | | |
| Mortality- SMR (rolling 12-months) | 100 | 89.2 |
| Mortality- SHMI (rolling 12-months) | 100 | 108 |
| MRSA- Actual cases | Nil | 6 |
| C. Difficile- Actual cases | 97 | 72 |
| C. Difficile- Avoidable cases | N/A | 7 |
| Safe Staffing- Registered staff hours on shift against planned | N/A | 92.5 |
| Safe Staffing- Care Assistant staff hours on shift against planned | N/A | 104.2 |
| Harm-free care (all harms) | N/A | 94.1% |
| Harm-free care (new harms) | 98.5% | 96.3% |
| VTE Risk Assessments | 96% | 96.4% |
| Medicines reconciled on admission | 95% | 81.8% |
| Nutrition risk assessment | 95% | 97.9% |
| Emergency re-admission within 30 days | 11% | 12.4% |
| Failure of safer surgery process | Nil | 0 |
| Serious Incidents reporting | Nil | 67 |
| Breaches of 'Duty of Candour' requirements | Nil | 0 |
| Reported Never Events | Nil | 2 |
| Prevention of Future Death Notices from HM Coroner | Nil | 7 |
| Trolley waits in A&E (12 hours +) | Nil | 0 |
| Responsive Service Provision | | |
| Less than 4-hour wait in A&E- Types 1 and 3 activity | 95% | 89.65% |
| Less than 4-hour wait in A&E- Type 1 activity only | N/A | 83.2% |
| Referral to treatment-complete pathways at 18 weeks | 92% | 92.61% |
| Referral to treatment- incomplete pathways at 52 weeks | Nil | 1 |
| Outpatient DNA rate | 6.5% | 8.31% |
| Last-minute cancelled operations | 0.8% | 1.08% |
| Urgent operations suffering a second cancellation | Nil | 0 |
| Delayed Transfer of Care (days) | N/A | 7,244 |

| | Target | Actual |
|---|---|---|
| Caring Service Provision | | |
| Friends and Family Test- positive responses (all) | N/A | 90.92 |
| Friends and Family Test- response rate (A&E and Inpatients) | 20% | 22.29% |
| Complaints received | N/A | 467 |
| Complaints responded to within the agreed timescale | 90% | 93.2% |
| Complaints upheld by the Health Service Ombudsman | Nil | 3 |
| RIDDOR incidents reported | Nil | 19 |
| Calendar days lost to staff accidents | N/A | 173 |
| Staff Accident Rate | 10 | 0.3 |
| Staff Attendance | 96% | 94.97% |
| Effective Service provision | | |
| Outpatient utilisation | 92% | 87.6% |
| Theatre Utilisation | 90% | 86.8% |
| Discharge Summaries- A&E issued within 48 hours | 95% | 51.6% |
| Discharge Summaries- Inpatients issued within 48 hours | 95% | 81.2% |
| Discharge Summaries- Outpatients issued within 5 days | 95% | 88.1% |
| Well-Led Service provision | | |
| HAS turnover | 95% | 94.8% |
| Ambulance handover- between 30 and 60 minutes | 30 | 629 |
| Ambulance handover- greater than 60 minutes | 10 | 199 |
| Capital Service capacity | -2.7 | -2.5 |
| Liquidity (days) | (80.6) | (60.7) |
| Income and Expenditure margin | (£22,088,000) | (£22,726,000) |
| Delivery of efficiency schemes | £9,134,000 | £10,038,000 |
| Spend on agency staffing | £6,599,000 | £10,771,000 |
| Use of Resources rating | 3 | 3 |
| NHS Improvement rating- Single Oversight Framework | 1 | 3 |
| CQC Rating | N/A | Good |

Certain figures in the above table are not available to the end of March 2018 at the date of publication of this report, as the underlying processes to produce the data could not be completed in the time available.

The Board receives exception reports where performance has not reached expectations, setting out the reasons for the position and the actions that management proposes to take to move back to compliance. Exception reports are also presented for certain items, whether or not performance is below expectation, where there are regulatory expectations to that effect.

The Board has set the KPI's in part to assist it in assessing the level of assurance available

regarding the risks to strategic performance set out in the Board Assurance Framework, maintaining compliance with CQC minimum requirements, and the requirements of the NHS Improvement Licence. During the year, the Trust has been developing robust systems for KPI identification and measurement in respect of Community services, having determined that the systems in place when services were transferred to the Trust did not provide sufficient assurance. There are no national standard indicators for these services, so the Trust is engaging in leading-edge development in this area. The Board expects that it will be able to set KPI's and begin monitoring during the course of the 2018-2019 year.

For each indicator, there is a level of uncertainty as to the achievement possible during the course of the year, which generally reduces (either positively or negatively) as the year progresses and there is less time for changes to be given effect  There is also environmental uncertainty, given that factors affecting performance may well be outside of the control of the Trust; for example, the prevailing weather conditions or political choices that affect funding or quality requirements for services. For each indicator there is also a risk that the Trust will fail to achieve the set performance. It is management's responsibility to ensure that all available actions are taken to achieve targets, and the Board will hold management to account for the actions that are taken. Equally, however, external factors beyond any reasonable anticipation or control may influence performance.

Development and performance through the year

Financial Performance

Income and Expenditure Summary

The Trust planned for a deficit position of £24.3m for the 2017/18 financial year. The year-end adjusted deficit is £23.7m, £0.6m better than planned. The improvement in the Trusts position relates to a National allocation received in December of £0.6m, which was mandated to be utilised to improve the Trust's deficit position.

The table below shows the summary statement of the Trust financial position:-

| | Actual 2016/17 £'000 | Plan 2017/18 £'000 | Actual 2017/18 £'000 | Variance £'000 | Plan 2018/19 £'000 |
|---|---|---|---|---|---|
| **Revenue:** | | | | | |
| Operating income from patient care activities | 188,196 | 194,543 | 198,304 | **3,761** | 199,405 |
| Other operating income | 24,227 | 10,209 | 14,454 | **4,245** | 9,600 |
| Operating expenses | (222,494) | (224,864) | (230,913) | **-6,049** | (229,253) |
| **Operating Deficit from continuing operations** | **(10,071)** | **(20,112)** | **(18,155)** | **1,957** | **(20,248)** |
| **Finance Costs:** | | | | | |
| Finance income | 22 | 25 | 28 | **3** | 25 |
| Finance expenses | (3,926) | (4,419) | (4,317) | **102** | (5,607) |
| Finance expenses - unwinding of discount | (7) | 0 | 0 | **0** | 0 |
| PDC dividends payable | 0 | 0 | (1) | **-1** | 0 |
| I&E Impairments | 0 | 0 | (50) | **-50** | 0 |
| **Net Finance Costs** | **(3,911)** | **(4,394)** | **(4,340)** | **54** | **(5,582)** |
| **Gains/(Losses) on Disposal** | **(11)** | 0 | **0** | **0** | **0** |
| **Deficit (including exceptional items)** | **(13,993)** | **(24,506)** | **(22,495)** | **2,011** | **(25,830)** |
| Exceptional Items | 672 | 159 | (1,232) | **(1,391)** | 132 |
| **Adjusted Deficit (excluding exceptional items)** | **(13,321)** | **(24,347)** | **(23,727)** | **620** | **(25,698)** |

The Trust's position has deteriorated from the 2016/17 deficit, although this relates almost entirely to a non-recurrent benefit received in 2016/17 of £9.5m for Sustainability and Transformation Funding (STF) from NHS Improvement.

Analysis of Income

The Trust received £212.8m of income in 2017/18 and the table below breakdown the income received:-

| | Actual 2016/17 £'000 | Plan 2017/18 £'000 | Actual 2017/18 £'000 | Variance £'000 | Draft Plan 2018/19 £'000 |
|---|---|---|---|---|---|
| **Income from Activities** | | | | | |
| CCGs and NHS England | 179,248 | 193,275 | 189,173 | **-4,102** | 192,540 |
| Local Authorities | 7,198 | 132 | 7,665 | **7,533** | 5,734 |
| Other | 1,750 | 1,136 | 1,466 | **330** | 1,131 |
| **Subtotal Income from Activities** | **188,196** | **194,543** | **198,304** | **3,761** | **199,405** |
| **Other Operating Income** | | | | | |
| STF | 9,428 | 0 | 0 | **0** | 0 |
| Other Operating Revenue | 14,799 | 10,209 | 14,454 | **4,245** | 9,600 |
| **Subtotal Other Operating Income** | **24,227** | **10,209** | **14,454** | **4,245** | **9,600** |
| **Total Revenue** | **212,423** | **204,752** | **212,758** | **8,006** | **209,005** |

The Trust has seen an increase in income of £0.3m between 2016/17 and 2017/18. This is in relation to:

- Income from activities – Increased by £10m when compared to 2016/17, primarily relating to:-
  - Income associated with the development of the Integrated Care Organisation funded by the GM and Social Care Partnership transformation funding.
  - Increases in Tariff.
  - National monies received to support winter pressures.

Other Income - has reduced by £9.8m, which relates almost entirely to Non-recurrent STF funding received from NHS Improvement in 2016/17.

Analysis of Expenditure

The table below sets out the Trust's planned and actual operating expenditure for 2017/18, also 2016/17 actual and 2018/19 plan as a comparative:-

| | Actual 2016/17 £'000 | Plan 2017/18 £'000 | Actual 2017/18 £'000 | Variance £'000 | Draft Plan 2018/19 £'000 |
|---|---|---|---|---|---|
| Employee expenses | 149,132 | 156,585 | 159,426 | **2,841** | 161,536 |
| Drugs | 9,454 | 9,800 | 10,084 | **284** | 10,632 |
| Clinical supplies | 16,028 | 16,238 | 14,878 | **-1,360** | 14,155 |
| Non clinical supplies | 4,035 | 3,238 | 4,610 | **1,372** | 2,532 |
| Depreciation and amortisation | 4,676 | 4,887 | 5,411 | **524** | 5,184 |
| Impairments of property, plant and equipment | 0 | 0 | -50 | **-50** | 0 |
| Redundancy | 0 | 0 | 23 | **23** | 0 |
| Misc other operating expenses | 39,169 | 34,116 | 36,531 | **2,415** | 35,214 |
| **Total** | **222,494** | **224,864** | **230,913** | **6,049** | **229,253** |

Impairments are not included in this analysis as they are excluded from the Use of Resources Risk Rating which is used by NHS Improvement to assess Trust financial performance.

The increase in financial expenditure of £8.4m between 2016/17 and 2017/18 is due to the following;

- Pay awards and Increments.
- Investments in staffing to improve quality and safety
- Revenue consequences of business cases to enhance the services provided by the Trust
- Revenue consequences of capital expenditure.
- Cost of borrowing to offset the Trust's deficit.
- Expenditure associated with the development of the Integrated Care Organisation funded by the GM and Social Care Partnership transformation funding.

The Trust is planning for £229m of expenditure in 2018/19.

Analysis of the Trust Efficiency Plan

The Trust delivered efficiency savings of £10m for 2017/18, £0.4m less than planned. This was £1.6m more than the Trust achieved in 2017/18. The table below indicates the savings over the last 2 years, plan and actual in 2017/18 and proposed plan for 2018/19:-

| | Actual 2015/16 £'000 | Actual 2016/17 £'000 | Plan 2017/18 £'000 | Actual 2017/18 £'000 | Variance £'000 | Draft Plan 2018/19 £'000 |
|---|---|---|---|---|---|---|
| Trust Efficiency Savings | 6,700 | 8,400 | 10,397 | 10,038 | (359) | 12,800 |
| % of Income | 4.1% | 4.0% | 5.0% | 4.2% | | 5.2% |

In 2018/19, the Trust is planning for a challenging £12.8m of savings; this includes £3.3m of Transformation funding.

Capital Spending

The Trust invested £4.8m in capital expenditure in 2017/18. A breakdown of the types of expenditure is shown in the table below;

| | Actual 2016/17 £'000 | Plan 2017/18 £'000 | Actual 2017/18 £'000 | Variance £'000 | Draft Plan 2018/19 £'000 |
|---|---|---|---|---|---|
| Estate and Facilities schemes | 1,130 | 447 | 1,504 | 1,057 | 1,638 |
| IM&T Schemes | 530 | 13,632 | 1,405 | -12,227 | 462 |
| Medical Equipment | 790 | 1,164 | 1,526 | 362 | 501 |
| Other | 485 | 0 | 393 | 393 | 199 |
| Organisational Development | 0 | 25,755 | 0 | -25,755 | 0 |
| Total Capital Expenditure | 2,935 | 40,998 | 4,828 | -36,170 | 2,800 |

The Trust is planning for capital investments of £2.8m in 2018/19. A new Computerised Tomography (CT) scanner (circ. £1 million) and the development of the A&E streaming (circ. £1.5

million) are schemes that are awaiting funding approval. These are not included within the detail above.

Cash Support

The Trust received Uncommitted Revenue Support loans from the Department of Health totalling £20.6m in 2017/18. These are repayable within the year 2020/21. The Trust now has a loan liability of £75.4m, which is currently repayable between 2018 and 2020. The 2018/19 annual plan assumes additional loans being granted in the year, totalling £25.8m.

Information about the Trust's performance on clinical matters, including the quality of service, is given in detail in the Quality Report.

Environmental Matters

The Trust recognises that its operations have an impact on the environment, particularly through the need to use fuel, electricity and specific consumable items in order to provide services to the required standards. It is the policy of the Board to minimise our impact on the environment, as far as possible, where that is consistent with our other obligations.

Detailed reporting about our environmental performance, together with our future strategy, can be found in the Sustainable Development section of this report on page 62.

Social, community and human rights

As a significant organisation in the local economy, the Trust recognises that it will have an impact on the local communities that it serves. In particular, as the main provider of secondary healthcare in the area, we are both a significant employer and contract with local suppliers for goods and services.

We seek to engage with the communities that we serve, in order both to inform the development of services and to understand the impact of our work on local communities. In particular, we are participating with the CCG and Tameside Council in a Public Engagement Forum structure, designed to enable us to obtain community feedback on various areas of policy development and delivery, with a particular focus on areas where policy development needs to be co-ordinated to be effective. We also benefit from the input of Governors, who have a statutory responsibility to represent the views of Trust Members and the public on the services provided by the Trust.

Information on the Trust's policies related to the employment of staff can be found in this report starting at page 31.

The Trust has adopted policies related to procurement that recognise that there may be advantages to locally-sourcing some products or services. Our policy, consistent with that of Government, is to ensure that local providers, and particularly small and medium-sized enterprises in the locality, obtain a fair opportunity to bid to provide goods or services when required by the Trust. Details of opportunities to bid are available on the national contracting service web-sites. All procurement exercises are undertaken in accordance with the Trust's local control systems, and also the *Public Contract Regulations 2015* where they apply.

As a public authority, the Trust is obliged to act in a way that protects and promotes human rights as defined under the *Human Rights Act 1998*. There are a number of areas where the work of the Trust may impact on the human rights of those utilising the services, including ensuring that consent is informed and a free choice; ensuring the liberty of the subject; and the prevention of prohibited discrimination to both staff, patients and the community. The policy of the Trust remains to protect and promote the human rights of those it deals with pro-actively, as far as possible within

the constraints of its working environment. In that respect, it sets out below a statement on compliance with the *Modern Slavery Act 2015*, although not formally bound by those provisions.

The Trust has adopted control systems, through the Standing Financial Instructions and other arrangements, to actively seek to prevent fraud, bribery and corrupt payments. A Local Counter-Fraud service is maintained to support the Trust in this area, and actively investigates allegations. During the year there have been a number of investigations, which have in appropriate cases resulted in both disciplinary and external action. This has included one criminal prosecution before the Crown Court, which resulted in a conviction for fraud-related offences.

Compliance with the *Modern Slavery Act 2015*

The Trust is understood not to be formally subject to the reporting provisions set out in Part 6 of the *Modern Slavery Act 2015*, as it is not a 'commercial organisation' as defined in the Act. However, the Board has decided that it will give an overview as if these responsibilities applied to the Trust. As part of the National Health Service, the majority of the supplies used by the Trust are obtained through the NHS supply chain arrangements, which operate nationally and provide support to all NHS providers. The NHS supply chain arrangements include arrangements to ensure that supplies provided to the NHS can be reasonably assured not to have involved slavery or human trafficking; and the Trust relies of these arrangements as its assurance for supplies obtained through the NHS supply chain.

For supplies obtained outside of the NHS supply chain arrangements, the Trust's procurement arrangements include undertakings by suppliers that the goods have been obtained in a manner compliant with the *Modern Slavery Act*, and that the appropriate checks have been undertaken for the earlier parts of the supply chain. The Trust retains a right of inspection if a query is raised as to the provenance of any goods supplied.

The Trust is also aware of the potential for certain operations, such as building works undertaken on site, to involve offences under the Act. We require contractors to provide proof that the individuals working on site are lawfully able to be present in the UK and to work, are paid and taxed according to law, and otherwise meet the requirements in place to comply with the *Modern Slavery Act*. These requirements are also imposed on any sub-contractors down the chain for works being undertaken on site.

Karen James
Chief Executive

23rd May, 2018

# Accountability Report

## Director's Report

Directors

During the course of the year, the following have served as Directors of the Trust-

Sallie Bridgen
Patricia Cavanagh
Paul Connollan (retired 31.10.17)
Anne Dray
Cathy Elliott
Anne Higgins (retired 31.1.18)
Karen James
Pauline Jones
Trish Kalloo (retired 31.5.17)
Jane McCall (appointed 8.1.18)
Tracey McErlain-Burns [a]
Peter Noble (appointed 5.2.18)
Brendan Ryan
Martyn Taylor
Claire Yarwood

a- Tracey McErlain-Burns was a Director, as Interim Chief Nurse, for two periods during sickness absence of Pauline Jones. She was a Director from 1st April 2017 to 28th September 2017, and again from 1st January 2018 to the date of approval of this report.

Paul Connellan served as Trust Chairman until his retirement as a Director on 31st October 2017. At that time, Anne Dray assumed office as the Acting Chairman until 8th January 2018, when Jane McCall took office as a Director and as Trust Chairman.

The Board appointed Anne Dray as Deputy Chairman and Senior Independent Director from 27th July 2017. This appointment continues until the conclusion of her term in December 2019.

Tom Neve was the Trust Secretary from 1st March 2017 until his retirement from the NHS on 9th June 2017. Steve Parsons, FCIS, joined the Trust on 3rd July 2017 as Trust Secretary.

Director's and Governors' Interests

During the year, the National Health Service introduced new national requirements and expectations for the management of potential conflicts of interest, with the aim to have a consistent approach across the service as a whole. This has led to a considerable increase in the range of interests expected to be declared, and in some cases requires declaration of interests whether or not the interest relates to the NHS. Directors also remain subject to the statutory requirements set out in S151(2) of the *Health and Social Care Act 2012*.

In accordance with the national guidance, information on the interests of the Directors and those in other groups identified in the national policy is available on-line, at https://tgicft.mydeclarations.co.uk. This information is available at all times, pro-actively published and updated in real-time with individuals able to directly update their entries.

Governors are outside of the scope of the new national policy, and the rules for the management of their interests are set out in the Standing Orders of the Council. Details of their declarations are available from the Trust Secretary.

Cost allocation and charging

Throughout the year ended 31st March 2018, and at all subsequent times until the approval of this annual report by the Board, the Trust has been compliant with the guidance on cost allocation and charging that has been issued for the NHS by Her Majesty's Treasury.

Payment to suppliers

The Trust is subject to the provisions of the *Public Contracts Regulations 2015*, which set out a requirement that all public bodies will pay all valid, undisputed invoices in a timely manner and in any event within 30 days of confirmation that they are valid and undisputed. The Trust does not participate in the *Better Payment Practice Code*, as the provisions of the Regulations set out the required statutory standard for the Trust.

The Trust's performance for the year ended 31st March 2018, calculated in accordance with Regulation 113(7) of the Regulations and reported in line with the requirements set out by NHS Improvement, is-

| | NHS Contracts | Other invoices | Total |
|---|---|---|---|
| Invoices paid within 30 days | 293 | 19,524 | 19,817 |
| Invoices required to be paid within 30 days | 1,699 | 46,175 | 47,874 |
| Proportion of those paid to required | 17.2% | 42.3% | 41.4% |

| | NHS Contracts | Other invoices | Total |
|---|---|---|---|
| Liability to interest under the *Late Payment of Commercial Debts (Interest) Act* | 0 | 10 | 10 |
| Interest actually paid under that Act | 0 | 10 | 10 |

Review of systems of internal control

Supported by the work of the Audit Committee and internal audit, the Board has reviewed the effectiveness of the systems of internal control in place during the course of the year. The review has been informed by the findings of the various internal audit reviews conducted during the year, together with relevant external reviews.

The outcomes of the Board's review are covered in the Annual Governance Statement, made by the Accounting Officer and bound into this report.

Quality Governance

NHS Improvement (as Monitor) has set out a framework for Foundation Trusts to follow in order to provide good governance in their operations, in the *Well-Led Framework*. As the successor to the Quality *Governance Framework*, this includes provisions specifically related to governing for quality; and the general provisions in the *Framework* are also applicable to the Trust's governance processes to ensure the quality of care and services. Having regard to the *Well-Led Framework's* provisions is a requirement under Condition G5 of the NHS Improvement Licence for providers, and informs compliance with Condition FT4.

The *Framework* sets out 8 key areas for review-

1. Leadership capacity and capability
2. Vision and Strategy
3. Culture of high-quality sustainable care
4. Clear responsibilities, roles and accountability
5. Effective risk management
6. Appropriate and accurate information
7. Involvement of service users, staff, public and stakeholders
8. Robust systems for learning, continuous improvement and innovation

In arriving at the overall evaluation of the Trust's performance that is set out at page 49, the Trust has had regard to the guidance in the *Well-Led Framework*. This has included reviewing the control systems in place, through the Quality & Governance Committee and the Audit Committee, against the *Framework's* guidance in order to provide the Board with robust positive assurance that the Trust is meeting these expectations. The Board is also supported by the various Committees in managing risk through the Board Assurance Framework. The risks on the Framework are reviewed at least annually following the adoption of that year's corporate objectives, to ensure the relevant risks are identified; and regularly monitored through the course of the year.

The Trust continues to maintain an improvement action plan for the Well-Led strand of the last inspection of services by the Care Quality Commission. The actions remaining on that plan are, of their nature, continuing; and positive progress is being made to improve in these areas. The action plan is regularly monitored by the Quality & Governance Committee.

The regular reviews of internal control systems undertaken by the internal audit service include action plans to address deficiencies, many of which will fall within the broad scope of the *Well-Led Framework*. Action plans from reviews are scrutinised in the first instance by the Audit Committee, and a six-monthly update on progress is provided to the Committee to ensure that all actions are implemented appropriately.

After careful review, the Board confirms that there are no material inconsistencies between the contents of this Annual Report and-

a. the Annual Governance Statement that starts at page 64;
b. The Corporate Governance Statement submitted to NHS Improvement, under Conditions G6 and FT4 of the NHS Improvement Licence, approved by the Board on 23rd May 2018;
c. the Quality Report that starts at page 75;
d. The report from the Care Quality Commission on the Trust, dated 7th February 2017.

Non-NHS Income

During the year, the Trust has received certain income beyond the provision of services for the purposes of the NHS in England, which we are required to report separately on under current legislation. The total income received in this was £525,000, and the split between the various categories can be seen in the Annual Accounts at note 2.1. The funds raised were re-invested in the services provided by the Trust.

The law requires that the Trust ensures that its income from goods or services provided for the purposes of the health service in England exceeds its income from goods or services provided for other purposes. In the year, the Trust complied with this requirement.

Director's disclosure to the Trust Auditors

The Directors, individually and collectively, acknowledge their responsibility for the accuracy and reliability of the contents of this Annual Report. Each individual who is a Director of the Trust at the date of the approval of this Report confirms that-

a. So far as each Director is aware, there is no relevant audit information which the Auditor is unaware of;
b. Each Director has taken all steps that they should have taken as a Director, in order to (a) make themselves aware of any relevant audit information, and (b) establish that the Auditor was also aware of the information.

Director's responsibility for the Annual Report and Accounts

The Directors acknowledge that they are responsible for the accuracy and reliability of the contents of the Annual Report, the Quality Report and the Annual Accounts for the year ended 31st March 2018. The Board has been supported by its Committees in the preparation of these documents, and by the Internal Audit service and the external auditors; however, the responsibility for the contents of the documents remains with the Directors themselves.

Having carefully reviewed the contents of the documents, and taking into account the advice of the Audit Committee and the Quality and Governance Committee, the Directors consider that taken as a whole the Annual Report and Accounts are fair, balanced, and understandable; and provides the information necessary for patients, regulators and other stakeholders to be able to assess the Trust's performance, business model and strategy.

# Remuneration Report

## Annual Statement on Remuneration

I am pleased to be able to present the report of the Board's Nomination and Remuneration Committee, related to Executive Director remuneration in the year.

During the year, the following major decisions have arisen for the Committee-

- Reviewing the remuneration of the Executive team, in the light of the national award of 1% rises for both *Agenda for Change* and Medical Contract staff. The Committee determined to give a 1% award to Executive team colleagues.
- Arrangements to provide for appropriate cover for the Director of Nursing during her long-term absence through illness.
- Arrangements for the appointment of a new Director of Finance, replacing Claire Yarwood as she moved on.

The context in which the Committee considered these matters was the need to ensure that the Trust is able to recruit and retain an Executive team that is able to provide the necessary leadership to the Trust and its staff, in a challenging situation, whilst not over-rewarding. This is clearly a difficult balance, and the Committee has regard to the various benchmarking information available in reaching its judgements. During the year NHS Improvement published more detailed expectations for salary ranges across various types of NHS provider organisations. These have been taken into account as appropriate.

*Non-Executive Directors*

On behalf of the Council's Nomination Committee, I am also pleased to be able to present the report on remuneration and service decisions related to the Non-Executive Directors. Whereas the Board's Committee has decision-making authority, the Council Committee can only make recommendations to the Council, who have sole authority under the law for making decisions.

During the year, there have been some significant changes to the Non-Executive team, including the appointment of myself as the new Chair of the Trust. As part of the process of appointing the new Chair, the Committee considered the remuneration for the position, and recommended to Council that no changes were made. The Non-Executive Directors continue to be paid a fee for service, at the same rate each, with additional payments (reflecting extra responsibilities) for those colleagues who serve as Chair of Audit Committee, Senior Independent Director and Deputy Chair. Council has not adjusted these during the course of the year.

Jane McCall
Chair of the Nomination and Remuneration Committee
Chair of the Council's Nomination Committee

## Policy on remunerating Directors

The Trust recognises that, in order to ensure that the Trust is led by Executive Directors with the skills, capacity and leadership required to provide an outstanding service to the public of the Tameside and Glossop area, it must adopt a remuneration policy that will attract and retain individuals with the necessary skills and personality. Equally, as an organisation funded by the public purse, it recognises that it must not pay excess amounts for the services of its Executive Directors, as this would not meet the requirement to be economic, efficient and effective.

The future policy on remuneration of Executive Directors, set by the Nomination and Remuneration

Committee, is as set out in the table on page 24.

As can be seen from the table on page 27, during the year two Executive Directors received more than £150,000 in remuneration. The Committee has considered whether these figures remain reasonable, given the objectives set out above and in the table of future policy. The Committee has concluded that it has positive assurance that these figures are reasonable, by means of comparison with the data available on pay rates for the equivalent positions in Trusts of comparative size; and also in regard to the tables published by NHS Improvement for the four quartiles of salary payments, set out by size of acute provider. In respect of the Medical Director, the Committee has also had regard to the level of remuneration that would be payable for a full-time Consultant of equivalent experience, recognising that the Medical Director also has additional responsibilities as a Director.

Regarding Non-Executive Directors, the current policy of the Council is to pay a reasonable fee for the services provided in office, having regard to the overall position of fees in the NHS and also that this is a public service position. The Non-Executive Directors are not retained on an employed basis, and are not eligible for secondary benefits such as pension provision in relation to their office.

Contract obligations

The Executive Directors have provisions in their service contracts that reflect the relevant provisions in the *Agenda for Change* provisions to provide for payments based on salary and length of service. Reckonable salary is capped at £80,000 and payments are based on one month's salary for each completed year of service, up to 24 month's payment. The maximum total payable is £160,000.

The Trust's approach to setting the notice period for Directors is that, unless specific circumstances indicate otherwise, a period of six months' notice on each side will be implemented. In line with relevant legislation and the *Code of Governance*, the notice period will only be shortened with the agreement of the Nomination and Remuneration Committee and following a risk assessment.

As noted above, the Trust provides contractual arrangements related to redundancy payments in appropriate circumstances. Where ill-health arises that means that an Executive Director cannot continue in office, they can also benefit from the statutory arrangements for ill-health retirement under the national pension scheme arrangements, managed by the NHS Business Services Authority.

All Executive Directors are eligible to participate in the statutory NHS Pension Scheme. This is a contributory scheme which provides benefits based on salary and length of service. Current joiners will obtain benefits based on an average of their salary across their service in the NHS; certain Directors will obtain benefits based on their final salary, as they joined the scheme when those benefits were offered. All participants obtain benefits related to their length of service in the NHS.

How we took into account other employees

In setting the remuneration of Executive Directors, the Nomination and Remuneration Committee takes into account a number of factors, including the national settlements in respect of other employees in the Trust. These are largely identified through the *Agenda for Change* and medical contract arrangements, negotiated between NHS Employers and the staff trade unions. For the 2017-2018 year, these arrangements gave staff (in general) a 1% increase in salary levels.

In setting remuneration for Executive Directors, the Nomination and Remuneration Committee has had regard to comparative information, including the information available through NHS Providers, in order to meet the twin goals of providing sufficient remuneration to recruit and retain Executive

Directors with sufficient knowledge and experience to lead the Trust, whilst not paying more than is required having regard to the duty to be economic, efficient and effective. The Trust has not consulted with staff or their representatives in setting the policy.

Future Remuneration policy table

| | How this component supports short and long-term objectives | How this component operates | Maximum payable | Recovery or withholding provisions |
|---|---|---|---|---|
| Salary | Appropriate salary enables the recruitment and retention of Executive Directors with the required skills, experience and talent. | Salary is paid *pro-rata* on a monthly basis, net of tax deductions, in accordance with the employment contract. | As per individual's contracts | There are no recovery or withholding provisions in respect of basic salary. |
| Bonus | The Committee considers that paying bonuses would not support the Trust's objectives. | N/A | N/A | N/A |
| Incentive schemes | The Committee considers that operating an incentives scheme would not support the Trust's objectives. | N/A | N/A | N/A |
| Notice periods | Having appropriate periods of notice enables the Trust to ensure smooth services during personnel changes | Each contract makes provision for the notice period to be served by the individual.<br>The Committee's policy is that the notice period should usually be six months. | N/A | The period of notice may only be shortened if the Committee is satisfied that there are appropriate alternative arrangements in place. |
| Benefits in Kind | No benefits in kind are offered, as the Trust considers them not to be necessary to support objectives. | N/A<br>Some Directors show taxable benefits in the table, owing to the operation of Inland Revenue rules. These are not benefits in kind but reflect expenses incurred. | N/A | Any improperly claimed benefits can be reclaimed (or their value) through contractual mechanisms. |
| Pension benefits | Provision of pension benefits encourages leaders to commit to the organisation.<br>There is a national defined-benefit scheme that salaried leaders automatically enter. | Each Executive Director participates in the NHS Pension Scheme arrangements, under the relevant statutory Regulations. | Trust contribution of 14.3% of salary | There are no withholding provisions for the Trust.<br>Recovery, or withholding of pension payments, is a matter for NHS Business Services and governed by the relevant statutory Regulations. |

The policy statements above represent the current view of the Committee. The Committee is aware that the Department of Health is considering issuing updated guidance to the NHS regarding the contractual arrangements for Executive Directors. Dependent on the contents of that guidance, which may be issued in a way to be compulsory on the Trust, the policy statements above may need to be updated.

Members of the Nomination and Remuneration Committee, and attendance

All of the Non-Executive Directors served as members of the Committee during the year, under the Chairmanship of first Paul Connellan, and then Jane McCall. The Committee met once during the year, and all members of the Committee attended.

The Committee's work during the year has been supported by the following-

- Amanda Bromley, Director of HR
- Karen James, Chief Executive
- Tom Neve, Company Secretary (until June 2017)
- Steve Parsons, Trust Secretary (from July 2017)

Service Contracts

| | Date of contract | Unexpired term | Notice period |
|---|---|---|---|
| Karen James | October, 2014 | Permanent contract | 6 months |
| Claire Yarwood | January, 2015 | Permanent contract | Leaving 31st May 2018 |
| Brendan Ryan | October, 2014 | Permanent contract | 6 months |
| Pauline Jones | February, 2016 | Permanent contract | 6 months |
| Patricia Cavanagh | August, 2014 | Permanent contract | 6 months |
| Tracey McErlain-Burns | February, 2017 | 31st October, 2018 | 3 months |

Members of the Council's Nomination Committee, and attendance

| | May 2017 | November 2017 | December 2017 |
|---|---|---|---|
| Paul Connellan | Interest | | |
| Gary Howard | X | | |
| Sally Lewcock | | x | X |
| Jane McCall | | | |
| John Phillips | X | x | X |
| Chris Webster | X | x | x |

The Committee's work during the year has been supported by the following-

- Amanda Bromley, Director of HR
- Karen James, Chief Executive
- Tom Neve, Company Secretary (until June 2017)
- Steve Parsons, Trust Secretary (from July 2017)

Expenses for Directors and Governors

*Directors*

| | 2017-2018 | 2016-2017 |
|---|---|---|
| Total number of Directors in office | 16 | 16 |
| Number of Directors receiving expenses for the year | 4 | 7 |
| Aggregate sum of expenses paid to Directors in the year | £400 | £1,600 |

*Governors*

| | 2017-2018 | 2016-2017 |
|---|---|---|
| Total number of Governors in office | 29 | 32 |
| Number of Governors receiving expenses for the year | 0 | 0 |
| Aggregate sum of expenses paid to Governors in the year | £0 | £0 |

# Remuneration Information

## Single Total Remuneration Figure

Information for year ended 31st March, 2018

| Name & Title | | Salary (bands of £5,000) | Expense Payments (taxable) to the nearest £100 | Performance pay and bonuses (bands of £5,000) | Long term performance pay & bonuses (bands of £5,000) | All pensions related benefits (bands of £2,500) | Total (bands of £5,000) |
|---|---|---|---|---|---|---|---|
| **Mrs K James** | | 160-165 | 0 | N/A | 0 | 47.5-50 | 210-215 |
| **Chief Executive** | | | | | | | |
| **Mrs C Yarwood** | | 130-135 | 0 | N/A | 0 | 50-52.5 | 180-185 |
| **Director of Finance** | | | | | | | |
| **Mr B Ryan** | | 165-170 | 0 | N/A | 0 | 65-67.5 | 230-235 |
| **Medical Director** | | | | | | | |
| **Mrs P Cavanagh** | | 110-115 | 0 | N/A | 0 | 67.5-70 | 180-185 |
| **Executive Director of Clinical Services** | | | | | | | |
| **Ms A Bromley** | | 90-95 | 0 | N/A | 0 | 35-37.5 | 125-130 |
| **Director of Human Resources** | | | | | | | |
| **Mrs Pauline Jones** | | 100-105 | 0 | N/A | 0 | 30-32.5 | 130-135 |
| **Chief Nurse** | | | | | | | |
| **Mrs T McErlain-Burns (Note 2)** | | 110-115 | 0 | N/A | 0 | 35-37.5 | 150-155 |
| **Interim Chief Nurse** | | | | | | | |
| **Mr P Connellan (Note 3)** | | 20-25 | 0 | N/A | 0 | 0 | 20-25 |
| **Chair** | | | | | | | |
| **Mr M Taylor** | | 10-15 | 0 | N/A | 0 | 0 | 10-15 |
| **Non-Executive Director** | | | | | | | |
| **Miss T Kalloo (Note 4)** | | 0-5 | 0 | N/A | 0 | 0 | 0-5 |
| **Non-Executive Director** | | | | | | | |
| **Mrs Anne Dray (Note 5)** | | 20-25 | 0 | N/A | 0 | 0 | 20-25 |
| **Deputy Chair & SID/Audit Committee Chair** | | | | | | | |
| **Ms A Higgins (Note 6)** | | 10-15 | 0 | N/A | 0 | 0 | 10-15 |
| **Non-Executive Director** | | | | | | | |
| **Ms C Elliott** | | 10-15 | 0 | N/A | 0 | 0 | 10-15 |
| **Non-Executive Director** | | | | | | | |
| **Ms S Bridgen** | | 10-15 | 0 | N/A | 0 | 0 | 10-15 |
| **Non-Executive Director** | | | | | | | |

Note 1: Mrs G Parker retired on the 31/03/17

Note 2: Mrs T McErlain-Burns commenced on an interim basis covering the role of Chief Nurse. This was initially as a contractor. The post was then transferred to a payroll arrangement in May 2017.

Note 3: Mr P Connellan term of office ended on 31/10/2017

Note 4: Miss T Kalloo retired on 31/05/2017

Note 5: Mrs Anne Dray was appointed as the Deputy Chair and Senior Independent Director in September 2018. She was Acting Chair from 1st November 2017 to 7th January 2018.

Note 6: Ms A Higgins retired on 31/01/2018

Note 7: Mrs J McCall commenced on the 08/01/2018

Note 8: Mr P Noble commenced on the 05/02/2018

Year ended 31st March, 2017

| Name & Title | Salary (bands of £5,000) | Expense Payments (taxable) to the nearest £100 | Performance pay and bonuses (bands of £5,000) | Long term performance pay & bonuses (bands of £5,000) | All pensions related benefits (bands of £2,500) | Total (bands of £5,000) |
|---|---|---|---|---|---|---|
| **Mrs K James** | 160-165 | 2 | N/A | 0 | 55-57.5 | 215-220 |
| **Chief Executive** | | | | | | |
| **Mrs C Yarwood** | 125-130 | 6 | N/A | 0 | 50-52.5 | 175-180 |
| **Director of Finance** | | | | | | |
| **Mr B Ryan** | 165-170 | 0 | N/A | 0 | 75-77.5 | 240-245 |
| **Medical Director** | | | | | | |
| **Mrs P Cavanagh** | 110-115 | 3 | N/A | 0 | 67.5-70 | 175-180 |
| **Executive Director of Clinical Services** | | | | | | |
| **Ms A Bromley** | 90-95 | 1 | N/A | 0 | 35-37.5 | 125-130 |
| **Director of Human Resources** | | | | | | |
| **Ms G Parker (Note 1)** | 85-90 | 1 | N/A | 0 | 30-32.5 | 120-125 |
| **Director of Estates and Facilities** | | | | | | |
| **Mrs Pauline Jones** | 120-125 | 1 | N/A | 0 | 75-77.5 | 200-205 |
| **Chief Nurse** | | | | | | |
| **Mrs T McErlain-Burns (Note 2)** | 25-30 | 0 | N/A | 0 | 0 | 25-30 |
| **Interim Chief Nurse** | | | | | | |
| **Mr P Connellan (Note 3)** | 40-45 | 0 | N/A | 0 | 0 | 40-45 |
| **Chair** | | | | | | |
| **Mr M Taylor** | 10-15 | 0 | N/A | 0 | 0 | 10-15 |
| **Non-Executive Director** | | | | | | |
| **Miss T Kalloo (Note 4)** | 10-15 | 2 | N/A | 0 | 0 | 10-15 |
| **Non-Executive Director** | | | | | | |
| **Mrs J Soboljew** | 5-10 | 0 | N/A | 0 | 0 | 5-10 |
| **Non-Executive Director** | | | | | | |
| **Mrs Anne Dray (Note 5)** | 10-15 | 0 | N/A | 0 | 0 | 10-15 |
| **Deputy Chair & SID/Audit Committee Chair** | | | | | | |
| **Ms A Higgins (Note 6)** | 10-15 | 0 | N/A | 0 | 0 | 10-15 |
| **Non-Executive Director** | | | | | | |
| **Ms C Elliott** | 0-5 | 0 | N/A | 0 | 0 | 0-5 |
| **Non-Executive Director** | | | | | | |
| **Ms S Bridgen** | 0-5 | 0 | N/A | 0 | 0 | 0-5 |
| **Non-Executive Director** | | | | | | |

## Total Pension Entitlement

Information for the year ending 31st March, 2018

| Name and Title | Real Increase in pension at pension age (bands of £2,500) | Real Increase in pension lump sum pension age (bands of £2,500) | Total accrued pension at pension age at 31 March 2018 (bands of £5,000) | Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000) | Cash Equivalent Transfer Value at 1 April 2018 | Real increase in Cash Equivalent Transfer Value | Cash Equivalent Transfer Value at 31 March 2017 | Employers contribution to stakeholder pension |
|---|---|---|---|---|---|---|---|---|
| **Mrs K James** | 2.5-5 | 7.5-10 | 65-70 | 200-205 | 1,453 | 1,322 | 131 | - |
| *Chief Executive* | | | | | | | | |
| **Mrs C Yarwood** | 2.5-5 | 0-2.5 | 50-55 | 145-150 | 1,010 | 918 | 93 | - |
| *Director of Finance* | | | | | | | | |
| **Mr B Ryan (Note 1)** | 2.5-5 | 10-12.5 | 70-75 | 210-215 | N/A | N/A | N/A | - |
| *Medical Director* | | | | | | | | |
| **Mrs P Cavanagh** | 2.5-5 | 2.5-5 | 45-50 | 135-140 | 926 | 822 | 103 | - |
| *Executive Director of Clinical Services* | | | | | | | | |
| **Ms A Bromley** | 0-2.5 | 0-2.5 | 25-30 | 70-75 | 414 | 367 | 47 | - |
| *Director of Human Resources* | | | | | | | | |
| **Mrs Pauline Jones** | 0-2.5 | 2.5-5 | 30-35 | 95-100 | 706 | 638 | 68 | - |
| *Chief Nurse* | | | | | | | | |
| **Mrs T McErlain-Burns** | 0-2.5 | 5-7.5 | 50-55 | 160-165 | 1,091 | 1,017 | 74 | - |
| *Interim Chief Nurse* | | | | | | | | |

**Note 1-** Mr Ryan has passed pensionable age, and there is therefore no CETV value available in relation to his pension benefits.

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 disclosures apply. 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 guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, 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 multiple

Foundation Trusts are required to disclose the relationship between the remuneration of the highest-paid Director in their organisation, and the medical remuneration of the organisation's workforce. During the year (with previous year for comparison), the ratio for the median remuneration for staff, and the mid-point of the remuneration band for the highest-paid Director (Mr B Ryan), was-

| | 2017-18 | 2016-17 |
|---|---|---|
| Median remuneration for all staff except Directors | £22,690 | £22,486 |
| Mid-point of the band of the highest-paid Director | £167,500 | £167,500 |
| Ratio | 7.38:1 | 7.45:1 |

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

There have been no significant changes to this structure during the 2017-2018 year.

Payments for loss of office

No payments were made for loss of office in respect of any Director who retired from the Board during the year.

Payments to past senior managers

The Trust made no payments during the year to any individuals who had previously been Directors.

Karen James
Chief Executive

23rd May, 2018

# Staff Report

Introduction

The Trust recognises that our staff are our greatest resource, delivering services to patients and ensuring that they are cared for to the highest standards. In providing a modern service of health care, we employ a range of colleagues from Consultants to Domestics; but we recognise that they all bring their own vital skills to our operations, and we could not operate without their contribution. Accordingly, we recognise that we have a responsibility to all staff to ensure that they are treated fairly, have the opportunity to maintain and advance their skills, and have a legitimate interest in the operation of the Trust as a public provider of healthcare services. The Board has decided to establish a Workforce Committee to ensure that there is an appropriate governance focus on the workforce issues and challenges that arise.

A significant challenge for the Trust, in common with most NHS provider organisations, is the recruitment and retention of a sufficient number of staff with the right skills to provide the services that the Trust has responsibility for. There are national debates regarding a number of areas of clinical education and training, most topical of which has been the Nurse Bursary Scheme, and the impacts of changes in policy on the number of candidates available to join the NHS. There is also a significant time-lag between changes in policy and potential effects on staff supply, as it takes a number of years for individuals to undertake training in order to become qualified as clinical colleagues. There are also specific services where skilled staff are recognised to be nationally (and in some cases, internationally) in short supply. During the year, the Board has agreed specific recruitment and retention strategies for medical and nursing positions, in order to address both the immediate and longer-term challenges recruitment and retention challenges.

The Board is also extremely pleased that the Trust's work on staff retention has been recognised within the Greater Manchester Region and nationally by our regulator NHS Improvement as delivering positive outcomes and an opportunity for other organisations to learn from. NHSI provided excellent feedback on our progress and invited us to speak about our journey at the NHSI national workforce conference.

The Board has also recognised that, as a smaller NHS provider organisation on the edge of a substantial metropolitan area, there are specific local challenges that we face in the recruitment and retention of staff. These reflect having larger organisations, with a more varied range of specialities, available in Greater Manchester on easy transport routes and with potentially greater opportunities to progress. The Trust has adopted an approach to develop our own staff, recognising their skills and experience offer the opportunity to meet some of the challenges without needing to seek outside recruitment. This includes the development and training strands discussed below.

As a relatively new Integrated Care Organisation, capacity, productivity and skill mix are currently a focus within our Community based services. Within District Nursing a New Models of Care work stream has been established, made up of Nurse team leaders and GP Leads. The core aim of the group is to pilot new initiatives, based on the outcome of an audit into District Nursing and the results of a workforce planning assessment, designed to address these capacity, productivity and skill mix issues. One such example is a pilot focussing on the feasibility of home care workers undertaking basic assessments or tasks that currently sit with the District Nurses. This will reduce reliance on the District Nurse team to provide basic assessments or tasks, with home care workers providing these services instead (e.g. provision of prescription eye drops). This should reduce duplication and improve productivity.

The Trust continues to operate a substantial training programme for staff, in order to ensure that they continue to maintain and develop their skills. The programme is underpinned by a compulsory

programme of training, focused on the skills needed from each type of role, in order to ensure that colleagues continue to meet the statutory and regulatory requirements in order to perform their role within the Trust. We also participate in regional programmes for continuing development of clinical colleagues, and of our support staff. The Board regularly reviews the Trust's performance against the targets it has set for training, and continues to seek to improve performance in this area.

The Trust has in place a comprehensive system of annual appraisal, which enables all staff to work within a structure of clearly-set objectives linked to the overall strategic objectives set by the Board. Colleagues are supported by regular in-year reviews of progress, and there is an annual appraisal meeting where performance overall is reviewed, and new objectives set. The appraisal process also identifies the development needs for colleagues, and the training and other support that can be provided during the course of the year. Managers are responsible for the completion of the appraisal processes for those who report to them, and completion rates form part of the manager's objectives and appraisal. A similar system operates to oversee the performance of the Non-Executive Directors, which is reported to the Council of Governors via the Council's Nomination Committee. Details of performance against the target for appraisals can be seen in the performance information on page 10.

Analysis of average staff costs

| | **Total** £000 | **Permanently employed total** £000 | **Other total** £000 |
|---|---|---|---|
| Salaries and wages | **118,201** | 114,916 | 3,285 |
| Social security costs | **10,914** | 10,914 | 0 |
| Apprenticeship levy | **539** | 539 | 0 |
| Pension cost - employer contributions to NHS pension scheme | **13,139** | 13,139 | 0 |
| Pension cost - other | **0** | 0 | 0 |
| Other post-employment benefits | **0** | 0 | 0 |
| Other employment benefits | **0** | 0 | 0 |
| Termination benefits | **0** | 0 | 0 |
| Temporary staff - external bank | **6,809** | | 6,809 |
| Temporary staff - agency/contract staff | **10,772** | | 10,772 |
| **TOTAL GROSS STAFF COSTS** | **160,374** | **139,508** | **20,866** |
| Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure | **(409)** | 0 | (409) |
| Recoveries from other bodies in respect of staff cost netted off expenditure | **0** | 0 | 0 |
| **TOTAL STAFF COSTS** | **159,965** | **139,508** | **20,457** |
| **Included within:** | | | |
| Costs capitalised as part of assets | **0** | 0 | 0 |
| Operating expenditure analysed as: | | | |
| Employee expenses - staff & executive directors | **159,092** | 138,635 | 20,457 |
| Research & development | **245** | 245 | 0 |
| Education and training | **605** | 605 | 0 |
| Redundancy | **23** | 23 | 0 |

| | Total | Permanently employed total | Other total |
|---|---|---|---|
| Internal audit costs | **0** | 0 | 0 |
| Early retirements | **0** | 0 | 0 |
| Special payments | **0** | 0 | 0 |
| **Total employee benefits excl. capitalised costs** | **159,965** | **139,508** | **20,457** |

Analysis of average staff numbers

During the course of the year, the average numbers of whole-time equivalent staff were-

| | Permanent | Other | 2017/18 Total | 2016/17 Total |
|---|---|---|---|---|
| Medical and dental | 284 | 72 | 355 | 353 |
| Ambulance staff | - | - | - | - |
| Administration and estates | 746 | 35 | 781 | 618 |
| Healthcare assistants and other support staff | 234 | 8 | 242 | 118 |
| Nursing, midwifery and health visiting staff | 1,444 | 256 | 1,700 | 1,330 |
| Nursing, midwifery and health visiting learners | - | - | - | - |
| Scientific, therapeutic and technical staff | 383 | 27 | 410 | 265 |
| Healthcare science staff | 49 | 1 | 51 | 56 |
| Social care staff | - | - | - | - |
| Agency and contract staff | - | - | - | - |
| Bank staff | - | - | - | - |
| Other | - | - | - | - |
| Total average numbers | 3,140 | 399 | 3,539 | 2,739 |

Gender Balance

| | Female | Male |
|---|---|---|
| Directors | 82% | 18% |
| Other senior managers | 64% | 36% |
| Employees as a whole | 82% | 18% |

The Board also notes that amongst medical staff the balance is 32% female to 68% male.

Sickness absence data

Details of the sickness absence of staff employed by the Trust is analysed as follows-

| | 2017/18 No. | 2016/17 No. |
|---|---|---|
| Total days lost | 36,921 | 34,193 |
| Total staff years | 3,281 | 2,913 |
| **Average working days lost (per WTE)** | **11** | **12** |

Staff policies, and actions to implement

The Trust recognises its responsibility, both as a major public provider and as a major employer, to provide equality of opportunity to all in the recruitment and employment process. We work hard to ensure that all 'protected characteristics' under the *Equality Act 2010* are treated fairly, including disability, whilst complying with the statutory requirements that our employees must be physically and mentally able to undertake the duties to be expected in their role.[1]

Applicants for roles who suffer from disabilities are given fair consideration in the recruitment process, and where possible adjustments and adaptations for both recruitment and employment will be positively considered. Where Trust employees have become disabled, we actively seek to retain them in employment where possible. They will be offered available roles that are consistent with their skills and abilities, or offered reasonable re-training to take available roles; and again, adjustments and adaptations will be positively considered where relevant.

Disabled employees are given equality of access to training and development opportunities, which will be identified for their individual circumstances through the appraisal process, in the same way as other employees. Where adoptions or adjustments are required in training to enable disabled colleagues to participate on an equal basis, these will be positively considered.

The Trust recognises the need to ensure that it has a continuing dialogue with its employees, to ensure that they have a better understanding of the objectives, aims and environment for the Trust's work; and also so that their concerns and suggestions for improvement can be received and considered. The Trust has in place a number of formal and informal processes to support this exchange of information.

There are regular formal meetings with the representatives of the Trust's employees through the consultative committee arrangements. There are two main consultative committees, reflecting national arrangements, covering medical and other staff respectively. These groups are formally consulted on policy developments, and also provide an opportunity for representatives to discuss with management issues of concern to the workforce. Employee representatives are also members of the Health and Safety Committee, in accordance with statutory requirements.[2]

There are also a number of informal methods that staff can use to obtain information about the development of the Trust, and raise any concerns or suggestions for improvement. These include 'Open House Forum', where the Chief Executive and the Executive team present directly to staff on the Trust's current operations and developments, and staff can raise points directly with the Executive Directors. These events are carried out both in the acute hospital and community settings, recognising that both groups of staff are important to the delivery of the Trust's objectives.

As a Foundation Trust, staff representatives have a formal position in the governance of the Trust, through the election of Staff Governors to Council. All staff are represented by a Governor, and all staff are eligible to seek election and to vote in choosing who should be elected.[3] Staff Governors

1 *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*, Regulation 19.
2 *Health and Safety at Work &ct Act 1974*, Section 2(6).
3 Directors would not be eligible to sit as a Governor if elected, under the current legislation.

have an equal voice and vote in Council meetings, and contribute to Council as a whole fulfilling its statutory duties to hold the Board to account through the Non-Executive Directors. The Trust continues to encourage staff to consider standing for election to Council, and to participate in the electoral process through the use of their votes.

As a public sector body, the Trust is committed to ensuring that fraud and corruption are minimised, detected and deterred. The Trust has clear policies in place to prevent corruption, and these take into account the statutory requirement to ensure that the Trust operates economically, efficiently and effectively. The Trust is supported in preventing fraud and corruption by the work of the Local Counter-Fraud Service, and more details on their work can be found in the report of the Audit Committee on page 56. Staff have direct access to the LCFS to raise any concerns.

Where potential fraud or corruption is detected, the Trust's policy is to respond robustly but proportionately. Disciplinary action will be commenced where there is appropriate evidence of misconduct, and referral to professional regulators will also be considered where appropriate. As can be seen in the Audit Report, criminal prosecution will also be considered where the evidence meets the relevant tests for the Crown Prosecution Service.

Recruitment and Retention

The Trust has put in place a Retention Action Plan, originally commissioned by NHS Improvement, to support the Trust (as part of a cohort of organisations) to reduce turnover amongst registered nurse. The target was for registered nursing turnover to reduce to 11.5% by end of March 2018, with an aspirational aim of 11%. Since its introduction in 2017, overall nursing turnover has reduced from the NHS Improvement baseline of 16.1% to reach 11.6% in March 2018.

The Trust had been identified by NHS Improvement as a Trust whose retention action plan demonstrates good practice, which can be shared with other Trusts. Particular learning is seen in the staff engagement work that the Trust has undertaken; how the Trust has developed the *#TeamTameside&Glossop* brand; and leadership displayed by the nursing and HR teams to achieve these improvements. The Trust was invited to present its journey at the NHS Improvement national workforce conference, and at a regional Masterclass session.

Latest initiatives to support nursing retention include:

- Rotational opportunities for nurses to experience different areas of the organisation, in order to develop their clinical or professional skills.
- Consideration of pilots for self-rostering, including on the Integrated Surgical & Gynaecology Unit.
- “Star” e-cards for staff will be launched with a pilot group of Kate Granger professionals. This will give the opportunity to quickly and easily generate “well done” e-cards congratulating staff on good practice.

A similar Retention Action plan has also been developed for Medical staff. The overall turnover rate for Medical staff is 14.3% and a target of 12% has been set for achievement by December 2018. Initiatives have been developed around medical recruitment, operational and professional support for doctors; flexible working opportunities; professional development opportunities, particularly for Trust Grade doctors; and reward initiatives such as Recruitment and Retention.

A specific intervention, to support the attraction of hard-to-recruit medical staff to our key vacancies, is a “medical recruitment pack” which integrates with the advert, job description and indicative job plan for medical roles. Launched with Divisions in April 2018, the pack outlines our recent ICFT journey, future plans, our USP as *#TeamTameside&Glossop* and a summary of our benefits package.

Facilities Time information

In accordance with the requirements of *The Trade Union (Facility Time Publication Requirements) Regulations 2017*, the Trust publishes the following information in relation to the year ended 31st March 2018. Compilation of the information is incomplete at the date of approval of the report; it will be published in full on the Trust web-site, by the end of July 2018, in accordance with the Regulations.

What was the total number of your employees who were relevant union officials during the year?

| Number of employees who were relevant union officials during the year | Full-time equivalent employee number |
|---|---|
| 15 | 13.17 |

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time? [4]

| Percentage of time | Number of employees |
|---|---|
| 0% | 0 |
| 1% to 50% | 1 |
| 51% to 99% | 1 |
| 100% | 0 |

Determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period. [5]

| | |
|---|---|
| Total cost of facility time | £20,112 |
| Total pay bill | £159,965,000 |
| Cost of facility time as a percentage of pay bill | 0.013% |

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

At the time of approval of the report, this information is not accurately available. It will be provided in the publication at the end of July 2018.

[4] Two members of Trust staff have an agreed and fixed amount of facilities time, reflected in the table. Other staff receive facility time release on an *ad hoc* basis. Final information on *ad hoc* release was not available at the writing of this report, and is not included in this table.

[5] This table has been calculated based on the amounts paid for the two individuals with agreed fixed facility time.

# Staff Survey

Overview

The Trust is committed to engagement with all of our staff, and has a number of formal and informal arrangements in place to support this aim. In additional to formal consultation mechanisms with staff representatives, the Trust has in place a number of forums, led by the Chief Executive, which enable staff to hear about developments and express opinions.

The Trust also participates in the two main schemes for obtaining staff feedback- the national Staff Survey, and the staff 'Friends and Family' test. This section covers the results of the staff survey reported in March 2018; with the staff 'Friends and Family' test being covered within the Quality Report. The Board has considered the results of the staff survey, and has approved the action plan as set out later in this section. It also regularly receives the results of the Staff 'Friends and Family' test, and challenges the management actions proposed as a result.

Summary of performance

The engagement score for the Staff Survey was 3.89, which compares positively to the score of 3.78 across the combined Community & Acute Trusts sector. Our ranking was seventh of the 43 Trusts in this group, keeping us in the top 20% for responses.

Looking specifically at engagement, we were ranked second of the eight Trusts in GM, and top amongst Community and Acute combined providers. The engagement score is derived from a combination of questions on the survey measuring the commitment and enthusiasm colleagues have for their roles and for the Trust.

Overall performance in the survey continued to be satisfactory, with 21 of the 32 areas covered in the survey showing as better than the average across the Community & Acute Trusts group. In four areas, the Trust had the highest score for Trusts in the comparator group.

| TOP FIVE RANKING SCORES | Trust Score 2017 | National Average for CA&CT | Trust Score 2016 |
|---|---|---|---|
| KF2. Staff satisfaction with the quality of work and care they are able to deliver (the higher the score the better, highest is 5) | 4.16 | 3.90 | 4.11 |
| KF4. Staff motivation at work (the higher the score the better, highest is 5) | 4.01 | 3.91 | 4.03 |
| KF8. Staff satisfaction with level of responsibility and involvement (the higher the score the better, highest is 5) | 4.05 | 3.89 | 4.06 |
| KF24. Percentage of staff / colleagues reporting most recent experience of violence (the higher the score the better) | 81% | 67% | 83% |
| KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month (the higher the score the better) | 94% | 91% | 96% |

| BOTTOM FIVE RANKING SCORES | Trust Score 2017 | National Average for CA&CT | Trust Score 2016 |
|---|---|---|---|
| KF20. Percentage of staff experiencing discrimination at work in the last 12 months | 10% | 10% | 8% |
| KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (the lower the score the better) | 14% | 14% | 13% |
| KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (the lower the score the better) | 28% | 27% | 25% |
| KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse (the higher the score the better) | 47% | 47% | 46% |
| KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (the lower the score the better) | 29% | 29% | 24% |

The Board recognises that, despite the overall positive results from the survey, there are areas where the survey shows that the Trust needs to improve, as our staff are identifying areas of concern. These include-

- Harassment and Bullying; The survey has shown 28% of respondents had experienced bullying, harassment or abuse in the year. These unacceptable behaviours are from patients, relatives or other members of the public whilst colleagues are attempting to provide care.
- Equal Opportunities; Staff's view of having an equal opportunity to progress their careers has dropped from 94% to 78%, with particular falls in Facilities and Medical Staff groups.
- Work stress; 33% of staff reported being unwell with stress related to work during the year. 49% reported attending work when feeling unwell owing to pressure from themselves, managers or other colleagues.

Our plans to improve

The Board has considered and agreed action plans as a result of the survey results, which will be monitored by the Workforce Committee on the Board's behalf. Actions that have been agreed to include-

- Aspirational interviews with Trust Grade Junior and Specialty doctors to understand what support/career development they would benefit from.
- A programme of resilience training throughout 2018 so that staff and teams can access tips and tools to increase their own resilience, and develop strategies to reduce levels of stress.
- Mental Health First Aid Training for Managers and Mental Health Champions.
- Conflict Resolution De-escalation training has been commissioned.
- A series of Focus Groups to be held at the end of April with BME staff, to explore their experiences in the workplace and further understand the survey results.
- Re-design of Equality and Diversity Training with a greater emphasis on discrimination.
- Benchmarking with other Trusts that have scored higher on those areas where we require improvement.

The actions above represent the key priorities identified by the Trust to improve the feedback being received from staff. The mechanisms in place are expected to remain, as in previous years, both direct through the national Staff Survey and the quarterly Staff 'Friends and Family' test; and informally through the various consultative and information forums that have been established. Additionally, the Trust will continue to benefit from the input of Governors elected to represent the staff in a formal capacity within the Trust's governance structures.

# High Off-Payroll arrangements

Policy towards 'off-payroll' arrangements

The Trust recognises that, on occasion, it is necessary to use the services of individuals who are only available as self-employed/ contractors ('off-payroll'). This may reflect particular market sectors, or the choice of individuals on how to structure their careers. Equally, the Trust is fully supportive of the principle that the NHS that it is not used to support aggressive tax avoidance practices, or practices that are questionable in terms of the tax effects.

The Trust will only utilise individuals on an 'off-payroll' basis on an exceptional basis, usually where the structure of the market means that individuals with the necessary skills and experience are not available on an employed basis. We will require all individuals to confirm, and if appropriate to evidence, that they are eligible to be paid gross and account for their own tax to HMRC, rather than being within 'Pay-As-You-Earn' arrangements operated through payroll.

Existing engagements at March 2018

This table reflects 'off-payroll' arrangements that are in place at the 31st March, 2018; pay more than £245 per day; and have been in place for six months or more

| | |
|---|---|
| Number of existing engagements at the 31st March, 2018 | 6 |
| The number of those engagements- | |
| • That have existed for less than a year | 4 |
| • That have existed for between one and two years | 2 |
| • That have existed for between two and three years | 0 |
| • That have existed for between three and four years | 0 |
| • That have existed for four years or longer | 0 |

The Board confirms that all arrangements for off-payroll services are risk-assessed to ensure that appropriate arrangements in respect of taxation are in place. Where appropriate, we will require assurance from the individual that their tax affairs reflect both the law and public expectations of the NHS, before they are engaged.

New engagements in the year

This table reflects new 'off-payroll' engagements made between 1st April 2015 and 31st March 2018, including those that exceeded 6 months in duration during the year; that paid more than £245 per day; and lasted longer than 6 months.

| | |
|---|---|
| Number of new engagements (including those exceeding 6 months) between 1st April 2017 and 31st March 2018 | 4 |
| Number assessed as within the scope of IR35 | 0 |
| Number assessed as not within the scope of IR35 | 4 |
| Of which: | |
| Number engaged directly (via PSC contracted to trust) and are on the trust's payroll | 0 |

| | |
|---|---|
| Number of engagements reassessed for consistency/assurance purposes during the year | 0 |
| Number of engagements that saw a change to IR35 status following the consistency review | 0 |

Board members and those with significant financial responsibility

This table sets out information on Board members, and those senior staff with significant financial responsibility, who were 'off-payroll' during the course of the year. For this table, there is no minimum pay level or length of contract applied.

| | |
|---|---|
| Number of off-payroll engagements of Board members and/or senior officials with significant financial responsibility during the financial year. | 1 |
| Number of individuals that have been deemed ‘board members and/or senior officials with significant financial responsibility’ during the financial year. This figure must include both off-payroll and on-payroll engagements. | 16 |

The individual who is identified in the table above as having been engaged on an 'off-payroll' basis was the Interim Director of Nursing. She was engaged on a short-term basis in order to provide cover during the absence of the substantive post-holder on a period of illness absence. A review of the market identified that, at that time, it was only possible to obtain someone with the required skills and experience to immediately pick up the challenges of the role, for the limited period anticipated, on this basis. The period of 'off-payroll' provision was 4 months, after which the individual moved onto the payroll as the arrangements had changed and the individual would be with the Trust for longer than previously anticipated.

# Exit payments

Staff Exit packages

| | Number of compulsory redundancies | | Number of other departures agreed | | Total number of exit packages by cost band | |
|---|---|---|---|---|---|---|
| | 2017-18 | 2016-17 | 2017-18 | 2016-17 | 2017-18 | 2016-17 |
| Less than £10,000 | 0 | 0 | 3 | 1 | 3 | 1 |
| £10,001 to £25,000 | 0 | 0 | 1 | 2 | 1 | 2 |
| £25,001 to £50,000 | 0 | 0 | 0 | 2 | 0 | 2 |
| £50,001 to £100,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| £100,001 to £150,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| £150,001 to £200,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total number of exit packages by type | 0 | 0 | 4 | 5 | 4 | 5 |
| Total resource cost (£) | £0 | £0 | £0 | £0 | £0 | £0 |

Non-compulsory departure payments

| | Number of agreements | | Total value of agreements (£'000's) | |
|---|---|---|---|---|
| | 2017-18 | 2016-17 | 2017-18 | 2016-17 |
| Voluntary redundancies, including early retirement- contract costs | 0 | 0 | 0 | 0 |
| Mutually-agreed resignations- contract costs | 0 | 0 | 0 | 0 |
| Early retirements in the interests of the efficiency of the service- contract costs | 2 | 5 | 14 | 112 |
| Contractual payments in lieu of notice period | 0 | 0 | 0 | 0 |
| Exit payments following Employment Tribunals or Court orders | 2 | 0 | 6 | 0 |
| Non-contractual payments, requiring approval of Her Majesty's Treasury [a] | 0 | 0 | 0 | 0 |
| Total | | | | |
| Of which: non-contractual payments requiring Treasury approval, made to individuals, where the payment value was more than 12 months' annual salary | None | None | None | None |

As a single exist package can be made up of several components, each of which is counted separately in this note, the total number above will not necessarily match the total numbers given in Note ?? to the Accounts, which will be the number of individuals.

[a.] Includes any non-contractual severance payment made following a judicial mediation, and £0 related to non-contractual payments made in lieu of notice.

The Remuneration Report on page 21 provides more detail on exit payments made to individuals named in that report (Directors, former Directors and other senior managers).

In respect of the amounts included in the table above as *Non-contractual payments, requiring approval of Her Majesty's Treasury*, the following were the maximum, minimum and median amounts-

| | 2017-18 | 2016-17 |
|---|---|---|
| Maximum | £0 | £0 |
| Median | £0 | £0 |
| Minimum | £0 | £0 |

# Director's Biographies

## Sallie Bridgen, Non-Executive Director

Sallie's career has been in housing and homelessness, working with Housing Associations, Local Authorities and charities. She has held senior positions at Shelter, the National Housing Federation, and Housing Diversity Network. She now works to improve integration between housing and health. She is a Group Director for Progress Housing Group, and a Trustee of Together Dementia Support.

Sallie is Chair of the Finance and Performance Committee. She also serves on the Quality & Governance Committee, Workforce Committee and the Nomination & Remuneration Committee. She is the Lead NED for Infection Control, Equality & Diversity, and Patient Safety.

## Trish Cavanagh, Chief Operating Officer

Trish joined the Board in July 2014 from University of South Manchester Foundation Trust, where she had been Associate Director of Operations. A registered nurse since 1986, and with an M.Sc. in Clinical Practice, Trish has long experience in operations and transformation in the NHS context.

Trish is responsible for the operational support provided to clinical functions in the Trust, including our community work and the contact-points with social care providers. She is also the lead for developing and implementing our transformational schemes, in partnership with local and regional partners. She is a member of the Workforce and Finance & Performance Committees.

## Anne Dray, Deputy Chair and Senior Independent Director

A qualified accountant, Anne has worked in senior positions in the NHS for most of the last 25 year, across both provider and commissioning organisations. She is currently undertaking senior interim NHS appointments, and is a member of the Expert Determination Pool for NHS England and NHS Improvement.

Anne was appointed as a Director in January 2014, and as the Deputy Chair and Senior Independent Director from September 2017. Her current term of office will end in December 2019.

Anne is the Chair of the Audit Committee, and also serves on the Finance & Performance and Nomination & Remuneration Committees. She is the Lead NED for Local Security Management Services, Local Counter-Fraud Services, Emergency Planning and Procurement.

| | |
|---|---|
|  | **Cathy Elliott, Non-Executive Director**<br><br>Cathy joined the Board in 2017 with a senior level background in the voluntary sector, and her current term is until February 2020. She currently undertakes a portfolio of work, including as Non-Executive Director for the Trust, in an independent Chair role for a national Fund for Department for Transport, a senior consultant advisor to the Power to Change Trust, and as a freelance philanthropy and social policy advisor. Cathy is a Senior International Fellow of the City University of New York, U.S.A; a postgraduate of Cass Business School, London, UK; a UK Clore Social Leadership Fellow; and a graduate of the University of Manchester, UK.<br><br>Cathy is the Chair of the Charitable Funds Committee, and also serves on the Finance & Performance, Quality & Governance, Workforce and Nomination & Remuneration Committees. She is the Lead NED for End of Life Care, Mortality reviews, and Maintaining Professional Standards (medical discipline). |
|  | **Karen James, Chief Executive and Accounting Officer**<br><br>Karen James joined the Trust in 2014, following a successful career in the NHS. Having started her career as a Registered Nurse, she has over the last fourteen years held a number of executive leadership roles in large acute tertiary providers. Karen has significant experience in managing large scale change across complex economies, and has been successful in the delivery of improvements in organisational performance.<br><br>Karen leads the Executive team, and also services on the Quality & Governance and the Finance & Performance Committees as Chief Executive. She is the statutory Accounting Officer for the Trust. |
|  | **Jane McCall, Chair**<br><br>Appointed as Trust Chair in January 2018, Jane has significant experience as a Non-Executive Director in the NHS, including at Stockport Foundation Trust and University Hospitals of South Manchester Foundation Trust; the latter as Deputy Chair. Her background is in social housing.<br><br>In addition to her role with the Trust, she holds Non-Executive positions with the Information Commissioner's Office, and is an external member of the House of Commons Commission.<br><br>Jane is the Chair of the Board and of the Council of Governors. She also Chairs the Nomination and Remuneration Committee of the Board, and serves on the Council's Nomination Committee. |
|  | **Tracey McErlain-Burns, Interim Chief Nurse**<br><br>Supporting the Trust during the illness of Pauline Jones, Tracey McErlain-Burns is a registered nurse with experience in a range of senior nursing and Board positions in the NHS, and at multi-agency level. Her most recent position prior to joining the Trust was as Director of Nursing for Rotherham Foundation Trust. Tracey has also supported the Trust with individual pieces of development work.<br><br>Tracey has a range of outside interests, including holding Her Majesty's commission as a Justice of the Peace. |

| | |
|---|---|
|  | **Peter Noble, Non-Executive Director**<br><br>Appointed to the Board in 2018, Peter has a long career in higher education and the NHS, most recently as Vice-President and Chief of Staff at the University of New South Wales. He has previously worked in the NHS in a number of locations and roles.<br><br>Peter is the Chair of the Workforce Committee. He also serves on the Audit Committee, the Quality and Governance Committee, and the Nomination and Remuneration Committee. He is a member of the Charitable Funds Committee. He is the Lead NED for Safeguarding Adults and Children. |
|  | **Brendan Ryan, Medical Director**<br><br>An active Consultant in Emergency Medicine, Brendan joined the Trust in 2014 from a similar role at University Hospitals of South Manchester Foundation Trust. Professionally, his particular incidents are in bereavement, pre-hospital care, and major incident planning/ response.<br><br>Brendan leads on medical-related issues, and serves on the Quality and Governance Committee and the Workforce Committee. He is also the Responsible Officer, leading the medical re-validation process for the Trust: and the Caldicott Guardian, responsible for ensuring the appropriate use of patient information. |
|  | **Martyn Taylor, Non-Executive Director**<br><br>Martyn is an Associate of the Chartered Institute of Bankers, and spent his career in banking. Prior to his retirement he led risk management related to troubled firms for a major bank, with a particular focus on the North of England. He also graduated from senior management development programmes at Harvard Business School and the Wharton University in Pennsylvania.<br><br>Martyn joined the Board in May 2015, and during the year Council agreed to appoint him for a second term of office. His new term will end in April 2021. He is the Chair of the Quality and Governance Committee, and serves on the Audit Committee and the Nomination & Remuneration Committee. He is the Lead NED for Freedom to Speak Up and for Organ Donation. |
|  | **Claire Yarwood, Director of Finance**<br><br>Claire has long experience working in the Greater Manchester health economy, with senior roles for both providers and commissioners. She joined the Board in 2015 from a role with NHS England.<br><br>Claire is the Board level lead on finance and procurement. She serves on the Finance and Performance Committee, and supports the Audit Committee. |

# Corporate Governance

## Introduction

The Trust seeks to have effective corporate governance throughout the organisation, in order to ensure that decision-making is undertaken in a considered manner and having reviewed all the relevant information that can reasonably be made available.

Corporate governance within the Trust takes place in the structure defined in the *National Health Service Act 2006*, and in particular Schedule 7 of that Act (as amended by the *Health and Social Care Act 2012*). It is also informed by the expectations of the Care Quality Commission, and the *Code of Governance for NHS Foundation Trusts* published by Monitor (now part of NHS Improvement).

The major corporate governance bodies within the Trust are the Council of Governors, largely elected by Trust members with responsibility for holding the Board to account and ensuring that the views of the public are represented to the Trust; and the Board of Directors, who are responsible for setting the direction and strategy of the Trust and for oversight of delivery. The Trust operates in a closely-regulated environment, with the main (but not only) statutory regulators being Monitor (now part of NHS Improvement) and the Care Quality Commission.

## Statement of the application of the *Code of Governance*

Tameside and Glossop Integrated Care NHS Foundation Trust has applied the principles of the *NHS Foundation Trust Code of Governance*, published by Monitor, on a comply or explain basis. The C*ode of Governance*, most recently revised in July 2014, is based on the principles of the *UK Corporate Governance Code* issued in 2012.

The information in this report about our compliance or explanations for non-compliance, with the *Code of Governance* is subject to review by the external Auditors.

## Explanations for areas of non-compliance with the *Code*

No areas of non-compliance with the provisions of the *Code of Governance for NHS Foundation Trusts* have been identified during the year.

# The Board of Directors and Council of Governors

High-level overview

Under the structure set out in the *National Health Service Act 2006*, and the Trust Constitution, the Board of Directors is ultimately responsible for the operation of the Trust, and for exercising the powers that the Trust has. The Council of Governors has a limited set of specified decisions that the Act has reserved to them, including the appointment of Non-Executive Directors and external Auditors, and which the Board cannot undertake; together with some other decisions where they must be consulted prior to the Board taking a decision.

The Board meets regularly for the formal transaction of business, usually with a session open to public observation and a further limited session in private. The regular agenda includes reviewing financial and operational performance; consideration of the risk environment affecting the Trust, both internal and external; and receiving assurance, positive or negative, from the detailed work undertaken by Board Committees. The Board also regularly considers the development of strategy, including external changes and challenges, in both formal and informal sessions. During 2017, the Board met on a monthly basis save in August. Following a change in the Standing Order agreed by the Board and the Council, the Board in 2018 has moved to a usual pattern of meeting formally on a two-monthly basis, with an informal meeting in other months (except August and December).

The Council is responsible generally for representing the views of the public and Membership, and holding the Board to account for its decisions through the Non-Executive Directors. Council meets on a scheduled basis of four meetings in each year, with additional meetings being held if required to deal with urgent business: in 2017 this included additional meetings in relation to the appointment of a Trust Chairman to succeed Mr Connellan. Each meeting is open to the public to observe, except where specific business needs to be considered in private; the Council regularly receives a report on the decisions made by the Board, which is used to hold the Board to account. Governors also regularly receive the papers for the public sessions of the Board, to support them holding the Board to account.

The Board has approved detailed delegations of powers from the Board to Board Committees and Executive Directors, as set out in Standing Financial Instructions, a Schedule of Delegations and a Schedule of Matters Reserved to the Board. Under the Standing Orders, there is a general rule that any powers not otherwise dealt with are delegated to the Chief Executive, who may sub-delegate as they judge appropriate.

Membership of the Board of Directors, and attendance at meetings

During the year, the following served as Directors of the Trust-

| Name | Office | Start date | Expected end of term |
|---|---|---|---|
| Sallie Bridgen | Non-Executive Director | 1st February 2017 | 31st January 2020 |
| Trish Cavanagh | Chief Operating Officer | August 2014 | N/A |
| Paul Connellan | Chairman | 1st November 2011 | Retired 31st October 2017 |
| Anne Dray | Non-Executive Director | 1st January, 2014 | 31st December, 2019 |
| Cathy Elliiot | Non-Executive Director | 1st February 2017 | 31st January 2020 |

| | | | |
|---|---|---|---|
| Karen James | Chief Executive | October 2014 | N/A |
| Pauline Jones | Chief Nurse | February 2016 | N/A |
| Trish Kalloo | Non-Executive Director | 1st December 2010 | Retired 31st May 2017 |
| Jane McCall | Trust Chair | 8th January, 2018 | 7th January, 2021 |
| Tracey McErlain-Burns | Interim Chief Nurse | Appointed February 2017 | Retired 28th September 2017 |
| | | Further appointed 1st January 2018 | October 2018 |
| Peter Noble | Non-Executive Director | 5th February 2018 | 4th February 2021 |
| Brendan Ryan | Medical Director | October 2014 | N/A |
| Martyn Taylor | Non-Executive Director | 1st May, 2015 | 30th April, 2021 |
| Claire Yarwood[6] | Chief Financial Officer | January 2015 | 31s May, 2018 |

Attendance at meetings of the Board, and its Committees, is set out in the table on page 55.

Independent Non-Executive Directors

The independence of the Non-Executive Directors has been reviewed during the year, having regard to the criteria in the *Code of Governance*, to identify any factors that might indicate that a Non-Executive Director was no longer independent.

Having considered those matters, the Board considers that all of the Non-Executive Directors are independent of the management of the Trust. No matters have been identified that might indicate that a Non-Executive Director was not in fact independent from Trust Management.

The Chair's other major commitments are as a Non-Executive Director at the Information Commissioner's Office; and as an External Member of the House of Commons Commission.

Completeness, balance and appropriateness of the Board

Details of the skills, expertise and experience of the individual Directors can be found in the biography section, on page 44.

During the year, the Board has reviewed the balance of skills and experience that the Directors being to the Board, having regard to the challenges facing the Trust. This review fed into the recommendations to the Council of Governors regarding the skills and experience to be sought in appointing a new Trust Chair and Non-Executive Director during the year. The Board formally reviewed the skills and experience available to it in March 2018, and is satisfied that it has available in its membership appropriate skills and experience to be able to effectively lead the organisation.

Performance evaluation

The Board recognises that having effective performance review of its work, the detailed work undertaken in Committee, and of individual Directors is important to ensure that the Board as a whole continues to effectively lead and set the strategic direction for the Trust. It is also a requirement in order to have continuing compliance with the requirements of the NHS

6 At the date of approval for this report, Claire Yarwood has given notice of her resignation from the Trust.

Improvement provider licence, Condition FT4.

Individual Directors are subject to performance evaluation through the appraisal process. For Executive Directors, the process is applied in the same way as for all other employees, with objectives being set at the start of the year, progress being reviewed, and the appraisal at the end of the year. Recognising their position as Directors and members of a unitary Board, the objectives and appraisal include an element reflecting their contribution to the Board, both in their direct area of responsibility and across the general responsibilities of the Board as a whole. The Non-Executive Directors are subject to a similar process, which mainly focuses on their contribution to the Board and effective governance; with the Chair's objectives being set in a process led by the Senior Independent Director. The outcomes of the process are reported to the Nomination and Remuneration Committee in respect of Executive Directors, and the Council of Governors (via the Council's Nomination Committee) in respect of the Non-Executive Directors.

During the year, the Board has reviewed the Committee structure to ensure that it continues to provide appropriate support to the Board. With effect from 1st April 2018, the Board changed the structure to create a Workforce Committee, recognising that this is a specific area of strategic challenge that the Board considers requires greater specific focus than was possible without the Committee. All Committees operate with written terms of reference, and as part of the changes from 1st April 2018 these have been fully reviewed with a view to making them consistent and easier to understand. Each Committee reports in summary to the following meeting of the Board, identifying key issues, levels of assurance and actions agreed to be taken. Minutes of each Committee's meeting are also laid before the Board for information.

In line with NHS Improvement's guidance, the Trust is currently planning to undertake a developmental well-led review, which will be undertaken by an independent external provider. The aim of the review will be to provide an external view of the strengths and weaknesses of the Trust's governance, together with guidance on how governance can be improved. Part of this process is for the Board to have an internal self-evaluation of its performance, which is being facilitated by a third-party and is currently underway. The self-evaluation will then feed into the external review, which is currently expected to be completed during the autumn of 2018. When complete, the Board will review the outcomes, establish an action plan to deliver improvement, and advise NHS Improvement of the report and actions being taken as a result. Additionally, CQC is currently rolling out an annual inspection of all providers against its 'Are they Well-Led?' strand, in line with the policy announced by Her Majesty's Government. The first review of this Trust under these arrangements is expected by the summer of 2019.

Review of internal controls

Based on detailed review by the Audit Committee, and also supported by the annual Head of Internal Audit opinion, the Board has reviewed the systems of internal controls in place within the Trust. The Board remains satisfied that appropriate systems of internal control are in place; and that, where weaknesses are identified, and appropriate steps are taken to improve the systems in place.

Membership of and attendance at the Council of Governors

The Council of Governors is largely composed of Governors elected by the public and staff members of the Trust, together with some Governors appointed by key stakeholders. During the year, the following were members of the Council of Governors-

| | Type | Constituency | Term Ends |
|---|---|---|---|
| John Bradley | Public | Denton | Resigned |
| Wendy Brailsford | Public | Audenshaw | April 2019 |

| | Type | Constituency | Term Ends |
|---|---|---|---|
| Dorothy Cartwright | Public | Stalybridge | March 2020 |
| D Cain | Public | Hyde | Resigned |
| Kalish Chand | Appointed | Action Tameside | |
| Victoria Collier | Appointed | Young Persons' | |
| Lesley Conroy | Public | Ashton | July 2020 |
| Anne Corrie | Public | Longendale | April 2019 |
| Alan Dow | Appointed | Tameside & Glossop CCG | |
| Tracey Heslop | Staff | Elective | Resigned |
| Mark Holden | Appointed | [PFI provider] | |
| Nuzrul Hoque | Public | Ashton | August 2018 |
| Gary Howard | Public | Mossley | Resigned |
| Murtaza Hussaini | Public | England & Wales | March 2020 |
| Sally Lewcock | Staff | Women's & Children's | January 2020 |
| Julie McCabe | Appointed | High Peak District Council | |
| Mike McClusky | Staff | Estates & Facilities | June 2018 |
| Beryl Murphy | Staff | Community Services | Resigned |
| Martin Pattrick | Staff | Medical & Urgent Care | Resigned |
| John Phillips | Public | Hyde | June 2020 |
| Vikki Rutter | Public | Duckinfield | December 2019 |
| Ken Simpson | Public | Droylsden | December 2019 |
| Peter Smith | Public | Denton | December 2019 |
| Adrian Smith | Staff | Clinical Support | December 2019 |
| Lesley Surman | Public | Glossop | December 2019 |
| Brenda Warrington | Appointed | Tameside Metropolitan Borough Council | |
| Chris Webster | Public | Glossop | March 2020 |
| George Wharmby | Appointed | High Peak District Council | Resigned |
| Jean Wharmby | Appointed | Derbyshire County Council | |

The Lead Governor during the year was John Phillips.

Attendance at meetings of the Council of Governors during the year was as follows-

(X- attended, A- apologies received)

| **Governors** | | | 10th May | 19th July | 6th September | 23rd November | 6th December | 27th March |
|---|---|---|---|---|---|---|---|---|
| Bradley | John | | x | x | A | x | x | A |
| Brelsford | Wendy | | | x | x | x | x | x |
| Cartwright | Dorothy | | | x | x | x | x | x |
| Cain | D | | x | Resigned | | | | |
| Chand | Kailash | | x | x | x | Interest Dec | | x |
| Collier | Victoria | | | | A | A | | |
| Conroy | Lesley | | x | x | A | x | | x |
| Corrie | Anne | | x | | x | x | | x |
| Dow | Alan | | | x | x | x | | A |
| Heslop | Tracey | | | x | A | A | A | |
| Holden | Mark | | x | x | x | | A | x |
| Hoque | Nuzrul | | x | x | x | x | A | A |
| Howard | Gary | | x | | x | Resigned | | |
| Husaini | Murtaza | | x | x | x | x | x | x |
| Lewcock | Sally | | x | x | A | x | A | |
| McCabe | Julie | | | | x | A | A | x |
| McCluskey | Mike | | | x | x | x | x | A |
| Murphy | Beryl | | x | | x | A | | Resigned |
| Pattrick | Martin | | | | | | | Resigned |
| Phillips | John | | | x | x | x | x | x |
| Rutter | Vikki | | x | | x | | A | A |
| Simpson | Ken | | | x | A | x | x | x |
| Smith | Peter | | x | | | | | |
| Smith | Adrian | | x | x | | A | | x |
| Surman | Lesley | | x | x | A | x | x | x |
| Warrington | Brenda | | x | x | A | x | x | x |
| Webster | Chris | | | x | x | x | x | x |
| Wharmby | George | | | x | Retired | | | |
| Wharmby | Jean | | | | | | | A |

| **Directors** | | | 10th May | 19th July | 6th September | 23rd November | 6th December | 27th March |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| Bridgen | Sallie | | | Interest Dec | x | Interest Dec | x | x |
| Cavanagh | Patricia | | x | Interest Dec | A | Interest Dec | x | A |
| Connellan | Paul | | x | Interest Dec | x | Retired | | |
| Dray | Anne | | | x | x | x | x | A |
| Elliott | Cathy | | x | Interest Dec | | Interest Dec | x | x |
| Higgins | Anne | | x | Interest Dec | | Interest Dec | | Retired |
| James | Karen | | | Interest Dec | x | Interest Dec | x | x |
| Jones | Pauline | | Sickness Absence | | | Interest Dec | Sickness Absence | |
| Kaloo | Tricia | | | Retired | | | | |
| McCall | Jane | | | | | | | x |
| McErlain-Burns | Tracey | | x | Interest Dec | | | x | x |
| Noble | Peter | | | | | | | x |
| Ryan | Brendan | | A | Interest Dec | x | Interest Dec | x | A |
| Taylor | Martyn | | x | Interest Dec | x | Interest Dec | x | x |
| Yarwood | Claire | | x | Interest Dec | x | Interest Dec | A | A |

Keeping the Directors aware of Governor and Member views

The Board acknowledges the need to keep Directors, and in particular Non-Executive Directors, aware of the views of Members and the public; and the views of Governors as their elected representatives. Directors attend the formal meetings of Council, both to support Council in holding the Board to account and listen to the views and concerns that Governors are expressing. Directors also attend the Annual Members' Meeting, where Members and the public can express their views directly on the performance and future strategy of the Trust. More widely, the Directors have a number of contact-points in the community, including with groups such as patient feedback groups, which provides a further perspective on views and opinions.

Contacting Governors and Directors

Members who wish to contact Directors or Governors should e-mail the Trust Secretary at Steve.Parsons@tgh.nhs.uk.

To post items to Directors or Governors, please write to-

c/o Trust Secretary
Tameside and Glossop Integrated Care NHS Foundation Trust
Silver Springs House
Tameside General Hospital,
Fountain Street,
Ashton-under-Lyne OL6 9RW

**Director attendance at Board and Committee meetings, April 2017 to March 2018**

| Name | Board of Directors | | Audit Committee | | Finance & Performance Committee | | Quality & Governance Committee | |
|---|---|---|---|---|---|---|---|---|
| | Actual | Possible | Actual | Possible | Actual | Possible | Actual | Possible |
| Sallie Bridgen | 10 | 10 | 3 | 5 | 3 | 3 | 9 | 11 |
| Trish Cavanagh | 9 | 10 | | | 7 | 12 | 7 | 11 |
| Paul Connellan [a] | 6 | 6 | | | | | | |
| Anne Dray | 9 | 10 | 5 | 5 | 10 | 12 | | |
| Cathy Elliott | 9 | 10 | | | 8 | 12 | 8 | 11 |
| Anne Higgins | 5 | 8 | | | | | 5 | 9 |
| Karen James | 9 | 10 | | | | | 8 | 11 |
| Pauline Jones [b] | 2 | 2 | | | | | 2 | 4 |
| Trish Kaloo [c] | 1 | 2 | | | 0 | 2 | 0 | 1 |
| Jane McCall [d] | 3 | 3 | | | | | | |
| Tracey McErlain-Burns [b] | 7 | 8 | | | | | 6 | 7 |
| Peter Noble [e] | 2 | 2 | 1 | 1 | | | 1 | 1 |
| Brendan Ryan | 9 | 10 | | | | | 6 | 11 |
| Martyn Taylor | 10 | 10 | 4 | 6 | 7 | 10 | 2 | 2 |
| Claire Yarwood | 10 | 10 | | | 8 | 12 | 8 | 11 |

a- Paul Connellan retired as a Director on 31st October 2017.
b- During the year, Pauline Jones had planned long-term medical absence. During this time, Tracey McErlain-Burns was the Chief Nurse until 28th September 2017, and again from 1st January 2018
c- Trish Kaloo retired as a Director on 31st May, 2017.
d- Jane McCall was appointed to the Board on 8th January 2018.
e- Peter Noble was appointed to the Board on 5th February 2018.

# Audit Committee

## Introduction to the work of the Committee

The Audit Committee is appointed by the Board to review, and advise the Board about the levels of assurance available from the various control systems in place to protect the public funds used by the Trust; and to ensure that the Trust's services are being provided economically, efficiently, and effectively. The Committee also has oversight of the work of the internal auditors and the Local Counter-Fraud service, together with regular reporting from the external auditors.

## Membership and attendance

In accordance with both statutory requirements and good practice, the Committee is composed only of Non-Executive Directors who are independent of the management of the Trust. During the year, the following Directors were members of the Committee-

- Anne Dray (Chair)
- Sallie Bridgen (until February 2018)
- Martyn Taylor
- Peter Noble (from February 2018)

During her period as Acting Chair of the Trust, Anne Dray stood down from the Chair of the Committee and the Board appointed Martyn Taylor as Chair *locum tenis*.

The Committee has been supported during the course of the year by regular attendance from the Director of Finance, Claire Yarwood, and her team. The representatives of the internal and external auditors, and of the Local Counter-Fraud service, attend each scheduled meeting of the Committee and have direct access to the Chairman of the Committee should occasion require. As required, the Committee consults with the Accounting Officer on any issues of concern.

Details of the attendance of Directors at the Committee during the year are given in the table on page 48.

## Our work during the year

During the year, the Committee has continued the work delegated by the Board to review in detail the effectiveness of internal control systems, led by detailed reviews from the Internal Audit service. This work has continued to provide assurance that, in general, the internal controls provide reasonable assurance around the effectiveness of internal controls; where areas for improvement have been identified, the Committee has also been positively assured that the management responses have been reasonable and focused on improving the internal control systems.

As part of the work related to internal controls, the Committee has conducted a complete review of the Standing Orders of the Board, the Schedule of Delegations, and the Standing Financial Instructions. These were substantively revised to ensure that they remain fit for

purpose, and the Board approved the changes to the Schedule of Delegations and the Standing Financial Instructions in April 2018. The Board Standing Orders, as part of the Trust Constitution, required the approval of both Board and Council; and this was obtained in March 2018.

Risk Review work has also been a key factor in the Committee's work, with focus both on the control systems and also some specific strategic risks that the Board has referred to the oversight of the Committee. The Committee has reasonable assurance that the internal control systems in place for the management of risk are effective to allow risk to be identified, managed and reported for governance consideration; including based on review work by the Internal Audit service.

Following the cyber-security challenges that occurred in Spring 2017, the Committee has taken steps to seek assurance through the Internal Audit service on the robustness of the control systems in place for information technology. Following an interruption of IT services experienced in March 2018, the Board requested that the Committee review the control systems in place for IT architecture, to give assurance that they were appropriate. This review is continuing and the Committee anticipates reporting back to the Board at the Board's July 2018 meeting.

The Committee has also reviewed the work of the Local Counter-Fraud Service, which is part of the national fraud prevention arrangements and whose work is outlined below.

The structure and work of Internal Audit

The internal audit service exists to support the Accounting Officer, the Audit Committee and the Board of Directors in assessing the amount and level of assurance available regarding the internal control systems in place in the Trust. It undertakes a planned programme of work, approved in advance by the Committee, which is designed to ensure that all the major control systems in the Trust are reviewed on a regular basis; the plan includes elements that are reviewed annually, together with a broader assessment informed by the perceived risk from the various systems. Each review is reported to the Committee, together with the response and proposals for improvement by management. Progress against the agreed recommendations is regularly reviewed, and the Committee will interview the relevant Director where progress is unsatisfactory. The year-end processes are supported by the production of the annual Head of Internal Audit opinion, which summarises the work of the internal audit service during the year, and states the Head of Internal Audit's opinion as to the available level of assurance in the internal control systems in the Trust.

The internal audit service is provided on an out-sourced basis by an external provider, Mersey Internal Audit. The service is regularly tendered in order to ensure that it continues to represent best value.

Other services provided by the Auditors

During the year, the external auditors did not provide any non-audit services to the Trust. In the event that the auditors wish to be considered for the provision of such services, the Trust has appropriate controls in place to ensure that having an independent audit service is the paramount consideration The external auditors are also subject to professional standard requirements to ensure that any non-audit services they provide do not prejudice the provision of the internal audit required by law.

Key issues of focus during the course of the year

During the year, the Committee has continued its work to assess assurance in control systems, including in their operation and compliance. In addition to the work undertaken through the internal audit process, it has reviewed and revised the Standing Financial Instructions, the Standing Orders for the Board of Directors, and the Scheme of Delegations. It has also regularly reviewed payments for losses and compensations, and has been kept aware of other issues such as the outcomes of the Information Governance Toolkit process. The work of the Local Counter-Fraud Service is discussed below.

In relation to the financial statements for the year, the Committee has received and considered the following significant audit risks raised by the external auditor in undertaking the audit-

- Estimation of NHS income;
- Valuation of the Trust's land and buildings
- Fraud risks, including from improper inclusion of income in accounts and from management over-riding control systems

The Committee were satisfied that the proposed audit plan gave adequate assurance that any such activities, if present and material, could be detected through the process. The Committee has also given consideration to the key estimates and judgements within the Annual Accounts, including those set out in the accounting policies in Note 1; and have concluded that there is reasonable positive assurance that they are appropriate.

The work of the Local Counter-Fraud Service

The Committee's work is also supported by the work of the Local Counter-Fraud Service (LCFS), which forms part of the national fraud prevention arrangements within the NHS. It is a contractual requirement for the Trust to have in place an LCFS, and the Trust has appointed the LCFS service from Merseyside Internal Audit to provide this service. The LCFS specialist attends each scheduled meeting of the Audit Committee, and reports regularly on progress against the plan agreed at the start of the year.

During the year, the LCFS has been actively involved in the prevention and detection of fraud within the Trust. This has included the successful prosecution of an offender in the Crown Court, which has led to a suspended custodial sentence and a requirement to re-pay the Trust the amounts illegally obtained.

Freedom to Speak Up

Following the report of Sir Robert Francis about NHS procedures to raise concerns about care and other matters without fear of reprisal, the Trust has adopted procedures under the 'Freedom to Speak Up' template. This aligns with the national arrangements within the NHS as a whole, under the leadership of the National Guardian's Office within the Care Quality Commission. The Trust is also covered by the *Public Interest Disclosure Act 1998*, and staff are able to make 'protected disclosures' including to NHS England and NHS Improvement.

The Trust has appointed a Freedom to Speak Up Guardian, shared with Stockport

Foundation Trust, who is independent from the management of the Trust in the discharge of their duties as the Guardian. The Guardian has access to Executive management to raise any areas of concern, and the Board has appointed a Non-Executive Director (Mr Taylor) as the link between the Guardian and the Board. In line with national guidance, the Guardian presents regularly to the Board and is available to the Board for challenge to give assurance.

Further detail on the Guardian's work during the course of the year is available in the Quality Report.

# Regulatory Ratings

## Single Oversight Framework

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

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

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

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's *Risk Assessment Framework* (RAF) was in place. Information for the first two quarters of 2016/17 relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

## Segmentation

Throughout the year, the Trust has been rated in Segment 3. This reflects that the Trust continues to be subject to Enforcement Undertakings accepted by NHS Improvement, which were agreed in 2015. The major driver of NHS Improvement's view that the Enforcement Undertakings continue to be needed is that the Trust continues to be unable to reach financial break-even in the year. The undertakings include that the Trust will seek to move towards financial stability through a greater integration of services across the local health economy, including with local statutory social care, as agreed by the Board in 2015 in accepting the CPT report prepared by PricewarterhouseCoopers LLP.

This segmentation information is the Trust's position as at 23rd May, 2018. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

## Finance and use of resources

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

| Area | Metric | 2017/18 scores | | | | 2016/17 scores | |
|---|---|---|---|---|---|---|---|
| | | Q4 | Q3 | Q2 | Q1 | Q4 | Q3 |
| Financial sustainability | Capital service capacity | 4 | 4 | 4 | 4 | 4 | 4 |
| | Liquidity | 4 | 4 | 4 | 4 | 4 | 4 |
| Financial efficiency | I&E margin | 4 | 4 | 4 | 4 | 4 | 4 |
| Financial controls | Distance from financial plan | 1 | 1 | 2 | 3 | 1 | 1 |
| | Agency spend | 1 | 1 | 2 | 2 | 2 | 2 |
| **Overall scoring** | | **3** | **3** | **3** | **3** | **3** | **3** |

As the Trust is subject to enforcement action from NHS Improvement, the Trust is not permitted to be rated above 3 in the segmentation.

# Sustainability

## Introduction

Sustainable development has been set as a key policy goal by HM Government and by the NHS. In the local and regional context, Greater Manchester has recently set targets at its *Green Summit*, with the Greater Manchester NHS committing to reduce its environmental impacts. The Board is fully supportive of ensuring that its operations move towards ensuring sustainability, whilst recognising that some benefits are provided to patient care through the use of items such as single-use plastics in the health sphere. Achieving sustainability is therefore a balance in this context.

Our aim, through our transformation programmes with our local and regional partners, is to develop a healthcare system that is integrated and provides care for all of our communities as close to home as possible, It is our belief that this is the best route to achieving a sustainable healthcare system which minimises our impact on the environment.

## Governance and Leadership

The Board recognises that leadership at the highest level is a key factor to deliver sustainable development for the Trust. Led by the Chief Executive, the Executive team has responsibility for delivering sustainable development in practice, and within their particular portfolios. The Board takes responsibility for the overall delivery of sustainable development. There are a number of procedural requirements to support this- for example, each Board paper is required to state any impacts on sustainability from the proposals that are being put forward.

## Our activities to promote sustainability during the year

Our transformation work with local and regional partners is designed to ensure that the systems for the provision of health and social care in Tameside and Glossop, and the wider Greater Manchester area, are sustainable.

- We have worked closely with the Clinical Commissioning Group (CCG), Derbyshire County Council and Tameside Council, together with local care homes, to create services through 'Care Direct' which reduce the need for elderly residents to attend the Accident and Emergency Department.
- We have continued to develop our work through the five Neighbourhoods, which bring together NHS, Local Authority and voluntary/ third sector services in a single place for our communities. This includes primary (GP) care and community-based secondary care.
- We have continued to review how services can be made more integrated, including where the organisational responsibility for their provision can be transferred to promote efficiency. The aim with such transfers would be to provide a 'seamless' service to the community, regardless of the legal background to the service.
- Models of care are being regularly and repeatedly reviewed to ensure that they remain fit for purpose and deliver sustainable care for individuals and the community. This has included supporting decision-making processes within our partner organisations related to service changes for Intermediate and Urgent Care provisions.

We are also participating fully in the work at a Greater Manchester level, undertaken under

the auspices of the Mayor of Greater Manchester and the GM Health and Care Partnership. This work is longer-term and takes place within the devolution settlement that has been agreed between the relevant local authorities and HM Government. The aim of the work is to ensure that a wider range of services provided across Greater Manchester is sustainable and comprehensive, through driving change that leads to efficiency and also reduces impacts where possible. Greater Manchester has set out 5 priorities (themes) for action-

1. A radical upgrade in population health prevention
2. Transforming community based care and support
3. Standardising  Acute Hospital care
4. Standardising clinical support and back office services
5. Enabling better care

The Trust is particularly engaged with the work in themes 3 and 4, and also engaged with theme 2 given our continued work towards integration of service provision with our partner organisations.

Like all publicly-funded organisations, a key requirement for the Trust is to ensure that it is financially stable. The Trust has delivered significant efficiency savings during the course of the year, releasing some £10 million of savings. This has enabled the Trust to meet the financial plan set by the Board, and supported the stabilisation of the Trust's deficit by preventing an increase in the in-year financial deficit. For the coming year, the Board has set a financial plan that calls for the delivery of a further £12.8 million in efficiency savings; this will be a significant achievement but is a minimum requirement to continue the move towards financial stability for the organisation.

The context of the Trust's operation is that there is a lack of financial stability in the local health economy, with both the CCG and the social care operations of Tameside Council showing deficits. (Figures isolating the social care spend of Derbyshire County Council on the Glossop area are not available.) This inevitably impacts on the Trust's efforts to achieve financial sustainability as an organisation, and we recognise the need for the local health economy as a whole to achieve that in order for all three organisations to meet their objectives.

However, the Board recognises that the operation of the Trust continues to be dependent on direct financial support through loans from HM Government, which is not a position that can be sustained indefinitely. Long-term financial stability will require that income received for providing treatment exceeds the costs incurred for that provision, by an amount sufficient to enable the Trust to pay back the loans and thereby reach financial sustainability, unless HM Government provides a form of loan forgiveness or other income sources become available.

Engagement activities

The Trust participates in co-ordinated engagement arrangements, together with Tameside Metropolitan Borough Council and Tameside and Glossop Clinical Commissioning Group. These include engagement and consultation relevant to the Trust being sustainable and operating in a way that minimises its impacts on others that themselves reduce sustainability. The Trust also benefits from having Public and Staff Governors, who are elected from the local community and whose statutory responsibilities include representing the interests of the public to and in the Trust.

The challenges we need to overcome

There are a number of challenges that the Trust faces in seeking to become more sustainable-

- As is common amongst NHS providers, we provide our services in relatively old buildings which, whilst good when constructed, may not meet current best practice in terms of sustainability and environmental performance. This may itself have a knock-on effect on financial sustainability of the organisation. Capital funding is limited, and the buildings may not lend themselves to appropriate transformation. Major capital funding for replacement of buildings is generally only available through HM Government, and has a substantial lead-in time.
- Parliament has currently put in place different legal structures for provision in health and social care, with health being the responsibility of the NHS as a national structure, whilst social care is the responsibility of the several principal Local Authorities. The two systems need to interact with each other at a number of contact points, including the transfer of care from health to social care, and at this point there can be inefficiencies, difficulties in communication and poor experience for patients/ service users. The current legislative provision can make it difficult to bring the services together to be more efficient, more sustainable and offer a better experience to the user.
- In order to be sustainable, the Trust must be able to generate a sufficient surplus from its operations to be able to re-invest for the future. Under current arrangements the Trust finds itself unable to meet the costs of the services provided from the income made available for the purpose. As a result, the Trust has experienced a deficit of income to expenditure, to a significant degree; and is currently required to rely on loan funding from HM Government to continue in operation.
- The Trust operates in a local health economy within which the CCG and Tameside Council have also brought their functions together. The Trust is also within a regional structure under the Greater Manchester devolution agreement. Both the local health economy and the Greater Manchester region are undertaking work to improve their sustainability in a number of facets, which may impact on the future structure of the Trust and whether it is sustainable.
- Given the geographic location of the Trust, we have to deal with a number of other statutory authorities who may have different priorities to this organisation. In particular, our operations in the Glossop area need to interact with both High Peak Borough Council and Derbyshire County Council; however, both those authorities will also need to interact with other healthcare providers, as this Trust does not provide services for all of their respective areas. There may therefore be more challenges in ensuring policy development is consistent for these areas.

Karen James
Chief Executive

23rd May, 2018

# Statement of Accounting Officer's Responsibilities

**Statement of the Chief Executive's responsibilities as the Accounting Officer of Tameside and Glossop Integrated Care NHS Foundation Trust**

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

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

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

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The Accounting Officer is responsible for keeping proper accounting records, which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust, and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and for safeguarding the assets of the NHS Foundation Trust: and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities. The Accounting Officer is also responsible for ensuring that the use of public funds complies with the relevant legislation, delegated authorities and guidance.

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

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

Karen James
Chief Executive

23rd May, 2018

# Annual Governance Statement

## Scope of responsibility

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

## The purpose of the system of internal control

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

The effective management of risk, and its reduction where possible, is a key priority at all levels of the Foundation Trust. It is a key component of all governance discussions, with the Board Assurance Framework and high-level entries on the Corporate Risk Register being reviewed and challenged at every meeting of the Board of Directors and of Board Committees. The Audit Committee regularly reviews and challenges the control systems underlying the management of risk in the Foundation Trust.

Operationally, risk management is led by myself and the Executive Directors, who have responsibility for the overall management and mitigation of risks within their areas of responsibility. I lead the overall Risk Management group for the Foundation Trust, which has an operational overview of risk across the Trust to support the Board and its Committees. All staff have both the opportunity and expectation of reporting all perceived risks within their area of operation, which are then subject to a process of review, validation and (if appropriate) scoring and management. Management of risk is undertaken at a level appropriate to the potential impact of the risk, including departments, divisions and on a cross-Trust basis. Additionally, the Board maintains a Board Assurance Framework, reflecting the risks identified to the achievement of the Trust's strategic objectives and how they are managed.

Risk management is a key part of the Trust's training for all staff, to ensure that all staff can identify and address risk within their area. Managers receive training appropriate to their grade, in order to have an appropriate oversight of risks and their management within their area, and to support more junior colleagues. Overall responsibility for ensuring that appropriate training and guidance is available sits within the Quality and Governance

Department, who are also responsible for ensuring that reporting to the Board and Board Committees is appropriate and complies with the conditions of the NHS Improvement Licence related to risk management.

The risk and control framework

The Trust has adopted a formal risk management strategy, which sets out how the Trust will seek to identify, control and manage risk. This strategy recognises that the Trust provides services that carry, in some cases, an inherently high level of risk; and seeks to manage and mitigate that risk as far as possible. At a corporate level, the strategy seeks to identify and manage the risks faced by the Trust in the local, regional and national environment, recognising that the Trust operates within a national service and within an environment which has significant political interest and controversy at all levels.

The aim of the risk management strategy is to support the Board, Board Committees and operational management to identify risk, evaluate its potential effect, and then manage that down to a level that is either acceptable or irreducible. The strategy recognises that, for some risks, it may not be possible to reduce the risk to a level that the Board would regard as acceptable, and therefore recognises that some irreducible risk levels must be taken given the services provided by the Trust.

All staff colleagues have a responsibility to identify potential risk within their area of responsibility, and to ensure that it is evaluated and controlled. There are comprehensive policies and systems in place for the identification and management of risks at all levels, within a single framework to ensure that the evaluation of risk is consistent and reliable. Risk are managed at the level appropriate to the identified impact and likelihood of the risk eventuating, including departmental, divisional and cross-Trust structures. Overall responsibility for management of operational risks is undertaken by the Risk Management Committee, led by myself, to ensure that there is appropriate leadership and accountability for the management of risk. The Board and Board Committees are regularly updated on high-rated risks on the operational risk register, enabling them to challenge and assess the level of assurance available.

The Board also maintains a Board Assurance Framework, which identifies the risks to achieving the strategic objectives that have been set by the Board for the Trust. Each identified risk is allocated to the oversight of a Board Committee (or occasionally the Board itself), and that Committee is responsible for regular challenge to the assessment and management of the allocated risks. Details of both the Board Assurance Framework, and the higher-rated risks on the operational risk register, are reported to each meeting of the Board of Directors for consideration, challenge and assessment of available assurance.

The Board recognises that, working in a healthcare environment, many of its day-to-day activities will carry relatively high risks that are not susceptible to effective reduction. This arises from the specialist nature of many medical procedures, and also the need to provide care and treatment for individuals who are undergoing acute health challenges.

Within that context, the Board has adopted an approach to desirable risk (the ‘risk appetite’). The assessment of each risk includes an assessment of the risk appetite in relation to that risk, which seeks to identify the Trust’s willingness to accept risk in that area; and a target score is set, which seeks to express the irreducible minimum risk associated with the activity (the point where the decision becomes to accept the risk or cease the activity). Each assessment of risk appetite and target risk score is reviewed regularly at the appropriate

level of governance, with the Board reviewing the assessments for risks on the Board Assurance Framework on a regular basis. The Board annually reviews the overall approach to risk appetite, as part of assessing the strategic risks following approval of the year's corporate objectives and key success criteria.

Ensuring that quality is at the heart of everything that the Trust does for patients is a key activity for the Board. This is undertaken in a number of ways;

a. At each scheduled meeting, the Board receives a detailed Integrated Performance Report, which includes performance data for all significant areas of activity. Areas that have failed to achieve the agreed or nationally-set targets are subject to exception reporting, which outlines the details of the failures, any identified underlying causes, and the steps being taken by management to bring performance back to target. The Board has the opportunity to challenge the steps proposed, and to require further or different actions to be taken in order to address these challenges.
b. The Board has appointed a Quality and Governance Committee, which is responsible to the Board for detailed oversight of management actions to ensure the quality of services; and for recommending to the Board strategic actions to improve service quality. The Committee meets on a two-monthly basis, and exercises detailed oversight of the quality of services provided by the Trust; including reviewing deaths and serious untoward incidents, quality performance data, and feedback from patients. The Committee also regularly triangulates its findings through scheduled 'walk-about' visits to operational areas such as wards, in order to ensure that the 'lived experience' of providing and receiving care is reflected in the information received. The Committee reports both findings and recommendations to the Board at each Board meeting following a Committee meeting, for consideration and approval.
c. As part of its responsibility to have oversight of relevant control systems, the Audit Committee reviews both the governance systems in place and the various data reporting systems, in order to give assurance that they are reliable and provide the necessary information, in a timely way, to comply with the Trust's obligations under the NHS Improvement Licence. The Committee is supported in this by the Internal Audit service, who undertake arms-length reviews to a programme agreed by the Committee: and which indicate both available levels of assurance, and actions to increase assurance. Management are required to formally respond to the recommendations, and the Audit Committee regularly reviews progress to ensure that actions are delivered by management to the agreed timetable.

Performance information is subject to regular review to ensure that it is reliable and continues to meet the requirements of the Trust. Performance information produced through data systems is regularly triangulated against the 'lived experience' of care, using qualitative information from sources such as complaints and complements, national and local surveys of patients experience (including the 'Friends and Family' test) and triangulation visits from Directors and senior managers. Mismatches are challenged in a variety of forums, and it is a responsibility of the Director of Performance to ensure that mismatches are explored to ensure that the data reporting systems remain reliable. Performance reporting systems are also subject to regular review by both the Internal and External Audit services.

Compliance with the Care Quality Commission's requirements, within the limits set by the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*, is a statutory requirement on the Trust as a provider of healthcare services. The Quality and Governance Committee regularly reviews the Trust's compliance with these requirements, including

reviewing progress against the action plan agreed by the Board following the CQC full inspection in 2016. The three year review plan for Internal Audit also includes regular reviews of the controls in place to ensure compliance with those requirements, which advise the Board about the levels of assurance available.

Management of risk to the security of the data held by the Trust, both on patients and staff colleagues, is a key activity. Data risks are included within the overall risk management process, and regularly reviewed. A comprehensive suite of policies and procedures are in place to ensure that data is handled appropriately and with care, and these are supported by a comprehensive programme of training for staff. The Trust participates in the annual assessment of our compliance through the national Information Governance Toolkit, which has given the Trust a rating of Level 2 for the year ended 31st March 2018.

The major risks currently identified by the Board as facing the Trust can be summarised as-

- Ensuring sufficient staffing to ensure the safe delivery of services; This is a challenge that is common across all provider Trusts, and reflects national and international labour supply issues. The risk is managed through a number of strategies, including long-term strategies to encourage recruitment and retention. However, the wider market supply issues are beyond the control of the Trust, lying with other agencies both within the NHS and in the wider public sector.
- Financial stability; The Trust continues to be unable to meet necessary expenditure with the available income for healthcare services, and is dependent on being able to access loan support from the Department of Health. Given the size of the loans and the continuing inadequacy of income to repay them, the Board has identified a material uncertainty in making the Going Concern statement. The Trust has continued to have challenging efficiency targets which were met in 2017-18, and continues to meet the financial targets set by the Board. Then sections below outline how the Board is addressing the short and medium-term challenges. The Board is looking forward to the longer-term financial settlement for the NHS that HM Government has indicated will be introduced in the Autumn of 2018, which will enable the Board to take a longer-term view of the financial sustainability of the Trust.
- Working with partners; The Trust seeks to operate in close partnership with statutory partners in the Tameside and Glossop local health economy: and particularly with the Clinical Commissioning Group and Tameside Council, who are operating with a single leadership team through the Strategic Commissioner arrangements. Whilst there is good partnership, some agencies have challenges that impact on the work of the Trust and the delivery of our statutory responsibilities. More widely, the Trust is located within the Greater Manchester region, and may be affected by the development of policy at the regional level. The Trust is actively involved in these areas of work with the intention of influencing them to ensure that they are effective and deliver services for all residents.

The Board particularly recognises the risk related to financial stability, which is outlined above. Our work to mitigate and manage this risk includes close working in partnership with both the local health economy, including the relevant local authorities in Tameside and Derbyshire; and also continuing to deliver an effective and challenging programme of efficiency savings, through the Trust Efficiency Programme (TEP). We have also reached agreement with the Clinical Commissioning Group (CCG) on future service strategy and commission intentions for the medium-term

In the Tameside area, we are joining with our partners (the CCG and Tameside MBC) to undertake the 'Care Together' programme with the aim of both improving the services provided and delivering them in a more efficient way, to the benefit of all three public services. Care Together also has local delivery of the Greater Manchester regional efficiency plans, under the GM Health and Social Care arrangements. During 2017-2018, Care Together delivered a total of £5.924 million efficiencies to the local health economy. For 2018-2019, further efficiencies of £5.924 million are planned through Care Together work.

The TEP has been developed to ensure that the Trust continues to improve its efficiency, whilst maintaining high standards of patient care and experience. It is informed by the Model Hospital research, which has identified areas where the Trust can seek to improve processes and thereby reduce expenditure. During 2017-2018, the TEP programme delivered £10 million in efficiencies, of which £6.2 million were recurrent. The Trust has agreed a further challenging TEP programme for 2018-2019, recognising that delivery of substantial and recurrent efficiencies are required to improve the financial stability of the Trust.

Under the NHS Improvement (Monitor) Licence granted to the Trust, the Trust has obligations (set out in Licence Condition FT4) to ensure that it has appropriate and effective systems of governance in place. The Trust is obliged, at least annually, to review the systems of governance in place, identify the key risks to their effectiveness and the mitigations of those risks, and make a declaration to NHS Improvement regarding whether or not the Trust is compliant with the requirements.

The Board considered the provisions of Condition FT4, the risks to its achievement, and the available mitigations, at its meeting in May 2018. The Board identified the following as the principal risks to compliance with these requirements;

| Key risk | Mitigation |
|---|---|
| Ensuring that the Trust is a going concern (FT4.4(d)) | • Careful and detailed financial planning<br>• Working in partnership arrangements within the locality (Care Together) and regionally (Greater Manchester)<br>• Continuing open dialogue with Commissioners on future direction<br>• Challenging efficiency schemes based on Model Hospital learning<br>• Close management and Board monitoring of performance against plans |
| Delivery of agreed business plans (FT4.4(g)) | • Detailed management structures to review progress and hold to account<br>• Detailed monthly reporting to governance through the Finance and Performance Committee<br>• Reserve plans for Financial Recovery Board arrangements if performance does not match agreed plans<br>• Regular performance updates to regulators |

| Key risk | Mitigation |
|---|---|
| Delivery of high-quality care within a challenging financial environment (FT4.5) | • Quality Assurance mechanisms for efficiency schemes<br>• Involvement of Medical Director and Chief Nurse in financial management discussions and setting of financial plans<br>• Involvement of clinical colleagues in the development and delivery of individual efficiency schemes |

During the year, the Trust has started the three-yearly review of the effectiveness of its governance structures mandated by NHS Improvement, under the *Well-Led Developmental Review* process. This process, which aligns to the key lines of enquiry under the CQC Well-Led inspection strand, is intended to support the Board in identifying areas where governance can be improved, through both internal self-evaluation and a review by an external provider. This process is expected to conclude with a formal report from the external reviewed, a Board-agreed action plan and a formal assurance letter to NHS Improvement, in the autumn of 2018.

The Corporate Governance statement, and the judgements made by the Board in agreeing it, have been supported through a number of channels-

- The Directors are intimately involved in the governance of the Trust through their work at the Board, and also as members of the Board's Committees. In reaching a conclusion on the judgements in the statement, they brought these experiences to bear, particularly those of the Non-Executive Directors who have a particular responsibility for providing challenge to proposals brought forward.
- As part of their regular programme of work, the Internal Audit service has reviewed the effectiveness of the governance systems in place, and has reported to myself and the Audit Committee. These findings have formed part of the evidence base that informed the judgements reached by the Board.
- During the course of the year, the Board has started the process of undertaking a Developmental Well-Led review, which all Foundation Trusts are required to undertake on a 3-year basis. At the date of the corporate governance statement, the Board has started the self-evaluation process, which is being undertaken with support from the internal audit provider. The Board currently anticipates that the process will be completed by the end of October 2018.
- The Board is responsible to the Council of Governors, and has benefitted from frank feedback and sometimes challenge from Governors about the way that it has sought to discharge its duties. Governors have regularly attended the public sessions of the Board's meetings, and also meetings of the Boards Committees.

Through these mechanisms, the Board has gained reasonable assurance that the Corporate Governance Statement is a fair representation of the governance position of the Trust at the date it was agreed.

The Trust recognises that it is vital to ensure that risk management is embedded throughout the Trust. There are a range of systems and procedures in place that support this embedding, including-

- The Trust continues to encourage all staff, at all levels, to identify and report incidents, including 'near misses'. There is a comprehensive system in place to enable colleagues to report incidents, supported by dedicated resource that reviews all reports and identifies the appropriate level for response. Learning from incidents is a key part of the process, and each colleague who reports an incident is entitled to a response that identifies both the response of the Trust and how learning will be taken to prevent recurrence of that type of incident. During the course of the year, the Trust has identified the need to improve the feedback to individuals and has worked to make this more effective.
- Similarly, there are systems in place to enable risk at all levels to be identified, from the 'shop floor' to the Board of Directors. Risks are regularly reviewed at the appropriate level: with the management-level Risk Management Committee, led by myself, meeting quarterly to provide oversight. Each Board Committee has responsibility for review and assessing available levels of assurance for risks within its area of responsibility, and the Board regularly reviews both the Board Assurance Framework and the high-rated risks on the Corporate Risk Register.
- The development of all projects are subject to an analysis of the risks that will be involved, which may include clinical, financial, reputational or other types of risk. Part of the process of developing an acceptable business care for a project includes both the identification of these risks, and also the ways in which they can be mitigated or managed; clear identification of the irreducible level of risk; and identification of the risk appetite to measure that irreducible risk against, in terms of determining whether to proceed with the project.

The Trust involves its public stakeholders in the management of risks in a number of ways. Many of the risks are being managed in association with the partners in the local health economy, which includes the elected members of Tameside Council, High Peak Borough Council and Derbyshire County Council. During the year, with those partners, we participated in the launch of a Tameside engagement forum; designed to enable all of the partners to engage the public on all developments in a joined-up way, and enabling that public consideration to be holistic. This does not replace the statutory requirements on consultation that apply for some areas, but is intended to complement and assist the development of policy, particularly taking into account the Trust's obligations under Section 242 of the *National Health Service Act 2006*.

The Trust also benefits from the input of its public Governors, who are elected by the local community to represent their views to the Trust. Public Governors are able to share the views of their communities with the Trust through a variety of formal and informal routes, which will then feed into the Trust's governance processes.

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

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

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

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

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

I and the Trust recognise that Parliament has set out a requirement for the Trust to ensure that the services that are provided have due regard to the economy, efficiency and effectiveness of the use of public resources. The Trust undertakes a number of activities to seek to ensure the Trust's activities deliver all three of these requirements, each of which Parliament has given an equal weighting.

Ultimate responsibility for ensuring that the Trust complies with this legal duty lies with the Board of Directors, through setting the strategic direction of the Trust, together with monitoring and oversight of performance. This work is supported by the Board's Committees, which look more closely at both performance and strategic direction and provide advice and recommendation to the Board. In particular, the Finance and Performance Committee has a close oversight of the Trust's efficiency plans which closely support the delivery of these responsibilities. The Quality and Governance Committee oversees the quality impacts, which impacts on the efficiency and effectiveness of delivery of services: both preventive of illness and treating illness when it arises.

The Trust's executive leadership is also aware of the need to ensure that the provision of services meet these requirements. When considering service developments, consideration is given to how the proposals will impact on these requirements, both when proposals are being developed and considered through governance for approval. When reviewing implementation, consideration is given to how well the project or development has advanced these requirements, and where further improvements might give better achievement of them.

The Trust maintains an internal audit service, part of whose remit is to review the delivery of economy, efficiency and effectiveness in the various reviews they undertake during the year. The Internal Audit service is formally accountable to me as the Accounting Officer, but operationally reports to the Audit Committee; and has direct access to both myself and the Audit Committee (through its Chair) whenever opportunity requires. Details of the work of the Internal Audit service are provided in the Annual Report.

As part of their annual work, and in accordance with the requirements set out by HM Treasury and NHS Improvement (Monitor), the external auditors review and express an opinion on compliance with the duty to provide services that are economic, efficient and effective. This opinion is made available to the Audit Committee in draft, and is formally given to NHS Improvement. For 2017-2018, the external auditors are reporting that the Trust had adequate arrangements to secure economy, efficiency and effectiveness, except in relation to achieving a break-even position in the foreseeable future or repay the loans from the Department of Health and Social Care.

Information governance

During the year to 31st March 2018, there was one incident that has been identified as a Level 2 information governance incident (under the Information Commissioner's guidelines), with patient information being accidently released to a third party. The incident was fully investigated, and no adverse outcomes were identified; and the Information Commissioner closed their investigation with no actions required.

Just prior to the approval of this statement, the General Data Protection Regulation has come into force across the European Union. This has extended the law's requirements regarding the security and effective management of data, but does not introduce fundamentally new requirements. Building on the systems already in place, the Trust has put into place the necessary controls and systems to give reasonable assurance that the Trust will be compliant with the new requirements. The new requirements include that the Trust notifies the Information Commissioner of all breaches without undue delay, and in any event with 72 hours of becoming aware of the breach.

Annual Quality Report

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

The Board recognises its responsibility to ensure that the Quality Report presents a balanced view of the Trust's performance, reporting areas of less good practice as well as those evidencing good practice. The following control procedures have been put into place in order to support the Board in ensuring this-

- Prior to consideration by the Board, the draft Quality Report is considered in detail by both the Quality and Governance Committee, and the Audit Committee. Both Committees give detailed consideration to the contents of the report, and advise the Board if there are areas of concern related to the balance of the content.
- The Audit Committee supports this review by receiving a quarterly update on performance against the areas expected to be required to be covered in the Quality Report (formal requirements are not normally confirmed until towards the end of the financial year). This enables the Audit Committee to influence the focus of the Quality Report during the course of the year, and also to identify and address any emerging areas of concern.
- Various operational systems underlying the Quality Report will be subject to review by the Internal Auditors, as part of their regular work, during the course of the year. These reviews are reported to the Audit Committee, and inform their assessment of the Report when they report assurance to the Board.

The Trust has a clear policy process in place, to ensure that the care provided to patients is safe and to the highest standards. It is important, in this context, to keep in mind that the general approach is that policies should normally be followed; but that it is recognised that, in some circumstances, the professional judgement of clinical colleagues will justify a departure from policy in the individual case and for the best interests of the patient. Policies are subject to a formal process of development, approval and regular review, to ensure that they continue to reflect best practice. In respect of each patient, the policy is to provide a care plan that responds to the individual needs of the patient, with a view to ensuring that they are

cared for in a way that minimises the period and impact of their condition. In appropriate cases, plans will be prepared on a multi-disciplinary basis, including colleagues from other agencies, in order to ensure that all relevant conditions are taken into account and that care is planned across agencies.

Having access to colleagues with the necessary skills and experience is also crucial in order to ensure that patient care is provided in a safe and appropriate manner. The Board, supported by the Quality and Governance Committee, regularly reviews the level of staffing available in the various areas of the Trust: in respect of nursing and midwifery staff, this is prepared in accordance with the guidance of the National Quality Board, and against local standards for medical and other staff. The Trust has also put into place workforce plans, taking into account anticipated acuity and demand levels, with the aim of ensuring that staff with the appropriate skills and experience are available when required. The Board has also sought to minimise the usage of agency staff, taking into account the national policy: and this is reviewed by the full Board at each scheduled meeting.

The Trust recognises the importance of having effective data collection and analysis, in order to understand the operation of the services and enable the Board to effectively judge what actions are needed to improve performance. The Trust has in place a number of systems for the collection of data regarding the operation of services, and these are automated where possible in order to reduce the possibility of human error. The Executive team receives every week a full suite of performance data from across the Trust, which is reviewed to identify any areas which are starting to be a concern and take immediate action to address them. The Board and its Committees review a more selective set of data, which enables them to focus on the key areas of strategic performance, together with exception reporting to identify the underlying cause of underperformance and the steps being taken to bring performance back to the required standard.

During the year, the Trust has completed the implementation and rollout of the EMIS web system across community services. The Trust took over provision of Community services in April 2016 which included inheriting a legacy information system requiring replacement due to the licence expiry and the system being no longer supported. In undertaking this implementation the Trust reviewed the business processes for all clinical services using the system and the associated data capture to ensure the quality and robust data collection and information provision. Whilst undertaking this the Trust has not been able to report on the full range of metrics for the year and is currently compiling data which will act as a baseline position for activity and performance. The provision of accurate and timely data on the performance of these services is now being provided and the Trust anticipates that these systems will provide for appropriate reporting during 2018-2019.

The Trust has developed its capability for RTT monitoring and reporting using its data warehouse and bespoke reporting tool, based on national RTT guidance, to ensure that it is able to maintain compliance with the requirements. The data used to generate these reports is subject to rigorous, and routine, validation.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality

Report attached to this Annual Report, and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Quality and Governance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board continues to recognise the importance of having effective internal control systems, for both financial and clinical systems. Our aim is to ensure that we have the necessary systems and controls in place to give reasonable assurance regarding the quality, efficiency and effectiveness of the Trust's services.

The systems of internal control are under continuous review, in order to ensure that they continue to meet the requirements of the Trust and appropriate standards for the management of public funds. During the year, a full review of the Standing Financial Instructions was undertaken, and they were substantially updated to provide a better control environment. The reviewed wording was considered and approved by the Audit Committee.

The Board has overall responsibility for the operation of the Trust, the effectiveness of the systems of internal control, and for ensuring that public funds are used responsibility in the provision of services. Supported by the Board Committees, the Board regularly reviews performance, both financial and operational, to ensure that the agreed plans are progressing as envisaged and that there is reasonable assurance that the targets set by the Board will be met. It also reviews issues such as patient experience, recognising that part of the control environment for an NHS provider is to ensure that patients receive the best available care and service whilst with the Trust.

The Audit Committee has primary responsibility for oversight of the controls systems for the Trust, including financial and governance, and for advising the Board as to the available levels of assurance. It is supported in this work by the internal and external audit providers, the Local Counter-Fraud Service (LCFS), and work undertaken by other Committees (as discussed below). Key functions that it undertakes which enable it to judge the amount of available assurance include-

- The regular reports of the Internal Audit service, which provide specific advice on the level of assurance available in relation to the area reviewed. These also enable the Audit Committee to review management's response and proposed actions to the review's findings, and to form a view about the level of assurance those responses provide
- Advice from both the internal and external audit providers on the environment in which the Trust is operating
- The work of the LCFS which provides evidence for the Committee to judge the available assurance for systems to detect and prevent fraud and misappropriation on the public funds made available to the Trust
- Regular review of the main documentation related to the Trust's control systems- this will usually cover the Standing Financial Instructions, the Schedule of Delegations, and the Schedule of Matters Reserved to the Board of Directors (for decision)

As indicated in the detailed section of the Annual Report, the Committee has met regularly through the year and has provided positive assurance to the Board from its work.

The Quality and Governance Committee operates to provide assurance to the Board about, *inter alia*, the systems of control in place to ensure that the quality of patient care and experience is as high as possible. The Quality and Governance Committee regularly reviews information related to the effectiveness of the control systems, including reports about serious incidents, patient experience, and complaints related to services. It also reviews a range of external reporting, including from HM Coroner, professional bodies, and professional regulators such as the General Medical Council and the Nursing & Midwifery Council. In its work through the course of the year, and in particular when reviewing the draft Quality Report for the Trust, the Committee is able to assess and report to the Board on the levels of assurance available, and areas for further consideration or development.

The Quality and Governance Committee also has oversight on behalf of the Board of clinical audit activities, which form an important part of the Trust's work. A plan for clinical audits is agreed at the start of every year, and progress is monitored through the course of the year to ensure that the work plan is being appropriately prosecuted. The majority of the programme reflects national audit programmes and similar, which the Trust is expected to participate in, and details of which are provided in the Quality Report. The Trust does seek to ensure that it obtains learning and implements change as a result of the work of clinical audit, and the Quality and Governance Committee is responsible for assessing the assurance available and reporting to the Board.

The Trust retains an internal audit service provided by an external provider, Mersey Internal Audit Agency (MIAA) MIAA is an internal NHS service, provided by a partnership of Trusts. The service is provided in accordance with the relevant national standards, and the Head of Internal Audit has direct access to both the Audit Committee and myself as the Accounting Officer. MIAA undertakes a planned programme of reviews across various areas of the Trust, within the context of a three-year framework. That framework is regularly reviewed in ensure that areas for review are selected based on perceived risk and that all relevant areas are covered in the review period. The detailed annual plan is reviewed and approved by the Audit Committee.

MIAA's individual reviews are undertaken on an arm's-length basis from the Trust's management, and are reported to the Audit Committee with an assessment of the overall assurance available, actions that are recommended to improve the control environment, and an assessment of the risk levels related to those actions. The reports are accompanied by a statement by Trust management, setting out how they intend to address the report and detailed actions to be taken to improve the control environment. The Audit Committee is authorised to review the reports, and where concerned regarding the response of management may require further action or report to the Board. Agreed actions are monitored in an co-operative process between MIAA and the Governance Department; and progress reported to the Committee at least every six months. For the 2017-2018 year, the Head of Internal Audit reported to the Audit Committee that there was Substantial Assurance available that that there was a good system of internal control designed to meet the organisation's objectives, and that controls were generally being applied consistently.

Conclusion

During the year, there has been one significant control issue that has arisen; this was the Level 2 Information Governance incident referred to earlier in this Statement, together with the actions agreed. The Information Commissioner's Office has confirmed that it has no continuing concerns regarding the controls in place.

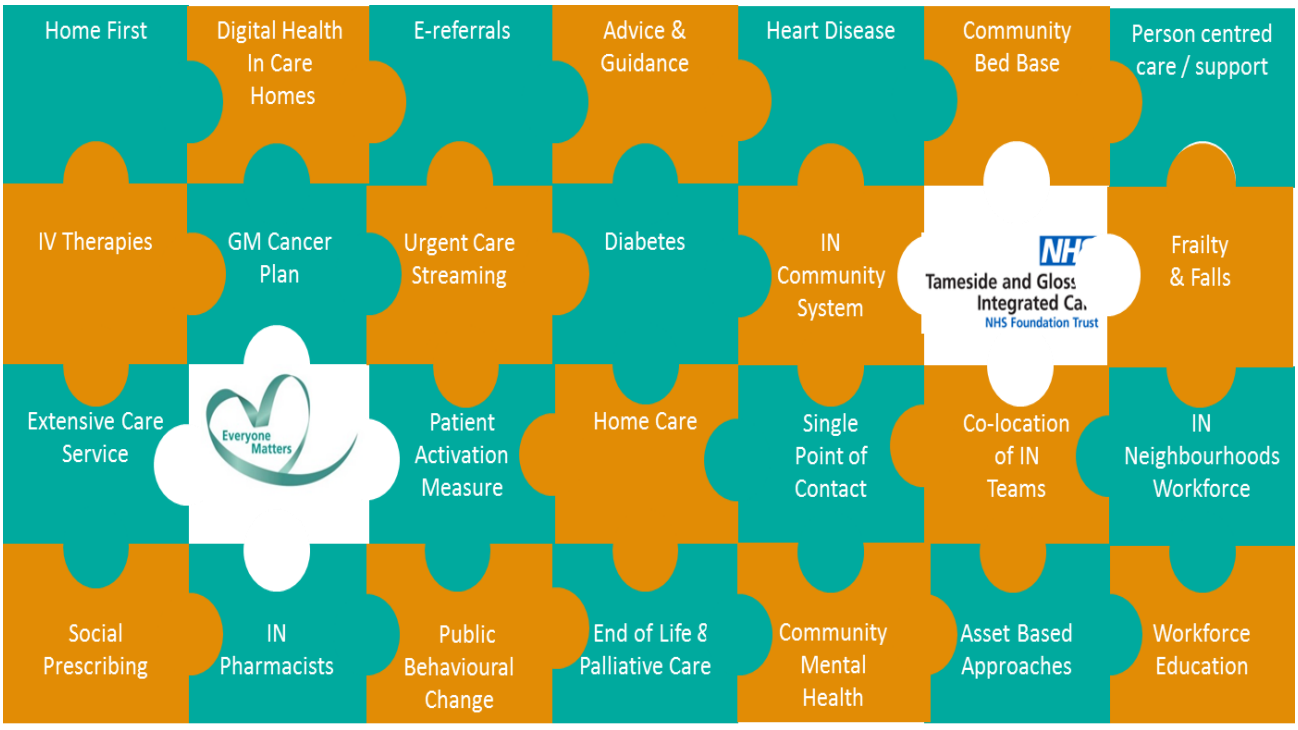
Aside from this incident, no significant internal control issues arose during the year ended 31st March, 2018; or in the period from then to the date of the making of this statement.

Karen James
Chief Executive

23rd May, 2018

Tameside and Glossop Integrated Care NHS Foundation Trust

# Annual Quality Account covering 1st April 2017 – 31st March 2018



## Contents

## Part One

# Statement on the Quality of Services from the Chief Executive

## Chief Executive's Overview

I am pleased to present our Annual Quality Account for 2017/18. This year has seen significant and important changes as we develop as an Integrated Care Organisation to develop closer working relationships and integration across health and social care sectors. This reflects the joint role we plan with our Local Authority colleagues to align our mutual ambitions to improve the health outcomes and wellbeing of our communities.

The formation and development of the five community neighbourhood locality service areas are already enabling and facilitating better and more responsive services defined by the needs of the local populations. The transformation programme to provide integrated care in partnership with our Commissioners and Social care partners enables us to continue our improvement strategy we began over three years ago.

We use every opportunity to ensure our regulators are aware of the service transformation being undertaken and the impact which this is having on the model of services we provide. Our transformation programmes are enabling us to deliver services differently across the whole health and social care economy (which is central to improving the health and wellbeing outcomes of our communities) to enable the Trust to meet its national and locally agreed quality standards. We continue to maintain those services which are rated Good by our regulators, but aspire to be rated Outstanding.

This year we welcomed our new Chair Jane McCall and a new Non–executive directors to the Trust Board. We continue to further strengthen our leadership teams ensuring we have the skills and capabilities to oversee and deliver our focus on service quality and safety.

I wish to record my gratitude to our staff for their hard work dedication and resilience during periods of transition and high demand. This also includes the ongoing support from our local health and social care partners as we strengthen our partnership to provide integrated and seamless services.

In this report I hope you will see evidence of the outcomes of our improvements which have been recognised by our regulators, service users and others. I remain confident that the continued enthusiasm and determination of our staff will drive forward our improvement and transformation programme. This will enable us to provide services that we can all be proud of.

I trust that you find our latest Annual Quality Account informative. I believe it is an accurate reflection of our performance against our quality indicators. We remain committed to continuous improvement and the use of innovative practice and welcome your feedback. To provide us your comments, or to request the Account in different languages or formats, please use any of the contact details on the rear cover of the report.

I confirm to the best of my knowledge the information in this document is accurate.

**Karen James**

**Chief Executive** **Date** **23rd May 2018**

**Part Two**

# Priorities for Improvement and Statement of Assurance from the Board

# Tameside and Glossop Integrated Care NHS Foundation Trust

## Statement of Assurance from the Board

Tameside and Glossop Integrated Care NHS Foundation Trust operates from Tameside General Hospital in Ashton-under-Lyne, providing a range of acute hospital and community services for a population of approximately 250,000 people living in the surrounding area.

The Trust became a Foundation Trust in February 2008 and in 2017/18 employed around 3500 WTE staff, across a range of professions.

## Review of Services

During 2017/18 the Tameside and Glossop Integrated Care NHS Foundation Trust provided and/or sub-contracted 7 relevant health services (defined using the Care Quality Commission's regulated activities).

The services provided were:

- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Family planning services
- Maternity and Midwifery services
- Surgical procedures
- Termination of pregnancies
- Assessment or medical treatment for persons detained under the Mental Health Act 1983

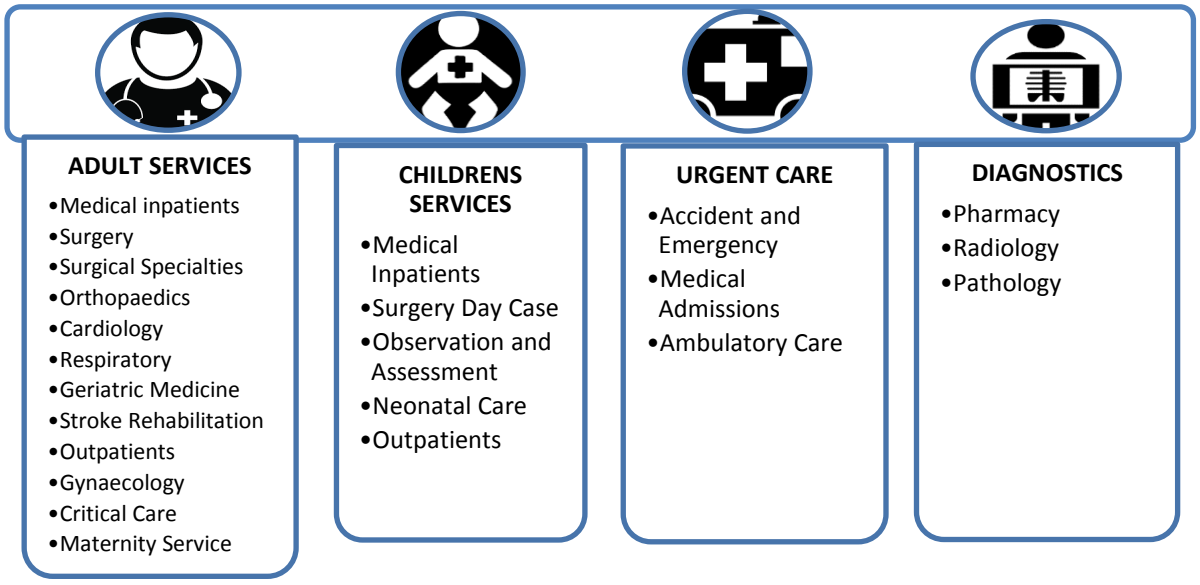
The Tameside and Glossop Integrated Care NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 7 of these relevant health services. The data the Trust has reviewed covers the three dimensions of quality patient safety, clinical effectiveness and patient experience where necessary. Where appropriate the Trust has indicated where the amount of data for review has impeded this objective. The Trust systematically and continuously reviews data related to the Quality of its services. The Trust uses its Quality, Safety and Performance metrics to demonstrate this. Reports to the Trust Board, the Trust's Quality and Governance Committee, Trust Executive Team and other key committees and the Performance Management Framework all include data and information relating to our quality of services. The Tameside and Glossop Integrated Care NHS Foundation Trust have reviewed all the data available on the quality of care in all of these NHS Services.

The income generated by the relevant health services reviewed in 2017/18 represents 93% of the total income generated from the provision of relevant health services by the Tameside and Glossop Integrated Care NHS Foundation Trust for 2017/18.

Tameside and Glossop Integrated Care NHS Foundation Trust provides a wide array of services which are set out below across the hospital and community settings in Tameside and Glossop.

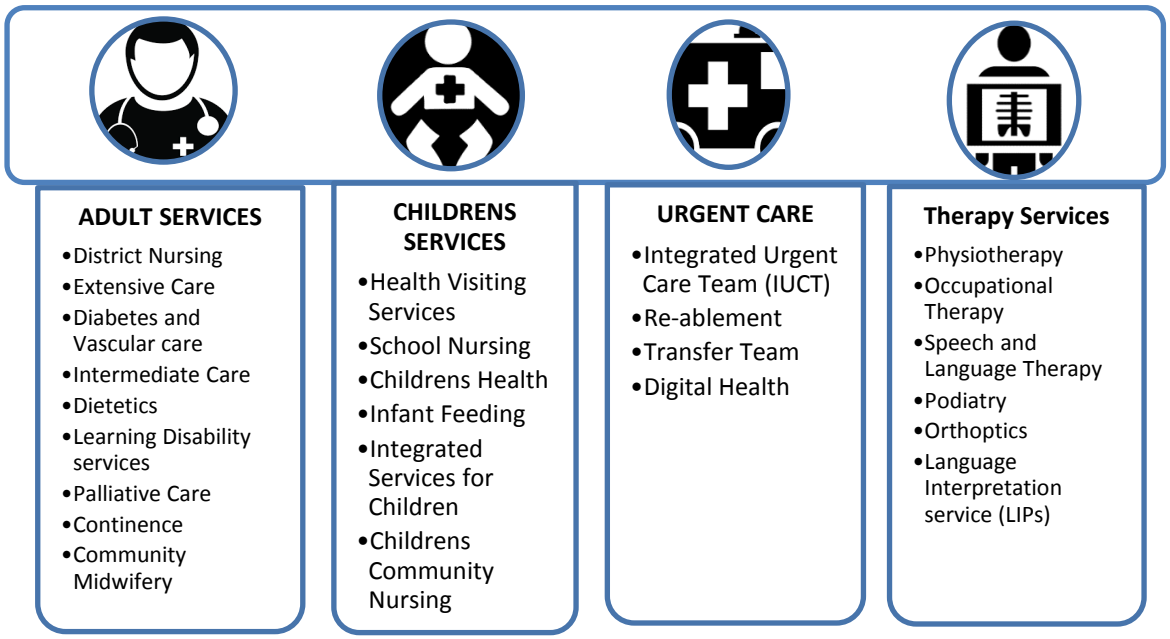
## Hospital Services

The ICFT provides local hospital services for the Tameside and Glossop population on the Tameside Hospital site.




## Community Services

The Trust provides community services from a range of premises within the Tameside and Glossop locality and in some cases in people's homes.




Whilst this describes the services provided the transformation work being undertaken by the Trust and the formation of integrated neighbourhood teams described later in the quality account will mean that the traditional boundaries of hospital and community service provision is increasing less distinct especially as further integrated working takes place with adult social care across the health and social care settings within the Tameside and Glossop localities.

## How Quality Initiatives are prioritised at the Trust

In prioritising our Quality initiatives we have considered the key requirements identified within National and Local Priorities informed by the Commissioning and regulatory requirements.

These have informed our improvement programme which has been agreed with key stakeholders to ensure delivery of the fundamental standards of Quality and Safety whilst also undertaking service improvement and service transformation. The programmes are evident in the agreed Trust Board objectives, and embrace the vision identified in the Quality Improvement strategy and Trust values and behaviours agreed and set out in the vision that “Everyone Matters “.

The service improvement and transformation programme are key drivers and the content of this Quality Account will provide an overview of progress against these. The Trust Board continues to oversee the delivery of these.

Tameside and Glossop Integrated Care NHS Foundation Trust has demonstrated that we are able to deliver our improvement plan and we have made significant progress with this which we believe are recognised by stakeholders and we have been actively looking to demonstrate to the CQC during our engagement with them.

The Trust has set out in its 5 year strategic plan “Beyond Patient Care to Population Health” its vision and aims which is aligned with the delivery of the triple aims of the national five year forward view and the Greater Manchester plan, Taking Charge, and sets out the vision, aims and how we will deliver the strategy.

### Our Vision

The Tameside and Glossop Integrated Care NHS Foundation Trust vision is to improve health outcomes for our population and influence the wider determinants of health, through collaboration with the people of Tameside and Glossop and our health and care partners.

### Our Aims

To deliver this vision our aims are to:

- Support local people to remain well by tackling the causes of ill health, supporting behaviour and lifestyle change, and maximising the role played by local communities to enable people to take greater control over their own care needs and the services they receive.
- When illness or crisis occur, provide high quality integrated services that are designed around the needs of the individual and are provided in the most appropriate setting, including in people’s own homes.
- Develop and retain a workforce that is fit for the future needs of the organisation; reward talent; and instil pride in the workforce which demonstrates our values and behaviours and has the skill and ambition for continuous improvement
- Work with partners to innovate, transform and integrate care provision in Tameside and Glossop and in doing so contribute to the delivery of financial sustainability

### Delivering the Strategy

The Trust acknowledges that delivering these ambitions will require a clear vision, strong leadership and a transparent implementation plan delivered through the Integrated Care Foundation Trust (ICFT) as the vehicle to deliver this fundamental change to the way health and social care is provided in Tameside and Glossop. The

ICFT has with partners started to develop and deliver integrated models of care.

However, we recognise that some key enablers which the Trust and its partners will need to develop to provide the capability and capacity to innovate and deliver integrated services, including our workforce, the estate and our informatics systems.

This is reinforced through the aims and drivers of the Quality Improvement Strategy, which sets out how we aim to Listen, Learn and Act to Improve. Our quality initiatives are identified and supported through our Patient Safety Programme, Patient and Service User Experience Strategy reinforced by our values and behaviours which should be evident in all that we do. These are set out in the pages below in schematic form

# Everyone Matters

## Our values and behaviours

### SAFETY

- We provide a clean safe environment for everyone.
- We take responsibility for everything we do.
- We challenge and respond to improve quality for everyone.

### RESPECT

- We recognise, value and respect everyone around us.
- We treat everyone with dignity and kindness.
- We are polite and professional.


### COMMUNICATION

- We actively listen to our patients, their relatives, carers and our colleagues.
- We are honest and open.
- We encourage and welcome feedback.

### CARE

- We are caring and compassionate.
- We offer comfort and show support and understanding.
- We involve patients and their relatives in their care.
- We care about our staff and their welfare.
- We respect privacy and confidentiality at all times.

### LEARNING

- We promote and encourage learning.
- We motivate, train and develop ourselves and others.
- We recognise and celebrate achievements.
- We learn and develop from incidents, complaints and compliments received.

# Quality Improvement Strategy

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

## Our Quality focus


## Enablers and drivers


## Our Quality Aims

- Improve consistency and reliability of care and treatment
- Implement integrated and innovative care closer to home
- Deliver what matters most to meet the individual needs
- Continuously reduce avoidable harm
- Reduce preventable deaths

**'Everyone Matters' - Our Aim is deliver with our partners, safe, effective and personal care, which you can Trust by always Listening, Learning and Acting to Improve**

The continuous improvement of clinical quality continues to be further incentivised through the contracting mechanism which includes quality schedules, penalties and CQUIN payments.

NHS England and regulation frameworks highlight the focus on quality, and are linked to the NHS Mandate and Constitution. We have worked with key partners Tameside and Glossop Clinical Commissioning Group and Tameside Metropolitan Borough Council to align our quality aims and to maximise the potential delivery through these mechanisms.

**Priorities for Quality Improvement**

The priorities for 2017/18 were set out in the Trust Objectives and in the previous Quality Account. These are identified below and what we are reporting on in this quality account

- We will maintain compliance with the CQC Fundamental Standards of Care
- We will maintain our overall CQC ratings at good and aspire to gain outstanding ratings in future service inspections
- We will maintain and or increase our incident reporting rate per 1000 bed days and aim to be in the top 25% of Trusts
- We will minimize levels of severe and catastrophic harm and be below the national average of 1%
- We will ensure our patient safety programme work streams uses metrics for anticipating and predicting potential future harm in at least five of the work streams for 2017/18
- We will achieve the identified CQUIN metric related to patient safety
- We will maintain or improve the completed eligible VTE risk assessment at an 98% or above
- We will continue to seek improvement of the Trust's mortality indices (HSMR and SHMI) and maintain them in the 'as expected' or "better than expected" bandings
- We will continue to ensure Learning from Deaths is part of the organisational learning and reported in line with the national requirements.

To improve our patient and service user experience through the delivery of a personalised, responsive, integrated, caring and compassionate approach to the delivery of care.

- We will further reduce the number of KO41 complaints per 1000 patient contacts to below 1 complaint per 1,000 patient contacts
- We seek to increase the number of recorded compliments and improve the Compliments to KO41 Complaints ratio by a further 20% to 40% from the Q4 2014/15 baseline.
- (PROMS) Patient reported outcomes continue to be reported on for a range of conditions. We will improve our participation rates for Hip and Knee procedures for questionnaires issued by the Trust from the March 2017 baseline and aspire to be better than the national average.
- We will improve our organisational PLACE Scores reported in 2017 to be at or above the 2016 national average reported scores: Cleanliness 97.57, Food and Hydration 88.49, Privacy, Dignity and Wellbeing 86.03, Condition, Appearance and Maintenance 90.11 and dementia 74.51

- The 2017/18 annual improvement measures for Patient and Service User Experience described in the Strategy are:
- Friends and Family Test - All in-patient areas to achieve a 30% response rate. Maternity to achieve a 30% response rate. ED to sustain the 25% response rate. Out-patients to achieve a 20% response rate. All areas to achieve 95% positive response rate. Adult community services to achieve a 95% positive response rate. Children's community services to achieve a 95% positive response rate.
- NHS Survey - Reduction in disturbance from noise in the in-patient environment. Improved levels of support at mealtime. Improved involvement in decision making.
- Active Patient Pathways - A minimum of 70 patients / service users on active pathways have been spoken to and their feedback is being presented to the Patient and Service Users Experience Group.

**Corporate Objectives 2018/19**

Tameside and Glossop Integrated Care NHS Foundation Trust's priorities for improvement in 2018/19 are embedded in the Trust Board agreed objectives provided in full at the end of the Quality Account. Our priorities for improvement are developed in the context of our Quality Improvement Strategy and Patient Safety Programme which have been implemented and are currently being redeveloped to reflect the changes in organisational structure and further integration and service transformation.

To ensure our patients and users receive harm free care by improving the quality and safety of our services through the delivery of our Quality, improvement and Safety programmes.

- Maintain compliance with the CQC Fundamental Standards of Care and our overall CQC rating of "Good", but aspire to gain "Outstanding" ratings in future service inspections.
- Further increase our NRLS incident reporting rate per 1000 bed days and aim to be in the top 20% of Trusts and will improve the staff survey feedback response related to incident reporting.
- Minimize levels of severe and catastrophic harm and be below the national average of 1% in NRLS reports
- Ensure our patient safety programme work streams delivers reduced harm by learning from experience, feedback and implementing agreed best practice care pathways for Pressure ulcers, Falls, Infection prevention, Venous Thrombo embolism, Sepsis, Acute Kidney injury and Hyperkalaemia
- Continue to seek improvement of the Trust's mortality indices (HSMR and SHMI) and maintain them in the 'as expected' or "better than expected" bandings.
- Continue to ensure Learning from Deaths is part of the organisational learning and reported in line with the national requirements and aim to have zero avoidable deaths.

To improve our patient and service user experience through the delivery of a personalised, responsive, caring and compassionate approach to the delivery of care.

- Introduce Dining Companions to 50% of adult in-patient wards.

- Manage the FFT within the Emergency department to achieve a 20% response rate and a >90% positive response.
- Further reduce the number of KO41 complaints per 1000 patient contacts from 1 to 0.7 per 1,000 patient contacts.
- Increase the ratio of recorded compliments to complaints received from the Q4 2017/18 baseline (Jan, Feb, March average) 21.84 by 5%.
- Increase the percentage of complaints responded to within an agreed time scale from 90% by 5%.
- Decrease the average time to close concerns (KO41 and PALS) from 12 days to 10 days.
- Improve our participation rates for Patient Reported Outcomes (PROMS) for Hip and Knee procedures for questionnaires issued by the Trust from March 2017 baseline and be better than the national average.
- Continue to work with our partners to reduce the number of delayed discharges to no more than 3.3% across the financial year.

These objectives build on those undertaken in the last year to continue our improvement programme and delivery of Safe, Effective and Personalised care in the services we provide. Progress against these objectives will be reported and monitored through the Trust Board and its subcommittees against agreed standards.

These priorities have been chosen based upon national/local priorities and taking analysed patient and stakeholder feedback. Where benchmarking information has been used in data provided in this report, unless otherwise stated, it has been taken from data available from the Health and Social Care Information Centre.

## Monitoring Priorities at Tameside and Glossop Integrated Care NHS FT

The strengthening of divisional and speciality governance systems across the Trust continues to be a priority to ensure that the organisation is assured of the services being provided through the divisional and directorate structures.

We have developed the capacity and capability in our divisional infrastructure with an emphasis on Clinical Leadership with overview and scrutiny from Non- Executive Directors, Governors and third party organisations. This enables the Corporate and executive teams to appropriately monitor, challenge and seek assurance on the improvement, innovation and transformation of services base on the agreed priorities. Furthermore they provide for systematically ensuring that concerns and risks are appropriately managed and escalated with assurance provided through the board subcommittees to Trust Board.

## Participation in Clinical Audits

Clinical Audit involves improving the quality of patient and service users care by looking at current practice and modifying it where necessary. We take part in national and regional clinical audits, and we carry out local clinical audits. The Trust also participates in clinical outcome review programmes which investigate an area of healthcare and recommend ways of improving it.

## National Clinical Audits

The National Quality Account requirement for 2017/18 contained 54 National Clinical audits and 4 Clinical Outcome reviews.

During 2017/18, 36 National Clinical Audits and 3 Clinical Outcome Review programmes (formally known as National Confidential Enquiries) covered relevant

health services that Tameside and Glossop Integrated Care NHS Foundation Trust provides.

During 2017/18, Tameside and Glossop Integrated Care NHS Foundation Trust participated in 100% of the national clinical audits and 100% of the clinical outcome review programmes which it was eligible to participate in. The high level of participation in Clinical Audits across the Trust demonstrates the commitment to improving care quality, and allows us to benchmark our performance with other Trusts nationally.

The national clinical audits and clinical outcome review programmes that Tameside and Glossop Integrated Care NHS Foundation Trust was eligible to participate in during 2017/18 are as follows and whether we participated during 2017/18 are listed below:

| National Clinical Audits | Participation |
|---|---|
| Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) | Yes |
| Bowel Cancer (NBOCAP) | Yes |
| Cardiac Rhythm Management (CRM) | Yes |
| Case Mix Programme (CMP) ICNARC | Yes |
| Diabetes (Paediatric) (NPDA) | Yes |
| Elective Surgery (National PROMs Programme) | Yes |
| Endocrine and Thyroid National Audit | Yes |
| Falls and Fragility Fractures Audit programme (FFFAP) | Yes |
| Fractured Neck of Femur (care in emergency departments) | Yes |
| Head and Neck Cancer Audit (HANA) | Yes |
| Inflammatory Bowel Disease (IBD) programme | Yes |
| Learning Disability Mortality Review Programme (LeDeR) | Yes |
| Major Trauma Audit | Yes |
| National Audit of Breast Cancer in Older Patients (NABCOP) | Yes |
| National Audit of Dementia | Yes |
| National Audit of Intermediate Care (NAIC) | Yes |
| National Audit of Rheumatoid and Early Inflammatory Arthritis | Yes |
| National Audit of Seizures and Epilepsies in Children and Young People | Yes |
| National Cardiac Arrest Audit (NCAA) | Yes |
| National Chronic Obstructive Pulmonary Disease Audit programme (COPD) | Yes |
| National Comparative of Blood Transfusion Programme | Yes |
| National Diabetes Audit – Adults | Yes |
| National Emergency Laparotomy Audit (NELA) | Yes |
| National End of Life Care Audit | Yes |
| National Heart Failure Audit | Yes |
| National Joint Registry (NJR) | Yes |
| National Lung Cancer Audit (NLCA) | Yes |
| National Maternity and Perinatal Audit | Yes |
| National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care) | Yes |
| Oesophago-gastric Cancer (NAOGC) | Yes |

| National Clinical Audits | Participation |
|---|---|
| Pain in Children (care in emergency departments) | Yes |
| Procedural Sedation in Adults (care in emergency departments) | Yes |
| Prostate Cancer | Yes |
| Sentinel Stroke National Audit Programme (SSNAP) | Yes |
| Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme | Yes |
| UK Parkinson's Audit | Yes |

| Clinical Outcome Review Programmes | |
|---|---|
| Child Health Clinical Outcome Review Programme<br>a) Young People's Mental Health<br>b) Chronic Neurodisability<br>c) Cancer in Children, Teens and Young adults | Yes |
| Maternal, Newborn and Infant Clinical Outcome Review Programme<br>a) Confidential enquiry into serious maternal morbidity<br>b) Maternal mortality surveillance<br>c) Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)<br>d) Perinatal mortality surveillance | Yes |
| Medical & Surgical Clinical Outcome Review Programme<br>a) Perioperative Diabetes<br>b) Heart Failure | Yes |

The national clinical audits and clinical outcome review programmes that Tameside and Glossop Integrated Care NHS Foundation Trust participated in, and for which data collection was completed during 2017/18 are listed below alongside the number of cases submitted for each audit or review as a percentage of the number of registered cases required by the terms of that audit or enquiry.

| National Clinical Audits | Number submitted | Percentage submitted |
|---|---|---|
| Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) | Continuous Data Collection | |
| Bowel Cancer (NBOCAP) | Continuous Data Collection | |
| Cardiac Rhythm Management (CRM) | Continuous Data Collection | |
| Case Mix Programme (CMP) ICNARC | Continuous Data Collection | |
| Diabetes (Paediatric) (NPDA) | Continuous Data Collection | |
| Elective Surgery (National PROMs Programme) | Continuous Data Collection | |
| Endocrine and Thyroid National Audit | Continuous Data Collection | |
| Falls and Fragility Fractures Audit programme (FFFAP)<br>a) Inpatient falls<br>b) Hip Fracture database | a) 30/30<br>b) Continuous Data collection | a) 100%<br>b) Continuous Data collection |
| Fractured Neck of Femur (care in emergency departments) | 100/100 | 100% |
| Head and Neck Cancer Audit (HANA) | No data collection required in 2017/18 | |
| Inflammatory Bowel Disease (IBD) programme | Continuous Data Collection | |
| Learning Disability Mortality Review Programme (LeDeR) | Continuous Data Collection | |
| Major Trauma Audit | Continuous Data Collection | |
| National Audit of Breast Cancer in Older Patients (NABCOP) | Continuous Data collection | |
| National Audit of Dementia | 20/20 | 100% |
| National Audit of Intermediate Care (NAIC) | 2/2 | 100% |
| National Audit of Rheumatoid and Early Inflammatory Arthritis | No data collection required in 2017/18 | |
| National Audit of Seizures and Epilepsies in Children and Young People | No data collection required in 2017/18 | |
| National Cardiac Arrest Audit (NCAA) | Continuous Data Collection | |
| National Chronic Obstructive Pulmonary Disease Audit programme (COPD) | Continuous Data Collection | |
| National Comparative Blood Transfusion Programme<br>a) Transfusion Associated Circulatory Overload (TACO)<br>b) Red cell and platelet transfusion in adult haematology patients | a) 37/37<br>b) 14/14 | a) 100%<br>b) 100% |
| National Diabetes Audit - Adults | 71/71 | 100% |
| National Emergency Laparotomy Audit (NELA) | Continuous Data Collection | |
| National End of Life Care Audit | No data collection required in | |

| National Clinical Audits | Number submitted | Percentage submitted |
|---|---|---|
| | 2017/18 | |
| National Heart Failure Audit | Continuous Data Collection | |
| National Joint Registry (NJR) | Continuous Data Collection | |
| National Lung Cancer Audit (NLCA) | Continuous Data Collection | |
| National Maternity and Perinatal Audit | Continuous Data collection | |
| National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care) | Continuous Data collection | |
| Oesophago-gastric Cancer (NAOGC) | Continuous Data Collection | |
| Pain in Children (care in emergency departments) | 50/50 | 100% |
| Procedural Sedation in Adults (care in emergency departments) | 50/50 | 100% |
| Prostate Cancer | Continuous Data Collection | |
| Sentinel Stroke National Audit Programme (SSNAP) | Continuous Data Collection | |
| Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme | Continuous Data Collection | |
| UK Parkinson's Audit | 71/71 | 100% |

| Clinical Outcome Review Programmes | Number submitted | Percentage submitted |
|---|---|---|
| Child Health Clinical Outcome Review Programme<br>a) Young People's Mental Health<br>b) Chronic Neurodisability<br>c) Cancer in Children, Teens and Young adults | a) 6/6<br>b) 4/4<br>c) N/A | a) 100%<br>b) 100%<br>c) N/A |
| Maternal, Newborn and Infant Clinical Outcome Review Programme<br>a) Maternal Mortality Surveillance<br>b) Perinatal Mortality and Morbidity (Term Intrapartum Related Neonatal Deaths)<br>c) Perinatal Mortality Surveillance | Continuous Data Collection | |
| Medical & Surgical Clinical Outcome Review Programme<br>a) Peri-operative Diabetes<br>b) Heart Failure | a) 6/6<br>b) 4/4 | a) 100%<br>b) 100% |

The reports of 36 national clinical audits were reviewed by the provider in 2017/18 and Tameside and Glossop Integrated Care NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. Reports are scheduled for presentation and discussion at speciality or multi-speciality audit/clinical governance meetings. At these meetings recommendations and action plans are agreed to improve practice to ensure care is improved. Examples are provided below of national audit reports received and the associated quality improvement actions taken or being implemented. Updates on all 36 reports reviewed are reported in the annual audit report.

| Audit Title | Quality Improvement Actions |
|---|---|

| Audit Title | Quality Improvement Actions |
|---|---|
| Sentinel Stroke National Audit Programme (SSNAP) | Findings of the national reports discussed at stroke business meetings, improvements identified include:<br>• Junior Doctor Induction training on Transient Ischaemic Attack and Stroke pathways<br>• Stroke team attend daily admission unit board rounds to identify overnight stoke admissions<br>• Liaison with community teams including daily handover with community neuro-rehabilitation team and the stoke association long term support service (commissioned third sector organization) who offer patient and family support<br>• Occupational Therapy – Speech and Language Therapy (SALT) are looking at increasing group work to maximize input and social interaction for the patients<br>• Exploring the approach to repatriate patients from the hyper-acute stoke centres following the first 72hrs of care.<br>• Working towards improving data completion rates by developing a process to monitor data submission timescales, establish thresholds and escalation alerts for patients 7 day discharge / transfer information. |
| National Diabetes Core Audit | Findings of the national report shared with the division.<br>• Diabetes improvement project being undertaken in conjunction with the commissioners.<br>• Practice level dashboards produced showing compliance with annual checks and non-elective attendances/admissions.<br>• Trust diabetic specialist nurses to provide education and training to GP practices. |
| National neonatal audit programme | Findings of the national report sent to the division and discussed at the Paediatric audit meeting:<br>• A revised thermoregulation policy introduced that includes the use of gel pads for all babies less than 13 weeks.<br>• Nurse/midwives measuring and documenting temperature prior to transfer and immediately on admission to Neonatal intensive Care unit (NICU), before removal from transport incubator.<br>• Incident forms submitted for any baby with an admission temperature outside the recommended range.<br>• Focus on minimising draughts in the delivery suite.<br>• Guideline regarding the use of magnesium sulphate re-circulated.<br>• Obstetricians ensuring clear documentation of administration of magnesium sulphate and midwives ensuring this is entered on the maternity information system (specific prompt now in place).<br>• Retrospective review of cases where magnesium sulphate was not administered.<br>• Data regarding consultation with parents shared with consultants quarterly. |
| National heart failure audit report | Findings of the national report sent to the division and discussed in the cardiology business group.<br>• Business case being developed to expand heart failure specialist nurse service.<br>• Review of cardiac unit set-up and resources to improve the rates of patients with heart failure being managed on a cardiac ward.<br>• Pathway awareness raising; medicine audit meeting, junior doctor teaching session and meeting with an emergency department consultant. |
| National Cardiac Arrest Audit (NCAA) | Findings of the report sent to Trust Resuscitation Lead to be progressed via the Managing Deteriorating Patient Group. Long term programme of quality improvement and local audit identified:<br>• Revised DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) Policy introduced |

| Audit Title | Quality Improvement Actions |
|---|---|
| | • New DNACPR form implemented across the organisation<br>• Local cardiac arrest test call and response audit being undertaken. |

The results of 64 local clinical audits were reviewed by the provider in 2017/18 and Tameside and Glossop Integrated Care NHS Foundation Trust intends to take the following actions to improve the Quality of healthcare provided. Reports are scheduled for presentation and discussion at speciality or multi-speciality audit/clinical governance meetings. At these meetings recommendations and action plans are agreed to improve practice to ensure care is improved. Examples are provided below of local audit reports received and the associated quality improvement actions taken or being implemented. Updates on all 64 reports reviewed are reported in the annual audit report.

| Audit Title | Quality Improvement Actions |
|---|---|
| Management of Acute Hyperkalemia | The results have been presented at various forums to highlight the main findings. The following actions have been taken:<br>• A local guideline for the acute management of hyperkalemia in adult inpatients has been introduced (incorporating The Renal Association Guidance)<br>• Teaching for Foundation doctors has been delivered |
| Standardising Ear Nose & Throat (ENT) Operative Notes | Four cycles of data collection have been undertaken, with various actions taken. The main focus was the introduction of an electronic ENT operative notes proforma, with compliance with the Royal College of Surgeons Guidance reaching 100%. |
| Fluid Balance on Surgical Unit & Acute Kidney Injury (AKI) on the Acute Medical Unit | These two projects have followed previous work to improve AKI management throughout the Trust. Following the collection of baseline data, a need for further education around AKI and the importance of effective fluid management was identified.<br><br>The following actions have been undertaken:<br>• New Trust Fluid Balance Chart developed and launched in conjunction with World Kidney Day<br>• Revised AKI Care Bundle introduced<br>• Training provided on all wards with ongoing point of care support provided<br>• Stage 2/3 AKI identified and attended by Clinical Effectiveness nurse<br>• Awareness raising through presentations at Divisional meetings/Trust events<br>• AKI training included in Trust Induction and available on request<br>• 'Improving AKI Care' Intranet page developed<br>Further data collection will be undertaken to monitor progress but feedback from observations suggests improved knowledge and patient management. |
| Sepsis CQUIN | Below are some of the actions implemented:<br>• Revised Adult Sepsis Care Bundle and a Sepsis Screening Sticker introduced in Emergency Department (ED)<br>• Clinical Effectiveness Nurse Lead for Sepsis designated<br>• Awareness raising through presentations at Divisional meetings/Trust events<br>• Sepsis training added to Trust/Junior Doctor/Nurse induction training programmes & point of care training delivered<br>• Sepsis recognition and treatment guidance cards provided for all clinical staff<br>• 'Improving Sepsis Care' intranet page developed<br><br>As a result, compliance with the administration of IV antibiotics to patients presenting with red flag sepsis or septic shock, within 1 hour of presentation is consistently achieving 100%. |
| Audit of British Dermatology Association (BAD) minimum standards for a phototherapy service | A compliance rate of > 80% was achieved in 17/22 of the audit standards. The following actions have been taken to improve in other areas:<br>• A consultant lead has been appointed for phototherapy<br>• A phototherapy nurse has been recruited<br>• The phototherapy request form has been redesigned to include skin phototypes<br>• When patient leaflets are given, this is now documented in the patient notes |
| Decontamination of Flexible Nasendoscopes | The results were presented and discussed, with the following actions taken:<br>• Decontamination instructions appropriately displayed<br>• Gloves provided close to the scope<br>• Sterile bags ordered for storing and transporting the scope |

| Audit Title | Quality Improvement Actions |
|---|---|
| | • Training in decontamination provided<br>Further data collection has showed significant improvements, with compliance of 100% in most areas. Further education has been provided regarding completion of the log book and a third cycle of data collection showed compliance of 80%. |
| Dermatology Record Keeping | The report highlighted significant improvements in the recording of a printed name, professional registration number and designation, with an increased use of professional stamps.<br><br>Further education has been provided to the clinical team. |
| Recognition and Management of Fragility Fractures | The following actions have been taken to improve:<br>• An Osteoporosis & Fragility Fractures Patient Information Leaflet has been designed and is now given to appropriate patients attending fracture clinic<br>• Fragility Fractures are now explicitly referred to in GP letters, with advice provided<br>• The potential for a Fracture Liaison Service is being discussed with the Rheumatology Department |
| Paediatric early warning score (PEWS) | Following audits in both the Children's Unit and Emergency Department (ED), the teams have worked together to introduce a new consolidated PEWS proforma , which is suitably sensitive to set appropriate early warning triggers in both areas.<br>An audit measuring compliance with the new proforma has shown significant improvements in doctor review times and correct completion of the PEWS score.<br>Training on the new tool is on-going and further data to measure the impact has recently been undertaken. |
| National Early Warning Score (NEWS) | As an action from data collected in 2016, a project manager was designated to design, co-ordinate and monitor a Trust wide NEWS improvement programme. This included extensive training and education, the introduction of a revised escalation protocol and a review of the Trust's Adult Observation Chart for NEWS, leading to the development and launch of a comprehensive Clinical Observation Booklet. Appropriate training has been incorporated into the Trust induction process.<br>Further data collection has found significant improvements in the scoring and calculating of NEW scores. |
| GAMMA Nail | Following the findings of the initial audit to assess degree of mismatching the lateral view of distal femur of all gamma nails, it was agreed to change length R200 to R150 Gamma Nail.<br>A re-audit noted an improvement from 80% of eccentric placement to 25%. These findings were discussed in the orthopedics audit meeting with the surgeons agreeing that the remaining eccentric placements are due to variation of angle in the population and are therefore acceptable. |
| Audit of the Discharge Policy for Children | To ensure accurate and timely transfer of information from the hospital to primary care, a discharge checklist has been introduced. A second cycle of data collection shows improved compliance at 100% in many areas. |
| Maternity early warning score (MEWS) | Following a number of quick data collection cycles, it was agreed that the MEWS chart should be aligned to the Trust's national early warning score (NEWS) chart.<br>Staff commitment to improving patient care has resulted in the below key achievements:<br>• A revised MEWS chart, aligned to the Trust NEWS chart has been integrated into the antenatal, labour and postnatal clinical care guidelines and launched via training sessions with appropriate staff throughout the trust<br>• The ward manager audits compliance with MEWS and escalates areas of concern via the O&G Clinical Governance Group<br>• Opportunity for compliance has been increased by placing the MEWS chart near the patient in specially procured folders |

| Audit Title | Quality Improvement Actions |
|---|---|
| | These measures have resulted in significant improvements between Nov 2016 and Nov 2017. |
| Unnecessary Admissions for Hyperemesis | In order to reduce unnecessary hospital admissions for women suffering from mild/moderate nausea and vomiting in pregnancy (NVP) and to ensure compliance with Royal College of Obstetricians and Gynaecologists (RCOG) Guidelines, the following improvements have been implemented:<br>• A new pathway has been introduced, with low/moderate risk patients presenting to ED/GP/Antenatal Clinic/Midwives provided with an out-patient IV therapy service to avoid hospital admission<br>• All appropriate services/stakeholders have been informed and appropriately trained in order to implement the pathway |
| Carbon Monoxide Screening | The audit resulted in the following improvements:<br>• All maternity staff have been trained on using CO2 monitors<br>• Stop smoking champions have been recruited in all maternity areas, undergoing training on behavioral support/use of Nicotine Replacement Therapy to enable them to support women to stop smoking<br>• $CO_2$ reading recording has been added to Euroking, with prompts at booking and 36 weeks<br>• Staff have been briefed on the problems caused by faulty boilers and passive smoking and how to discuss smoking with mums<br>A further audit cycle is currently being undertaken to measure the impact of the changes made. |
| Audit of Neonatal Sepsis Guidelines | This audit was based on NICE guidance for early onset sepsis to prevent this significant cause of mortality and morbidity in newborn babies. The audit resulted in the following quality improvements:<br>• A cannulation trolley has been purchased<br>• The observation proforma has been redesigned<br>• Consensus of IV antibiotics to neonates has been disseminated<br>• IV antibiotics administration in neonates training for midwife is continuing |
| Adherence to Ventilator Associated Pneumonia (VAP) Bundle | The audit found encouragingly high levels of compliance with the care bundle throughout, with the following actions for improvement currently being implemented:<br>• VAP teaching sessions to be delivered and integrated into the induction programme<br>• A section on 'sedation hold' is to be added to the daily clerking sheet |
| Perioperative Hypothermia | Following previous cycles of data collection, the results were discussed at various forums and the following actions implemented:<br>• Core temperature probes introduced for major surgery<br>• Importance of temperature monitoring in relation to inadvertent hypothermia communicated<br>• Guidance/pathways for temperature monitoring displayed in theatres<br>The results show some encouraging results but progress will be monitored through further data collection cycles. |
| Nutrition and Hydration | Three cycles of data collection have been undertaken with significant improvement in dietician referral for high scoring patients demonstrated. The following are some of the actions taken:<br>• Body Mass Index (BMI) calculation charts made available on patient note trolleys and ward based teaching on their use delivered<br>• Tape measures made available/new standometers purchased<br>• The weighing hoist has been located centrally in Adult Medical Unit (AMU)<br>• Hoist scales training included in Trust mandatory manual handling training for all clinical staff<br>• A revised Malnutrition Universal Screening Tool (MUST) proforma has been launched and is included in the AMU Quality & Safety Round checklist<br>• MUST e-learning completion is encouraged<br>• Regular MDT Nutrition Study days offered<br>• Dieticians/nutrition nurse led nutrition sessions delivered to FY1 Doctors |

## Learning from Deaths

The National Quality Board (NQB) Learning from Deaths framework requires hospital trusts to adopt a standardised and transparent approach to learning from the care provided to patients who die.

The Tameside & Glossop Integrated Care NHS Foundation Trust has undertaken mortality reviews (case review) on all deaths since November 2014 as part of its Quality Improvement Programme which we believe is best practice and avoids us having to identify which cases need to be reviewed. We focus on learning from the care provided, and being accountable for our actions and ensuring improvement if sub-standard care is identified.

The mortality review process under the leadership of the Medical Director is in place to support the Trust in developing a culture of learning, openness and transparency and sharing information with the bereaved family or carer by providing them with the opportunity to inform the review of investigation process in addition to the Duty of Candour requirements. We have commenced reporting to Trust board on a quarterly basis and have an identified non-executive director lead in this regard.

The reviews are completed by trained multi-disciplinary team members, using standardised documentation which is aligned to the National Learning from Deaths Guidance and the requirements of the Child Death Overview Panel (CDOP) and Learning Disability Mortality Review (LeDeR) Programme.

All case reviews and investigations are completed with an aim of identifying any learning by way of missed opportunities or to identify practice related issues. The reports are shared through divisional and trust governance and safety forums, and the executive led Mortality Steering Group to share the learning trust wide and across the health economy.

Through the Mortality Steering Group the clinical teams are required to develop comprehensive action plans to address missed opportunities, the group also recognise and highlight areas of good practice which are shared with staff involved in the care.

The Trust is committed to learning from the mortality review process and continues to develop and strengthen the process, for 2018/19 the Trust recognises the importance of gaining the views of bereaved relatives and carers and is developing a process to ensure that they are involved and may direct any investigation.

The Trust Learning from Deaths Policy applies to all patients that die in hospital and where the Trust has been involved in the care of the patient (including deaths that have occurred outside of the organisation whereby shared care has been provided).

The scope of the policy therefore may include deaths where other triggers for investigation are evident. Wherever possible an integrated approach to investigations is adopted to ensure investigations provide for the requirements of any incident, complaint, safeguarding concerns or coronial inquests requirement to avoid unnecessary duplication.

During 2017/18, 1101 Tameside & Glossop Integrated Care NHS Foundation Trust patients died.

By 31st March 2018, 983 case record reviews and 10 Investigations have been carried out in relation to 10 of the patient deaths detailed. In 10 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:

10 representing 1.0% 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:

- 4 representing 1.9% for the first quarter;
- 0 representing 0.0% for the second quarter;
- 2 representing 0.7% for the third quarter;
- 1 representing 0.2% for the fourth quarter;

The table below shows the quarterly breakdown of required activity in each quarter of that reporting period:

| | Patients that died | Completed case record reviews | Case review and investigation (Number) | Case review and investigation (%age) |
|---|---|---|---|---|
| Q1 Apr – Jun 17 | 210 | 210 | 7 | 1.9% |
| Q2 Jul – Sep 17 | 202 | 202 | 0 | 0.0% |
| Q3 Oct - Dec 17 | 273 | 273 | 2 | 0.7% |
| Q4 Jan – Mar 18 | 416 | 298 | 1 | 0.2% |

0.3% (2) 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:

- 0% of deaths for the first quarter
- 0.9 % (2) for the second quarter
- 0% of deaths for the third quarter
- Completed fourth Quarter data not available at time of report

These numbers have been estimated using the following methods

Mortality reviews completed using the standardised mortality review process in accordance with the Trusts Learning from Deaths Policy. Investigations completed in accordance with the Trusts Incident Reporting, and Incident and Complaint Investigation Policy.

The focus of the case reviews and investigations is to identify any learning by way of missed opportunities or practice related issues. The outcomes are shared through divisional and trust wide governance and safety forums, including the executive led Trust Mortality Steering Group to share the learning Trust wide, and the information triangulated with other sources of information to ensure thematic learning is understood and actioned.

The Table below highlights the learning and action taken

| Learning | Action taken |
|---|---|
| Inconsistent communication and documentation documented in plans of care, handover or escalation plan when patients deteriorate by clinical teams | Reminders to all Clinical teams and staff of the importance and requirement for consistent and comprehensive documentation to enable high quality patient care and treatment.<br>The Trust has also implemented an E CAS card system to standardise processes and approach providing greater clarity and consistency. |
| Necessity for ensuring senior clinician oversight, review and awareness of patients prior to discharge from the emergency department | Implemented process for consistent senior clinical oversight prior to discharge. |
| Inconsistency in NEWS scoring and calculation and therefore appropriate escalation of the deteriorating patient | Review and implementation of a revised National Early Warning Score (NEWS) Chart incorporating NEWS 2 in line with National Guidance overseen by the Managing the Deteriorating Patient Safety Workstream.<br>The Trust has also implemented an E CAS card system which standardises this process. The development will be considered for Trust wide implementation to provide clarity and consistency. |

| Learning | Action taken |
|---|---|
| Delay's in the recognition, timely management and treatment of Acute Kidney Injury (AKI), hyperkalaemia & Red Flag Sepsis with inconsistency in completion of fluid balance charts | AKI – Generation of a daily laboratory report to identify patients with AKI stage 2 & 3, a clinical review of the patient is completed to ensure timely interventions and management in line with the implemented revised AKI pathway and guidance<br><br>AKI Awareness training delivered to all clinical staff on trust induction and various MDT forums – including toolbox talks in clinical areas<br><br>AKI Risk Assessment Flow Chart Guidance incorporated into a new Fluid Balance Chart that also incorporates a Recommended Protocol for Commencing Fluid Balance Monitoring to support clinical staff, implemented Trust wide. Awareness training delivered to all clinical staff on trust induction and various MDT forums – including toolbox talks in clinical areas<br><br>Sepsis Care Pathway and Screening Tool updated to reflect revised NICE guidance in association with the clinical teams - Awareness training to all clinical staff on trust induction and various MDT forums – including toolbox talks in clinical areas<br><br>Management of acute Hyperkalaemia Guidance developed and implemented - Awareness training to all clinical staff on trust induction and various MDT forums – including toolbox talks in clinical areas |

As a Trust we continue to learn and improve our approach to learning from deaths following the implementation of the actions described above the impact of these is that we do not anticipate these issues arising again and or have reviewed the effect of implementation of revised care pathways and guidance and can demonstrate:

- Sepsis: compliance with the administration of IV antibiotics to patients presenting with red flag sepsis or septic shock, within 1 hour of presentation is consistently reported at 100% in monthly audits as part of the CQUIN.
- NEWS: following an extensive training programme further audit data collection has showed significant improvements, with compliance in the scoring and calculating of NEW scores.
- Clinical review of patients identified with AKI has found encouragingly high levels of compliance by the clinical teams with use of the AKI care bundle and reduction in time taken to reduce the stages of AKI to 0, progress will be monitored through further audit cycles to validate these observations.

Compliance and assurance has been assessed during the reporting period and taken from monitoring of action plans in place within Divisions, clinical audits of compliance and reviews at point of care for these patient groups.

Whilst the Quarterly learning from deaths reporting process started formally to Trust

board in September 2017, 2 deaths that were subject to both a case record review and an investigation have been completed during the reporting period April 17 to March 18) which related to deaths which took place before the start of the reporting period.

0% of the 2 patient deaths before the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. This number has not been estimated as we review all deaths using the methods as described above.

The total number of deaths identified in the 2017/18 reporting period and the previous reporting period for Tameside & Glossop Integrated Care NHS Foundation Trust is 0.3% (2) that were judged to be more likely than not to have been due to problems in the care provided to the patient. However a number of deaths are still to be reviewed through the Coronial process and this may change the reported figure.

**Implementing the priority clinical standards for seven day hospital services.**

The Trust has considered the priority clinical standards for seven day services and the potential impact of these. We have undertaken a gap analysis and developed a business case to set out the consequence of the implementation. This is being discussed with commissioners.

The service improvement and transformation programmes being implemented are also being used where possible to ensure that where service review and redesign is being undertaken that we make progress towards achievement of these standards where possible. The Trust undertakes the national audits of the four priority standards to assess it compliance and progress towards the requirements by 2020. The results of these are captured in the annual audit report published separately.

## Research and Development

Research is vital to improve the knowledge needed to develop the current and future quality of care for patients. Carrying out high quality research gives the NHS the opportunity to minimise inadequacies in healthcare and improve the treatments patients receive. The Trust is only involved with research studies that have received a favourable opinion from the Research Ethics Committee within the National Research Ethics Service (NRES), and the Health Research Authority, signifying the research projects are of high scientific quality and have been risk assessed.

The Research Department is committed to providing patients with the opportunity to participate in research, if they wish. We aim to ask all eligible patients if they would like to participate in a clinical trial.

The number of patients receiving relevant health services provided or sub-contracted by the Tameside and Glossop Integrated Care NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 588 (at 23/01/2018). This has surpassed our target of 544 participants, set by the Clinical Research Network.

Currently, there are 108 research studies, a growth from 2016/17, either in the planned stage, are active or in follow up. We have 34 actively recruiting studies which are adopted on to the National Institute for Health Research (NIHR) Clinical Research Network portfolio. These studies are high quality trials that benefit from the infrastructure and support of the Clinical Research Network (CRN) in England. We are currently hosting 4 actively recruiting clinical trials involving medicinal products, with two further CTIMP studies in the planning stage, which demonstrate the Trusts enthusiasm to improve and offer the latest medical treatments.

The Trust has strong team of 6 (3 full time and 3 part time) dedicated research nurses working generically on a variety of research studies and 2 clinical trials administrators. The Trust has strong research activity in Cancer, Orthodontics and Paediatrics and we continue to get more and more departments involved. This year, we have seen a large increase in recruitment to reproductive health & childbirth and Stroke studies. The recruitment to musculoskeletal disorders has also increased in recent months. The ophthalmology department has recently opened to their first research study. A number of other departments have shown interest in becoming research active, in areas covering dementia, cardiology and ENT and we are waiting for suitable studies to become available to get involved with. There are currently over 20 clinical staff acting as the Trust lead investigator on approved research studies.

The Trust research nurses work closely with the investigators to identify suitable research studies that fit with the patient population and also to identify eligible patients to participate. It is envisaged that the continued dedication and flexibility of the research nurses, together with the enthusiasm and support of the clinicians will further raise the profile of Research and Development in 2018/19.

2017/18 has seen a number of achievements for the research department;

- The research department held its first Research Conference at Tameside hospital in February 2018. This will hopefully become an annual occurrence.
- The research team and EPAU staff enrolled 150 patients to the VESPA study within 6 weeks. This is the result of the dedication to work out of hours and weekends.

- Tameside Hospital is the highest recruiter to the Stroke Rehabilitation and Dementia study with 45 patients recruited, exceeding our target of 40 patients.
- Tameside Hospital is the highest recruiter in Greater Manchester to the international study PRED 4.
- The research department has surpassed its annual recruitment target for 2017/18, well ahead of the end of the financial year.
- The research department holds an annual stand for International Clinical Trials Day, to promote research within the Trust
- Tameside Hospital is regularly praised for recruitment achievements at the Clinical Research Network: Greater Manchester Board meetings
- The research team continue to achieve high performance rates and regularly surpass the study recruitment targets and the Clinical Research Network targets

The Trust continues to participate in research studies that are feasible in terms of the services we offer and our patient population and aspire to raise the profile of research further in 2018/19.

## Goals agreed with the Commissioners

The Clinical Commissioning Group for Tameside and Glossop holds the NHS budget locally and they decide how it is spent within the hospital and other community health services. This is known as commissioning. Tameside and Glossop CCG is the lead commissioner of services at Tameside and Glossop Integrated Care NHS Foundation Trust and incentives based on Quality and Innovation. These payments support Quality as a driving principle.

A proportion of Tameside and Glossop Integrated Care NHS Foundation Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between Tameside and Glossop Integrated Care NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The monetary total for the amount of income in 2017/18 conditional upon achieving quality and improvement goals was £3.60m and the monetary value to CQUIN in 2017/18 which was achieved was £3.58m compared to £3.36m in 2016/17.

Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at http://www.england.nhs.uk/nhs-standard-contract/

The summary detail of Tameside and Glossop Integrated Care NHS Foundation Trusts CQUIN goals are identified in the table below

## 2017/18 CQUIN Goals

| Indicator Number | | Indicator Name | year ends status |
|---|---|---|---|
| National | 1a | Improvement of health and wellbeing of NHS staff | Achieved |
| | 1b | Healthy food for NHS staff, visitors and patients | Achieved |
| | 1c | Improving the uptake of flu vaccinations for frontline clinical staff | Partial achievement |
| | 2a | Timely identification of patients with sepsis in emergency departments and acute inpatient settings | Achieved |
| | 2b | Timely treatment for sepsis in emergency departments and acute inpatient settings | Achieved |
| | 2c | Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours. | Achieved |
| | 2d | Reduction in antibiotic consumption per 1,000 admissions | Achieved |
| | 4 | Improving services for people with mental health needs who present to A&E | Achieved |
| | 6 | Advice & Guidance | Achieved |
| | 7 | E-referrals | Achieved |
| | 8a | Supporting proactive and safe discharge - discharge pathways | Achieved |
| | 8b | Supporting proactive and safe discharge - Emergency Care data set | Achieved |
| | 8c | Supporting proactive and safe discharge - increased discharges within 7 days of non-elective patients | Achieved |
| | 10 | Improving the assessment of wounds | Achieved |

| | | | |
|---|---|---|---|
| | 11 | Personalised care and support planning | Achieved |

## What others say about Tameside and Glossop Integrated Care NHS Foundation Trust

The Care Quality Commission (CQC) regulates and inspects Health and Social Care organisations. If it is satisfied that the organisation provides care which meets the Fundamental Standards of Quality and Safety it registers the organisation to provide services "without conditions".

Tameside and Glossop Integrated Care NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "GOOD".

Tameside and Glossop Integrated Care NHS Foundation Hospital Trust has no conditions on its registration.

The Care Quality Commission has not taken enforcement action against Tameside and Glossop Integrated Care NHS Foundation Trust during 2017/18.

Tameside and Glossop Integrated Care NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2017/18.

In August 2016 the CQC undertook a Chief inspector of Hospitals comprehensive inspection, and inspected specific core services of the Hospital Trust identified in the matrix below, covering all acute services. The report was issued in February 2017 and the matrix of current outcomes reported is identified in the table below by service area.

**CQC Ratings for Tameside and Glossop Integrated Care NHS Foundation Trust**


| | Safe | Effective | Caring | Responsive | Well led | Overall |
|---|---|---|---|---|---|---|
| Medical care | Good | Requires improvement | Good | Requires improvement | Good | Requires improvement |
| Medical care (including older people's care) | Requires improvement | Requires improvement | Good | Good | Good | Requires improvement |
| Urgent and emergency services (A&E) | Good | Good | Good | Requires improvement | Good | Good |
| Surgery | Good | Good | Good | Good | Good | Good |
| Intensive/critical care | Good | Good | Good | Good | Good | Good |
| Maternity and gynaecology | Requires improvement | Good | Good | Good | Good | Good |
| Services for children & young people | Good | Good | Good | Good | Good | Good |
| End of life care | Good | Requires improvement | Good | Good | Good | Good |
| Outpatients | Good | Not rated | Good | Good | Good | Good |

The Tameside and Glossop Community Services have not yet been inspected and rated as part of the Trust.

The Chief Inspector of Hospital's review made 1 non-urgent recommendation relating to Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities), drawn from the "MUST DO's "within the CQC report to enhance the Safety, Effectiveness and Responsiveness of care provided by the Trust.

The key themes of these recommendations were related to:

- Improving patient flow throughout the hospital minimise transfers and ensure timely access to services to meet the patient's needs.
- Maintaining staffing levels to meet the needs of patients.
- Achievement of consistent levels of mandatory training and appraisal in all areas.
- Consistent management of medicines in line with best practice in all areas.

We have implemented actions or reviewed ongoing work programmes to ensure the issues identified are addressed. Oversight and improvement arrangements have been put in place to support the changes required. The required improvements have been integrated into the Trust Patient Safety Programme work streams or Improvement work streams which are systematically monitored and provide updates and assurance on progress through our Divisional and Corporate Governance structures.

The Quality and Governance committee continues to oversee the organisational assurance of these actions and progress through direct reports to the committee or by use of Assurance walk rounds which committee members participate in to obtain real-time assurance on actions previously reported to the committee.

**Tameside and Glossop Clinical Commissioning Group Quality walk round visits**

Tameside and Glossop Clinical Commissioning group have not undertaken Quality walk round visits in 2017/18, however the CCG Director of Nursing and Quality continues to be a routine invitee to the Trust Quality and Governance committee meetings and walk rounds during the year and Chairs the Contact Quality and performance meeting to seek and receive assurance on service provision.

**Other Reports**

**UNICEF Baby friendly award**

Our Health Visitors and Children's Centres have been awarded the UNICEF Baby Friendly Award in 2017

**JAG (Joint Advisory Group on Gastrointestinal Endoscopy) Accreditation**

The Trust successfully retained its JAG (Joint Advisory Group on gastrointestinal endoscopy) accreditation. This accreditation is a quality improvement and service accreditation programme which assesses endoscopy units for quality of service provision to provide assurance to patients and commissioners of the quality of service being provided.

**GIRFT (Get It Right First Time) reports**

The Getting It Right First Time (GIRFT) Programme is helping to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improving patient outcomes. The Trust is engaging with these work streams and the

analysis provided to identify learning and service changes that could impact on the Quality and Safety of Care and impact on the effective use of resources.

**Data Quality**

Tameside and Glossop Integrated Care NHS Foundation Trust recognise that good data quality and information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. Improved Data quality will improve patient care and improve value for money.

**NHS Number and General Medical Practice Code Validity**

Tameside and Glossop Integrated Care NHS Foundation Trust submitted records during April 2017 to March 2018 to the Secondary Users Service (SUS) for inclusion in the Hospital Episode Statistics. These are included in the latest published data (Jan 2018). The percentage of records in the published data which included the patient's valid NHS number was:

- 99.9% for admitted patient care;
- 100% for outpatient care; and
- 99.6% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care;
- 100% for outpatient care; and
- 100% for accident and emergency care.

Tameside and Glossop Integrated Care NHS Foundation Trust continue to take the actions to improve data quality. The Trust recognises that the metrics listed above constitute an extremely narrow view of data quality and has, therefore, created a forum to monitor and manage data quality, using a wider definition, across the organisation. The Data Quality Steering Group is designed to provide assurance on the implementation and maintenance of information quality assurance standards, ensuring that system users are engaged in the enterprise of continuous data-quality improvement through informed discussion and shared knowledge on the accuracy, completeness and timeliness of data entry and the resolution of any issues with data quality. The Data Quality Steering Group will manage and oversee the Trust's Data Quality Improvement Plan and continuously reviews the Trust's Data Quality Scorecard, identifying areas for improvement and supporting the development of strategies and processes to facilitate this.

**Information Governance Toolkit attainment levels**

Information Governance is about how NHS and social care organisations and individuals handle information. This can be personal, patient, sensitive and/or corporate information. Tameside and Glossop Integrated Care NHS Foundation Trust Information Governance Assessment Report for 2017/18 was 68% and was graded Green (satisfactory for all requirements).

**Clinical Coding Error Rate**

Tameside and Glossop Integrated Care NHS Foundation Trust was not subject to the Payment by Results (PbR) Clinical Coding Audit during 2017/18 by the Audit Commission.

The Trust's 2016/17 Clinical Coding Audit Report conducted in November 2016 by our Accredited Clinical Coding Auditor, related to coded activity from the period July to September 2016 identified that:

The overall standard of clinical coding was good and the Trust had attained the recommended information governance level 2 target. (See table below for details).

The general standard of clinical coding at the Trust is good and has shown improvement since last year's audit. 93% of primary diagnoses audited and 94% of the primary procedures were correctly recorded. Therefore the Trust has attained the recommended information governance level 2 targets.

Table of main findings

| | **Total from episodes audited** | **Total correct** | **% correct** |
|---|---|---|---|
| Primary diagnosis | 200 | 186 | 93 |
| Secondary diagnosis | 592 | 520 | 88 |
| Primary procedure | 178 | 168 | 94 |
| Secondary procedure | 449 | 391 | 87 |

In order to deliver the further improvement the Tameside and Glossop Integrated Care NHS Foundation Trust will be taking the following action to improve data quality through its Clinical Coding Department by continuing to internally audit and action the results and provide a training programme.

The purpose of the programme is to ensure continuous improvement and increased effectiveness of the clinical coded data being produced. The impact of the training and validation during the last 12 months has resulted in further improvement in data quality evidenced in the results provided.

## Reporting against Quality Account Core indicators

The prescribed requirement for reporting against core indicators listed below has been undertaken and is provided in the next section of the Quality account - How we performed on Quality in 2017/18 alongside the reporting of the current performance for the indicator.

| Core indicator requirement number and description | Reported on |
|---|---|
| 12. (a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and<br>(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. | Page 80 |
| 18. The trust's patient reported outcome measures scores for:<br>(i) groin hernia surgery,<br>(ii) varicose vein surgery,<br>(iii) hip replacement surgery, and<br>(iv) knee replacement surgery, during the reporting period. | Page 75 |
| 19. The percentage of patients aged - (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period. | Page 76 |
| 20. The trust's responsiveness to the personal needs of its patients during the reporting period. | Page 66 |
| 21. The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends | Page 69 |
| 23. The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. | Page 52 |
| 24. The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period. | Page 55 |
| 25. The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death | Page 58 |
| Friends and Family Test results | Page 61 |
| Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway | Page 67 |
| A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge | Page 67 |
| All cancers: 62-day wait for first treatment from: | Page 68 |

## Part Three

# How we performed on Quality in 2017/18

This section of the Quality Account provides an overview of the quality of care based on performance in 2017/18 against indicators selected by the Board in consultation with stakeholders following the regulatory reviews and agreed as part of the Trust Improvement programme. Where appropriate and available historic information has been provided, and where mandated for Core indicators with national benchmarking data and commentary as required.

The benchmarking data provided reflects the information currently available via the NHS digital indicator portal at the time of finalising the report.

## Organisational Transformation and Quality and Safety Initiatives progressed throughout 2017/18

The Trust strategic plan sets out the organisational goals for continuous improvement by developing and transforming the services we provide. To progress these we have continued to implement a range of quality initiatives, service development and a programme of transformation. In doing this we continue to ensure service provision meets the requirements of the Fundamental Standards of Quality and Safety. Implementation has been monitored internally and assurance provided through the Trust Governance structures. In order to ensure openness and candour with our key stakeholders we continue to invited attendance at the Trust Quality & Governance Committee of the CCG Director of Nursing and Quality and the Healthwatch Tameside manager, and Trust Governors have also attended the Quality and Governance meetings.

## Service improvement and transformation

Throughout 2017/18 we have focussed on a number of system-wide transformational schemes and improvement programmes to improve the way we provide our services and improve the Quality, Safety and effectiveness of the care provided. Each of these schemes have agreed performance indicators and criteria which are monitored through the Governance structures in place.

Our system-wide Care Together Programme across Tameside and Glossop aims to:

- support local people to remain well by tackling the causes of ill health, supporting behaviour and lifestyle change, and maximising the role played by local communities.
- ensure that those receiving support are equipped with appropriate knowledge; skills and confidence to enable them take greater control over their own care needs and the services they receive.
- provide high quality integrated services that are designed around the needs of the individual and, where appropriate, are provided as close to home as possible.

The following highlights are intended to provide an update on the work being progressed in delivery of the trust agreed strategy and transformational work programmes.

### Integrated Neighbourhoods

The purpose of five neighbourhood teams is to support residents in choosing healthy lifestyles, encouraging them to take more control and responsibility for their own health. The neighbourhood teams will enable care closer to the person's home through a co-ordinated approach with primary care, health and social care services in addition to voluntary, community and faith sector services.

The integrated neighbourhood teams will facilitate the provision of, and access to, place based care with local services responding to local need. By working together these teams will aim to work in a multi-disciplinary way to provide joined up services. Where possible people will be treated and cared for closer to home and will only access hospital based care when necessary.

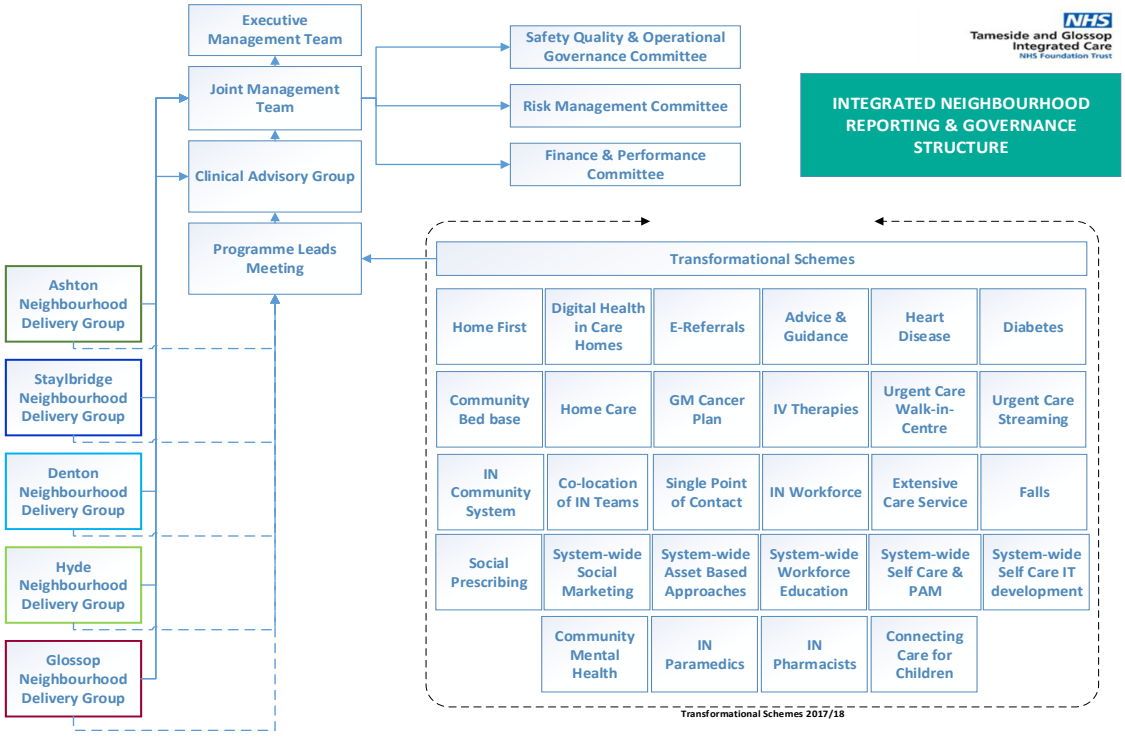
***Leadership*** – we have appointed a Neighbourhood Clinical Director in each neighbourhood, who are supported by three Integrated Neighbourhood Managers working across the five neighbourhoods. The neighbourhood leads are:

| Neighbourhood | Clinical Director | Neighbourhood Manager |
|---|---|---|
| Stalybridge | Dr S Ahmed | Julie Moore |
| Ashton | Dr N Riyaz | |
| Denton | Dr S A Ali | Jeanette Leach |
| Hyde | Dr L Gutteridge & Dr J Harvey | Julia Worthington |
| Glossop | Dr G Wilkinson & Dr R Jha | |

Each neighbourhood has established a monthly Neighbourhood Delivery Group (NDG) which is an operational group, working with key stakeholders in each area.

A formal governance and reporting structure is in place:

*Diagram 1: Integrated Neighbourhood Transformation Schemes Reporting & Governance Structure*




Phase one of the organisational development sessions for senior Health and Social care leaders and neighbourhood teams have been completed, and the planning for phase 2 of this programme is now underway.

**Co-location of neighbourhood teams**

In order to achieve more integrated working we are progressing with our plans to co-locate district nursing and adult social care teams across the five integrated neighbourhoods, and to co-locate those teams identified as being part of the Intermediate Tier across Tameside and Glossop. There is a strong clinical case for change in favour of bringing these teams together, in addition to providing benefits to our local population and our staff. The issue of co-location has been long understood amongst staff groups to be one of the benefits of the Care Together Programme, in strengthening the integrated services for the benefits of our people of Tameside & Glossop.

A base has been confirmed in four of the five neighbourhoods, with options in the Hyde neighbourhood still being explored. These are:

- Stalybridge – Stalybridge Civic Hall
- Ashton – Ashton Primary Care Centre
- Denton – Denton Festival Hall
- Glossop – Glossop Primary Care Centre
- Hyde – options being explored

The Intermediate Tier Teams work programme was completed in April 2018 and is based in Crickets Lane in Ashton, operating across all five neighbourhoods.

Now staff are co-located the emphasis is to develop systems and processes to effectively work together; learning from each other; reducing duplication of effort to provide a quality service for our location population. This will include:

- A focus on early action and prevention
- Community based multi-professional teams promoting close working and communication between colleagues and across organisations
- A single point of contact, with single assessment and shared clinical records
- Targeting individuals who are a high risk of future emergency admission to hospital before they deteriorate
- Proactive personalised care planning bringing together an individual's personal circumstances with their health and social care needs
- Continuity of care, including effective communication processes where information is streamed through appropriate teams

**Single Point of Contact**

The establishment of a joint Single Point of Contact (SPOC) for health and social care is a key element within our service model to develop integrated neighbourhood teams. It is envisaged that the SPOC will be based in Crickets Lane co-locating health and social care staff, and will operate 7 days a week. This service will provide entry into the Neighbourhood teams and urgent care for all new referrals and those in crisis. The fundamental principle of the SPOC is to ensure that an individual is assessed for the level of care they require. The model takes a proactive approach to the management of individuals across the whole risk spectrum and not just those at the higher end of need. This will ensure the first assessment is responsive, holistic and multi-professional.

**Digital Health in Care Homes**

Digital Health has been developed to support a reduction in the attendances and subsequent admissions to hospitals from care homes (both residential and nursing). This programme compliments the existing tele-health model already in operation and connects healthcare staff in care homes with an advanced practitioner in the Acute Trust through Skype for Business. This programme aims to ensure that an individual's needs are accurately assessed and met as swiftly as possible while individuals remain in their own home when possible.

Whilst our focus initially is on the introduction of new digital technologies to help need the healthcare needs of people living in care homes, the opportunities for this technology is endless by providing a platform for people to have a 'virtual consultation' with the digital health nurse where clinically appropriate. In doing this, we aim to improve care, prevent health conditions escalating, and to reduce unnecessary admissions which can be uncomfortable and disruptive for individuals as well as costly for the healthcare system.

The Digital Health Centre (DHC) opened on 6th March 2017 and now includes almost all care homes in Tameside and Glossop and also encompasses the Tameside Council Community Response Service which provides a service that enables people, especially older and more vulnerable individuals, to live independently in their own home with the provision of technology known as lifestyle monitoring which can provide early warning of deterioration, prompting a response from family or professionals. To the end of November 2017 the team DHC has completed over 1300 calls and avoided 907 attendances at ED and potential non-elective hospital admissions.

The DHC is receiving great interest both locally and from across Greater Manchester.

**Home First – Discharge to Assess**

In order to be responsive to patients needs and deliver against this principle the Trust has implemented the "Home First" service model, which responds to meet an urgent/crisis health and/or social care need for patients. Home First is fundamental to the intermediate care offer and is a key interface between the integrated neighbourhoods, community services and the acute setting ensuring that people are supported in the environment that is suited to their own care needs and most likely to achieve positive outcomes, and supports the intermediate care aims of;

- Help people avoid going into hospital unnecessarily;
- Help people to be as independent as possible after a stay in hospital; and
- Prevent people from having to move into a residential home until absolutely necessary.

The Home First service ensures that individuals are supported through the most appropriate pathway with "home" always being the default position. However, it is recognised that not all individual's intermediate care can be managed safely in their own home and there is a need for an alternative community based bed, for a short period of time, to enable the appropriate interventions to be undertaken with the individual to enable them to return home, whether this be following an admission to the hospital or to avoid the need for an admission in the first place.

This service began in July 2016 and has been rolled out to all acute wards within the

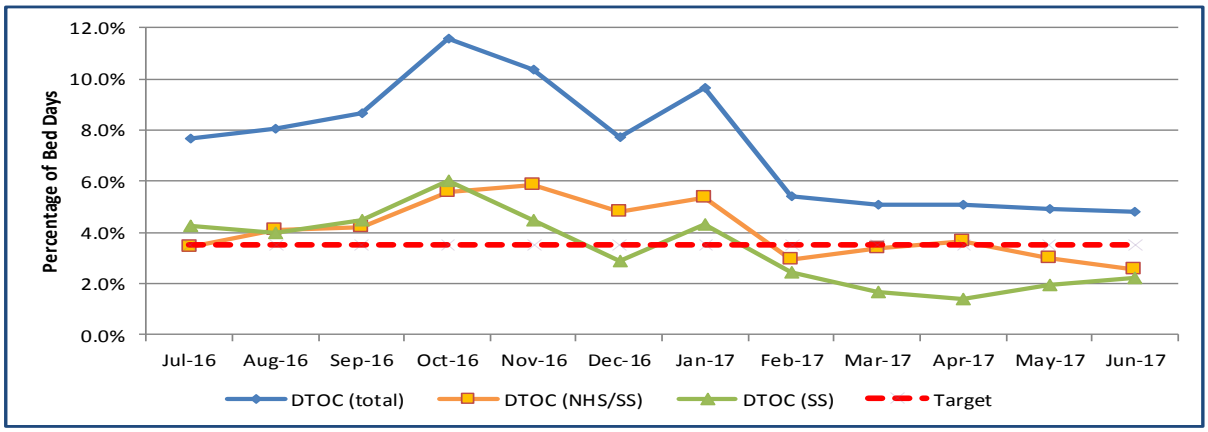
hospital including the Stamford Unit, and is a key element of our patient flow campaign 'On the Move, On the Mend'.

*Diagram 2: On the Move…. on the Mend Campaign*




There has been a general increase in the uptake of this service and we are seeing a positive impact in a number of areas, including a reduction in the number of delayed transfers of care (DTOC)

*Chart: Delayed Transfers of Care*




## Extensive Care Service

Extensive Care is a fundamentally different way of organising care around the needs of a specific cohort of people, which includes all aspects of need: medical, social, psychological, functional, pharmaceutical and self-care.

The aim of an extensive care service model is to work closely with people with long term conditions, complex needs and those who are intensive users of the health and social care system. Within an agreed timeframe it aims to move to predicting exacerbations of underlying conditions, whilst helping people improve the management of their condition and their overall general health and well-being, therefore reducing the need for hospital admissions. The service has also reduced the number of appointments that patients attend at different locations within our local health and social care system. The service includes health and well-being support that pulls together health and social support, including a range of community assets to ensure early intervention and proactive prevention.

We have appointed four part-time neighbourhood-based doctors known as an Extensivist, who will be supported by a multi-disciplinary team of health and social

care professionals.

Using the risk stratification data available across the system, this new service recruited its first patients in the middle of July 2017, focussing on the Ashton neighbourhood. The team have now successfully recruited over 60 patients and the roll out programme continues, moving to incorporate the other neighbourhoods from February 2018. Early indications are that this service is highlighting areas for improvement across the health and social care system and this invaluable learning is being shared with the members of the Clinical Advisory Group.

The team have faced some early challenges in relation to data sharing with some primary care colleagues but with the support from the Executive Team the team are resolving these.

**Community Intravenous Therapy Services**

Community IV therapy services can be of significant benefit to both patients and the NHS. They can prevent hospital admissions and facilitate early discharge, improve patient safety by reducing the risk of infection and improve choice by enabling patients to stay in their homes.

Aligned to our commitment to provide optimum quality of care across Tameside & Glossop we have expanded the service offer from our Community Intravenous (IV) Therapy Team to ensure we can provide care closer to home for our patients. This service was launched on 18 August 2017 and will provide IV therapy treatment in patient's own homes and/or at community out-patient clinics.

**Integrated Neighbourhood Pharmacists**

The role of the Neighbourhood Pharmacists is to extend and expand upon the work undertaken by the GP practice pharmacists to optimise patient outcomes through effective use of medicines and contribute to a reduction in A&E attendances, unplanned admissions, length of hospital stay and outpatient attendances. They will contribute to reducing medication-related hospital admissions and readmissions, supporting patients to get the best outcomes from their medication and identifying and addressing medication-related issues.

At practice level, pharmacists are reviewing high cost - high volume prescribing areas, establishing Long-Term Condition (LTC) medication optimisation clinics, reduce prescription wastage and support the integrated neighbourhoods, patients and carers with medicine related queries, ultimately aiding medicines optimisation. The neighbourhood pharmacy team work with GP practices and in an integrated way across the new models of care with all our neighbourhood and community teams, including colleagues from the Intermediate Tier.

**Neighbourhood Mental Health**

A fundamental component of our integrated neighbourhood offer for Tameside and Glossop is to improve and integrate mental health services to better support the needs of individuals in line with the Mental Health Five Year Forward View. As a priority, our plans seek to increase mental health capacity within the integrated neighbourhoods through:

a) Commissioning an integrated Improving Access to Psychological Therapy Plus (IAPT+) service. This will increase access to emotional and mental health well-being workers by offering easy accessible drop-ins in GP surgeries and other community locations and a broadened mental health offer with a wider range of interventions;

b) developing a new model, integrated with the Neighbourhood Teams, to meet the needs of people with complex needs who are currently falling between secondary care and IAPT;

c) increasing dementia support in the Neighbourhoods by integrating Dementia Practitioners and Admiral nurses in the Neighbourhood Teams and commissioning a Dementia Support Worker Pilot from the Alzheimer's Society; and

d) Establishing a self-management education college to support people to develop the knowledge and skills to manage their own health.

In addition to this, we are working to improve mental health crisis support through reviewing the needs of the population, existing crisis support including crisis resolution and home treatment within the locality, and appraising new models of care, with a view to improve and integrate mental health crisis care across all tiers. This will include identifying a local model that meets the national standard of establishing a Core 24 service offering mental health support throughout the hospital. We are also working to improve services for people with serious mental health needs including those with early psychosis as well as those stepping down from secondary care mental health services.

**System-wide Self-care**

Our approach to health and care in Tameside and Glossop is one where we work harmoniously with local communities and people for the benefit of all our residents. It acknowledges that the population of Tameside and Glossop is changing and with this change comes a need for a greater focus on the ageing population and the increased prevalence of chronic diseases, as well as a need to shift resources from merely treating ill health to proactively preventing and managing health and wellbeing. This means fostering a 'social model of health' that combines a deep understanding of what matters to people, with excellent clinical care, timely data, and strong, sustained social support.

We have therefore worked with a range of partners, including the voluntary/community sector, to develop a comprehensive supported self-care programme of work, and will be investing additional funds in the voluntary care sector over the next three years, which will develop capacity in the following key areas:

*Diagram: System-wide Self-care & Social Prescribing Programme*


A fundamental part of the self-care programme is the implementation of asset based

approaches, delivering targeted investment in the voluntary, community and faith sector to ensure that at a neighbourhood level we can support universal access to a range of opportunities that support people's health and wellbeing by capitalising on community assets. The providers for Tameside (Action Together) and Glossop (The Bureau) are currently designing the system and application process for the grants fund specifically ring fenced to pump prime community assets and resources that promote the health and wellbeing of people with long term conditions.

**Social Prescribing**

The social prescribing service will deliver a comprehensive, flexible, and proactive service, which includes: non-medical case management, information, advice, signposting, and support to people within Tameside and Glossop to optimise their potential health and wellbeing, with the aim of participants gaining greater control and remaining healthy and independent within the community. The programme will offer a person-centred approach to identifying individual assets, needs and aspirations and support people to access a menu of services and self-help groups. The programme is not a replacement for statutory health and care services, but rather acts in a complimentary manner alongside and integrated within these services. Our social prescribing service will:

- signpost and support individuals to opportunities for a range of activities including arts, physical activity, advocacy, peer support, befriending as well as signposting to support for welfare advice, debt, housing etc.;
- become a fully integrated part of the health and social care system, providing a bridge between traditional health and care services and more than medicine approaches usually accessed in the voluntary, community and faith sectors;
- align with the five neighbourhood footprints of Tameside and Glossop with staff linked to each integrated neighbourhood team and also linked to the hospital site with a focus on links with A&E, admission avoidance and discharge teams;
- work with individuals, their families, carers and supporters viewing peoples' needs holistically and supporting them to tackle non-medical influences on health and wellbeing;
- build capacity in the local voluntary, community and faith sector, working with a range of groups to support their development and growth. The funding for social prescribing will include capacity for investment in the sector, including spot purchasing and the award of small contracts/grants.

Our social prescribing service is already working in Glossop – led by Glossop Volunteer Centre working in partnership with High Peak Community and Voluntary Services and other agencies. To date the Glossop service has received 297 referrals.

The new provider for Tameside is currently at the early stages of implementation of the new service.

In addition to the transformation schemes described above we are managing a portfolio of change programmes to support a reduction in health inequalities across Tameside and Glossop, working with our clinical and management colleagues in achieving operational improvements and outcome benefits for both patients and staff. Tackling premature mortality and health inequalities is vital to rebalancing our

local health economy and achieving sustained reductions in health inequalities and improvement in local life expectancy. The projects within this portfolio include:

- Heart Disease
- Diabetes
- Respiratory
- End of Life / Palliative Care
- Musculoskeletal

**E-referral system implementation**

The NHS e-Referral service combines electronic booking with a choice of place, date and time for first hospital or clinic appointments. Patients can choose their first hospital or clinic appointment; book it in the GP surgery, online or on the phone. This process harnesses the use of new technologies to deliver modern and efficient healthcare. The benefits include:

- Fewer missed appointments
- Fewer inappropriate referrals
- Shorter referral to treatment times
- Cost and time savings
- Choice of hospital or specialist
- Choice of appointment date and time

A phased implementation programme across all specialties has been developed and began in March 2017. Our plans are to see the completion of this scheme ahead of the national deadline in 2018. This successful implementation of this improvement work will also bring about the introduction of an electronic solution for hospital referrals, thus reducing the need for paper.

**Advice & Guidance Service**

We first began a pilot of this new way of working in August 2016 with our Cardiology Service, offering 'advice and guidance' to our local general practitioners. This advice and guidance service enables general practitioners to contact the Cardiology Team at the hospital, obtaining access to timely specialist opinion on patient diagnosis and treatment, thereby reducing unnecessary referrals to secondary care.

This model aims to build on clinical best practice, provide flexibility for innovation, and allow for shared care of patients. Our pilot with Cardiology resulted in a number of significant benefits for patients and clinicians, including:

- A reduction in unnecessary hospital admissions
- A reduction in unnecessary hospital out-patient attendances
- Increase in skills and knowledge for local clinicians

We have recently started to offer this same service for paediatrics and are working with other specialties to agree an implementation plan.

**Improving Endoscopy Productivity** to deliver a more cost effective endoscopy service which is capable of meeting current demands, whilst at the same time deliver on its internal and external access standards. This improvement project was aligned to our Corporate Objectives to

- ensure our patients and users receive harm free care by improving the quality and safety of our services through the delivery of our Quality and Safety Programme.

- improve our patient and service user experience through the delivery of a personalised, responsive, caring and compassionate approach to the delivery of care.
- develop our staff and future workforce to support the integration and transformation of our services whilst ensuring we recruit and retain talented individuals.
- deliver against the required local/national regulatory frameworks and standards in addition to securing the most effective and efficient use of resources to deliver services that we provide directly or indirectly through our partner organisations.

The project has delivered on a number of key work streams and the operational team are now taking the improvements forward as business as usual, with a key future aim for the Unit to be in a favourable position to take additional work derived from the national bowel screening programme.

**People powered health improvements**

The 100 day challenge is a rapid improvement methodology that generates innovation and progress on key challenges by empowering leadership from the frontline. The challenge is supported and facilitated by the Nesta People Powered Results Team. Nesta are a national health innovation charity.

In Tameside & Glossop we have just reached the end of our 100 day challenge and seen some fantastic results. Three teams (in Denton, Glossop and Hyde) were established and identified a problem and solutions to test all in the window of 100 days. The teams comprised of frontline staff from health, social care, the voluntary and community sector, and patient groups, all working together on an equal footing, to demonstrate leadership in driving change forward on some of our most testing issues.

The **Denton and Hyde teams** both delivered pieces of work that aimed to identify and work differently with people at risk of diabetes. Overall, they contacted over 700 people to participate in action to reduce their blood sugar levels through community events, brief intervention on the phone and lifestyle support. Some of those people hadn't engaged with health services for over 2 years, and others said they weren't even aware that they were pre-diabetic. Those that did engage have had some great results; the vast majority of people re-tested at the end of the intervention had reduced their diabetes risk as measured by HBA1c. 49% of all people retested are no longer categorised as pre-diabetic. In another cohort the average increase per week in physical activity of 155 minutes and an average decrease in waist circumference of 6cm. There was a cumulative 79kg weight lost amongst participants who were measured at the end. A register of people at risk of diabetes has been created by those practices involved, and a protocol for managing pre-diabetes in primary care produced.

**The Glossop team** focused on improving end of life care for their residents. Using a family who had a particularly negative experience (not being identified until the final 48hrs of life) as the inspiration for change they built local partnerships to transform the way in which people are identified and then subsequently supported through end of life. The % of people identified as being in the final 12 months of life at each of the three practices involved has increased dramatically (in one case by 438%). They have introduced, tested and improved a new IT tool, and developed bereavement support, connecting with social prescribing and volunteering

approaches in the voluntary sector. The Patient Neighbourhood Group has been at the centre of the work.

In addition we have progressed the following initiatives during 2017/18:-

**To improve patient safety**

- Continued to implement our Patient Safety Programme workstreams. This formed our "Signed up to Safety" campaign and formed a key part of our Improvement programme to enhance the quality and safety of care provided. (The programme is shown on page 11) the workstreams are focus on
    - Pressure Ulcer Prevention
    - Early recognition of the deteriorating patient and managing the acutely unwell
    - Reducing the number of falls and falls with injury
    - Improved nutritional care and hydration
    - Reduction of harm from Venous Thrombosis
    - High Risk Medicines and Safe Medicine Management
    - Infection prevention
    - Local Safety Standards for invasive procedures
    - Maternity services governance
    - Results governance
- We have implemented a system of patient bed mattresses which are able to be adapted to provide additional pressure relieve if required without the need to transfer the patient or wait the delivery of specialist equipment.
- We have developed a further 30 AQuA Patient Safety Champions across the organisation in the process of undertaking our Quality improvement initiatives.
- Continued to implement best practice with regard to Infection prevention and commenced a health-economy wide programme to enable awareness of good hand hygiene with patient relatives and carers to improve the rate of acquired infections.
- Continued to implement our policies and ensure best practice relating to harm free care including Implemented revised Care bundles with increased surveillance to improve compliance with clinically effective care pathways for Sepsis, Acute Kidney Injury, and hypercalcemia.
- Continued to increase our incident reporting rate and embed the incident reporting culture across the organisation, whilst ensuring that lessons are learnt.
- Continued to work across the Health Economy to promote best practice in relation to Pressure ulcer prevention and management and infection prevention.
- Continued to undertake Mortality reviews on every death in hospital.
- Sharing our learning through a range of media including our "Closing the Loop" newsletter and our newsletter for Learning from Deaths.
- Implemented our electronic CAS card in the emergency department which has been developed with the clinicians to ensure effective capture of data and recording of key measures is accurate and timely and help us improve the escalation, management, discharge and handover of patients

**To improve our effectiveness**

- Implemented initiatives to enable admission avoidance through Digital health.
- Implemented our “on the move on the mend” process to encourage patients to be more active in preparation for discharge including our pledge to “end PJ paralysis”.
- Established our Neighbourhood management teams and recruited lead GP’s to each of the 5 teams, and commenced co-location and integration of the teams to facilitate closer more integrated working and working
- Commenced GP streaming to reduce the pressure on the emergency department
- Continued to deliver our Health Care assistant - Care Certificate training programme for new recruits and existing staff.
- Recruited additional New Trainee Nurse Associates to the Trust programme
- Continue to Implementation of our Medicines Optimisation action plan through our integrated Medicines optimisation group which spans the health economy
- Continued implementation of a Clinical handover policy and professional standards to improve consistency of the clinical handover process and improve continuity of care.
- Retained our Joint Advisory Group (JAG) on gastrointestinal endoscopy accreditation
- Revised the Clinical audit team to ensure emphasis and focus on Quality improvement and learning.

**To improve our responsiveness**

- Implemented monthly review/reset weeks to ensure that issues relating to patient flow are optimised
- Continued to implement our range of initiatives aimed at admission avoidance including Digital health services to provide remote consultation with nursing homes and other agencies to provide advice and clinical review and develop links with social care provider tele-healthcare provision.
- Continued implementation of our Home first initiative.
- Commenced implemented our extensive care service
- Continued work to Improve the percentage of discharge summaries issued in 2 days for urgent and 5 days for routine
- Continued to implement and further strengthen our clinical coding service team and continue to deliver our data quality assurance programme

**To improve our caring**

- Continued to implement values based recruitment for all staff.
- Continued to implement and strengthen the use of Volunteer dining companions in selected wards to support meal times
- Continued to reinforce the “Hello my name is campaign” and appointed our first Kate Granger professionals as champions of these values
- Continued implementation in year 3 of the dementia strategy with increased dementia awareness

- Revised and updated our patient and service user experience strategy
- Officially opened the Tameside Macmillan unit and through Macmillan introduced the Cancer Recovery Package
- Opened our new refurbished antenatal clinic facilities
- Launched our 3rd Thursday café and our "chatter and natter initiative" to support patients and carers.

**To ensure we are well led**

- Undertaken service Integration and commenced the transformation of services with Community colleagues
- Further strengthened our capacity and capability to manage Service transformation by ensuring Neighbourhood, Divisional and Directorate Medical, Nursing and Management structures are in place
- Continued to run streamlined Nurse Recruitment process as a "one stop shop". Shortening the time to undertake Nurse Recruitment.
- Continued to implement our "If in doubt speak out - Speak out" campaign to remind staff that they are able to raise concerns or issues of concern.
- Continue to ensure the presence of our "Freedom to Speak up Guardian" and the associated reporting from them is captured and informs the organisation.
- Implemented a Mandatory training improvement programme.
- Continue to strengthened the Finance function to ensure managers and directors receive high quality information to ensure all resources are used effectively and efficiently in order to deliver safe high quality care
- Delivered our £10m savings programme
- Introduced a ban on sugary snacks in the restaurant and provision of healthy choices

## How we performed on Quality in 2017/18

This section indicates how some of the Quality Initiatives were progressed during 2017/18 and outlines the performance against the priorities and goals we set ourselves in 2016/17 Quality Account.

The following symbols have been used to identify our performance and whether we achieved our goals.

**Achieving our aim/goals**

**Improving Performance**

**No change in Performance**

**Deteriorating Performance**

**Significant Concerns about Performance**

# Patient Safety

## Patient Safety Programme

| | |
|---|---|
| NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. |  |

The Trust has continued to use the Patient Safety Programme as a focus for ensuring quality improvement. Each work stream has agreed performance monitoring metrics in place to identify improvement and how well we are protecting patients from avoidable harm.

- Pressure Ulcer prevention, improved Tissue Viability
- Earlier recognition of the deteriorating patient and management of the acutely unwell (including improved communication/ handover).
- Reducing the number of falls and falls with injury.
- Improved nutritional care and hydration.
- Reducing harm from Venous Thrombosis.
- Reducing harm from high risk medicines and providing safe and effective medicines management.
- Improving peri-operative outcomes through safer surgery.
- Infection prevention.
- Maternity
- Results Governance

Performance against the 10 work streams are captured in this part of the Quality account with further metrics being developed for each work stream for 18/19.

We continue to produce monthly know your safety data packs which provide speciality level range of safety metrics with the ambition of providing a source of information to help drive local quality improvement and consistent measurement.

We will continue to embed and develop these work streams and work to further improve our performance during 2018/19.

| NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. |  |
|---|---|

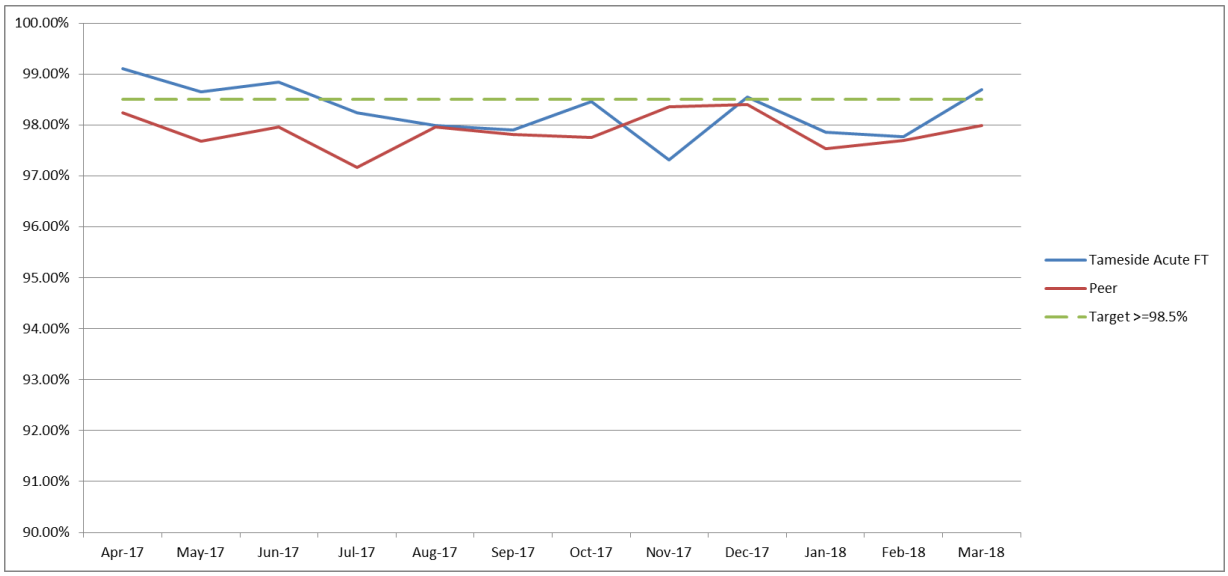
The Safety Thermometer is a monitoring tool for inpatients areas including Community Wards to identify the provision of harm free, safe care in relation to 4 Patient safety areas of Pressure ulcers, Falls, Catheter acquired urinary tract infections and Venous Thrombo Embolism (VTE).

It is well documented that health care has high levels of system harm; the Safety Thermometer tool is unique in identifying the impact of collective harms within the ward areas and attempts to measure this as a composite score across 4 key areas to understand the impact and support improvements to deliver harm free care to our patients.

The thermometer captures a snap shot sample of data from 100% of patients on sample day in order to attempt to suggest the prevalence of harm across those patient groups sampled. We publish monthly data in line with the CQUIN requirement and this is demonstrated below.

We pledged to improve patient safety by increasing the percentage of harm free care from our revised baseline of 98.5% with the aim of harm free care for every patient. We did not consistently achieve this but achieved an average of 98.4% in 2016/17.

**New Harm free care graph for all 4 harms**



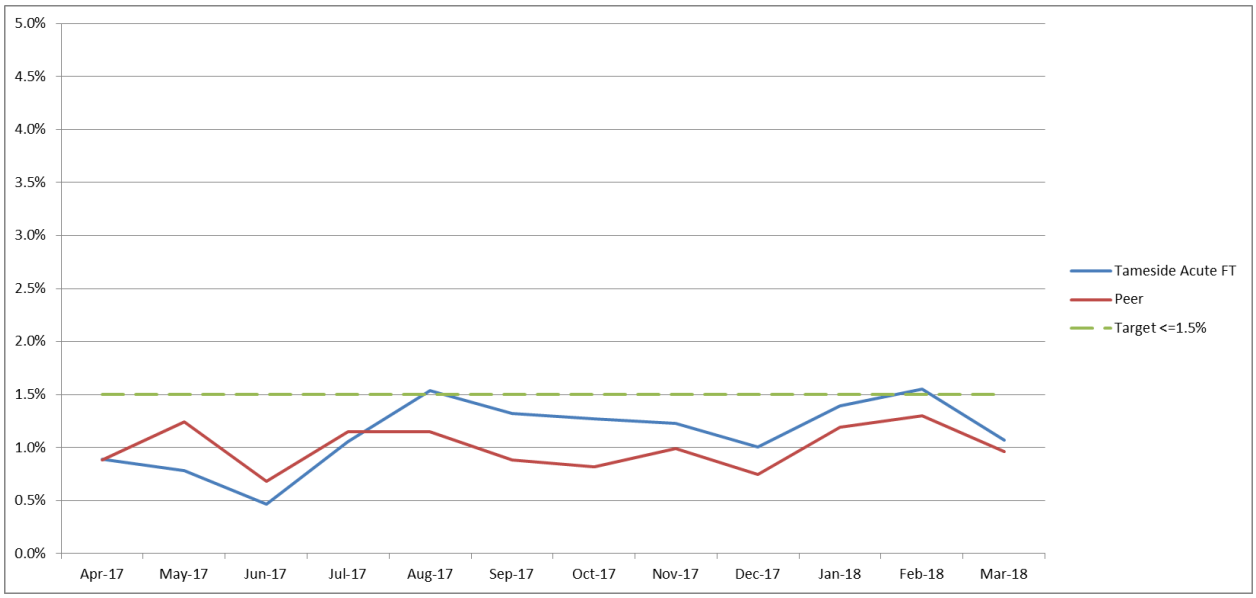

The performance data is reported monthly and included in our board reports available on the Trust website. We continue to aim for our stretch target for Harm free care to be consistently at or better than 98.5% all new harms in 2018/19.

## T&G Integrated Care - Safety Thermometer New Harm Free Care Performance

### Pressure Ulcer prevention

We pledged to improve patient safety by reducing the number of avoidable Inpatient (including community wards) acquired pressure ulcers and we will reduce the incidence of pressure sores Grade 2 and above.

In 2017/18 we aimed to ensure less than a 1.5% incidence rate, we achieved an average of 1.25%.

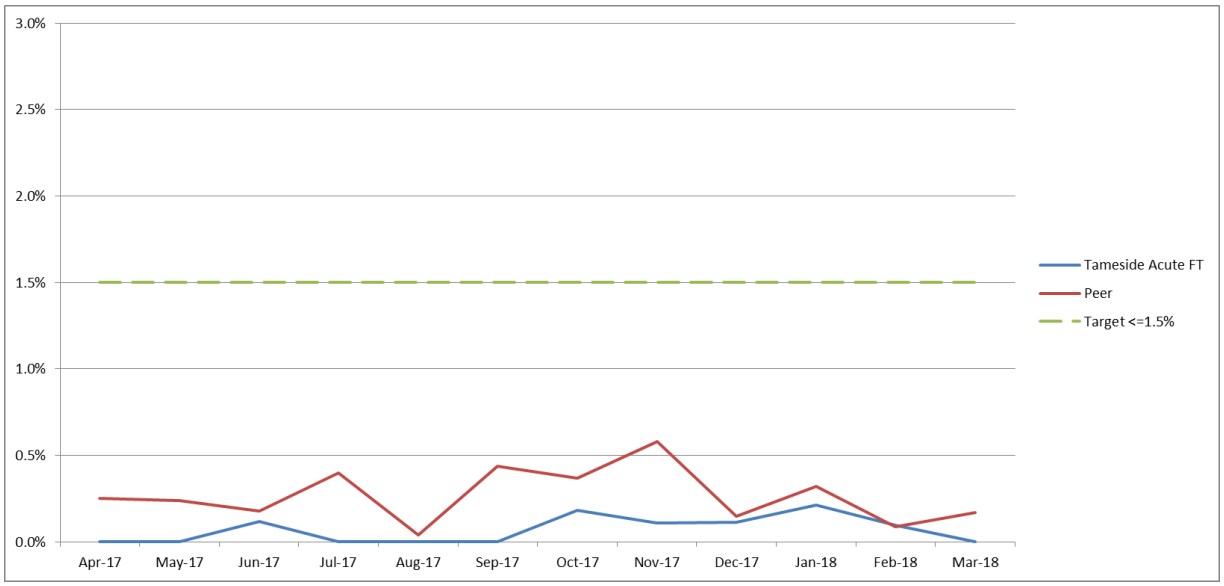



Within our local quality initiatives for 2017/18 we committed to a work programme to improve pressure care further across both Acute and Community service settings. Whilst the Safety thermometer trajectory was achieved we identified that a lot more work needs to be done to assertively progress further improvement in patient safety across the health economy. We have been part of the NHS improvement collaborative quality initiative on pressure ulcers and won the Most improved Trust & Most Innovative Idea award for the focused work undertaken to and is address upskill team members with the roll out of a training package and the launch of the Sskin bundle.

**Catheters & New Urinary Tract infection (UTI) Performance**

We pledged to improve patient safety by reduction in catheter associated urinary tract infection ensuring 99% of patients receive no avoidable UTI.

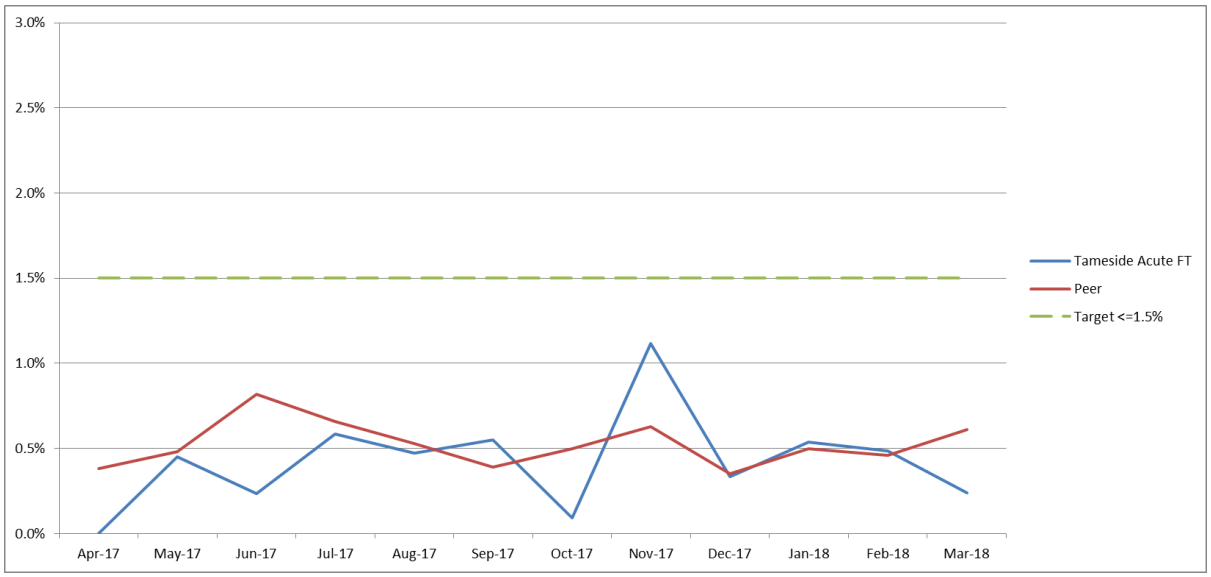
In 2017/18 we achieved this with an average 0.02% incidence of Inpatient (including community wards) acquired Catheter Acquired Urinary Tract infections. We aim to maintain or improve on this performance in 2018/19




**Reducing the number of falls and falls with injury.**

We pledged to improve patient safety by reduction inpatient (including community wards) falls resulting in harm ensuring less than 1% incidence resulting in 99% of patients receiving harm free care.

In 2017/18 we achieved this with an average 0.59% incidence of falls resulting in harm

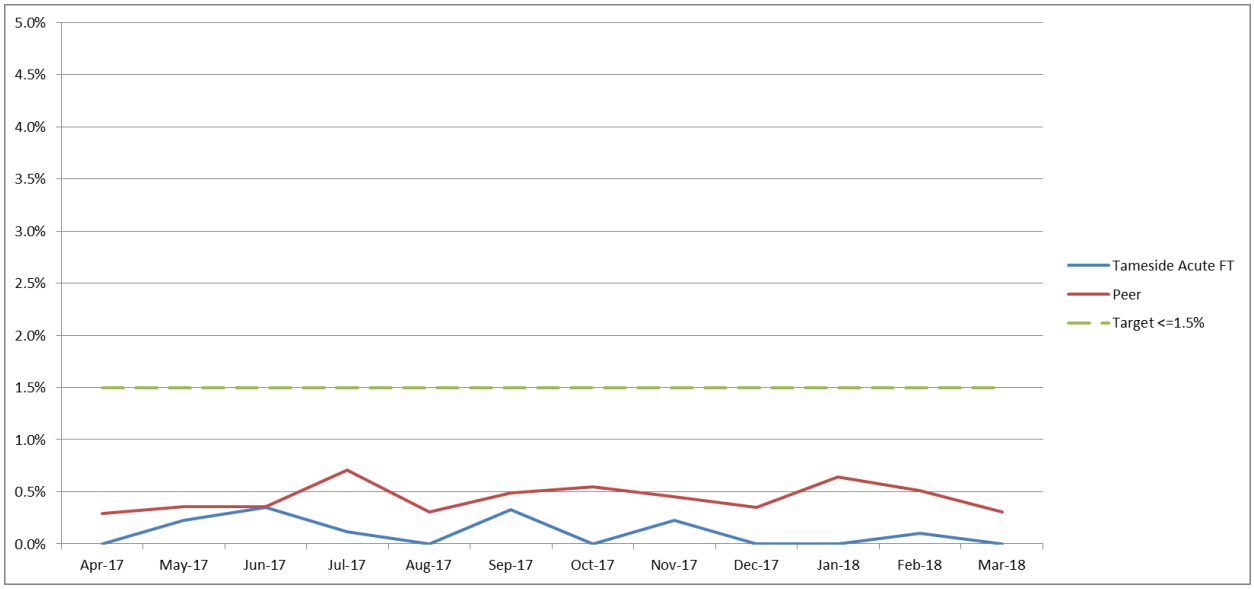


| NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. |  |
|---|---|

## Venous Thrombo Embolism (VTE) Risk Assessment

We pledged to improve patient safety by reduction in harm from VTE through appropriate risk assessment and thromboprophylaxis for all inpatients (including Community wards).

In 2017/18 we achieved this with an average 0.12% incidence of number of new VTE risk assessments not being completed using the Safety Thermometer data.




The Trust also records assessment of all inpatients (including Community wards) requiring a VTE risk assessment on Lorenzo, and this data is produced by ward to ensure that compliance is monitored daily. The tables below demonstrate the continued year on year improvement where we are now consistently recording over 98% compliance with these risk assessments

| 2016/17 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Recorded Risk assessment | 96.2% | 96.0% | 96.0% | 97.7% | 97.6% | 97.7% | 97.7% | 97.1% | 97.6% | 97.7% | 97.9% | 97.5% | 97.23% |
| Target | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% |

| 2017/18 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Recorded Risk assessment | 97.3% | 97.8% | 97.8% | 98.8% | 98.5% | 98.4% | 98.6% | 98.2% | 98.0% | 98.4% | 98.8% | 95.5% | 98.0% |
| Target | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |

Tameside and Glossop Integrated Care NHS Foundation Trust consider that this data is as described for the following reasons. We have taken the assertive action to ensure compliance with the required standard.

- Having a VTE workstream in place as part of our Patient Safety Programme to monitor and drive improved provision of the correct care to prevent VTE for all patients and the avoidance of hospital acquired VTE.
- Reviewed the process for recording to ensure correct data collection guidance is followed for patient
- Ward based system in place to ensure completion of VTE assessment and electronic recording.
- Continued reinforcement and training of medical, nursing and administration staff in assessment and data collection.
- Daily compliance data provided at ward level with follow up visits by VTE nurse to drive compliance.

| VTE risk assessments | Q1 2016/ 17 | Q2 2016/ 17 | Q3 2016/ 17 | Q4 2016/ 17 | Q1 2017-18 | Q2 2017-18 | Q3 2017-18 | Rank in most recent reporting period |
|---|---|---|---|---|---|---|---|---|
| THFT Risk assessment rate | 96.1% | 97.7% | 97.2% | 97.8% | 97.7% | 98.6% | 98.4% | 23 |
| Lowest Nationally | 80.6% | 72.1% | 76.5% | 63.0% | 51.4% | 71.9% | 76.1% | n/a |
| Highest Nationally | 100% | 100% | 100% | 100% | 100% | 100% | 100% | n/a |
| National average | 95.7% | 95.5% | 95.6% | 95.5% | 95.1% | 95.2% | 95.4% | n/a |

Tameside and Glossop Integrated Care NHS Foundation Trust has taken the action described above to improve this indicator and so the quality of its services by the implementation of a Trust wide improvement program agreed with key stakeholders and progress monitored by the Trust board.

Performance is expected to continue to improve with continued year on year improvement demonstrable in 2018/19.

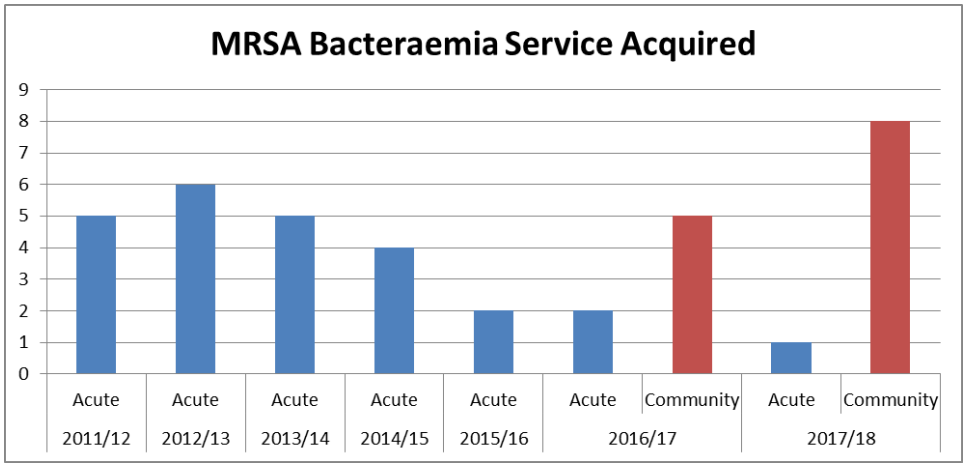
## Infection Prevention and Control – MRSA bacteraemia

| NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm |  |
|---|---|

Tameside and Glossop Integrated Care NHS Foundation Trust aimed to comply with the NHSE 'zero tolerance' trajectory for MRSA bacteraemia.

The Trust continues to systematically implement its agreed policies and procedures to minimise the occurrence of Service Acquired MRSA cases and has a zero tolerance approach to these. In year the Trust recorded only 1 Hospital cases and 5 community cases none of these have been identified as avoidable cases.

All cases of MRSA infection undergo a detailed investigation to identify how and why it occurred, to ensure learning and further reduce harm. The Trust has robust systems and processes in place to reduce the likelihood of this, however, it is recognised that there is still more to do to ensure full compliance with the zero tolerance approach.



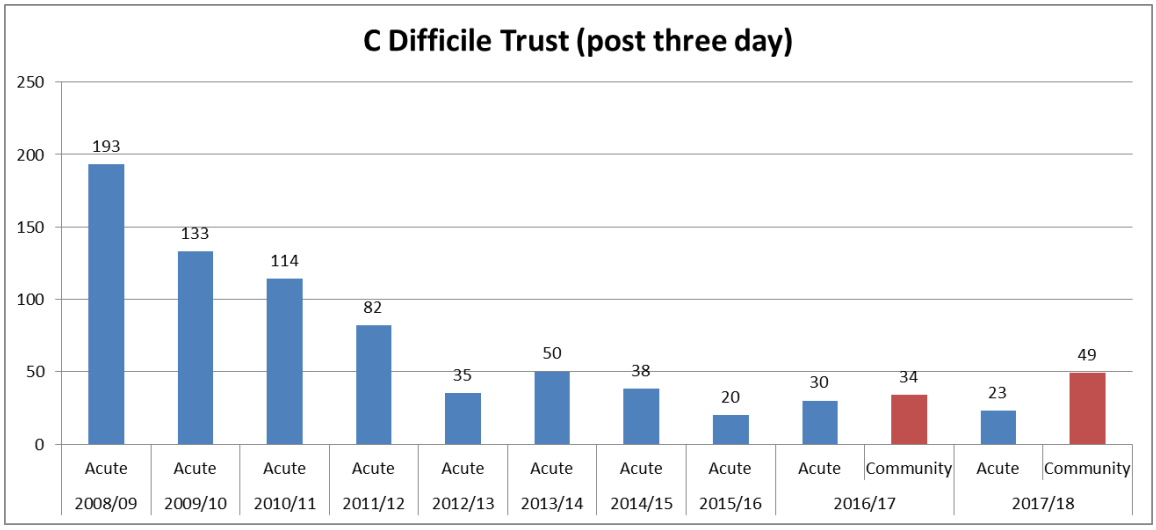

Tameside and Glossop Integrated Care NHS Foundation Trust aims to continue to achieve a reduction in the rate of numbers of MRSA Bacteraemia working to achieving 'zero'. We will improve our performance by a number of actions included in the 2016-18 HCAI Whole Health Economy (WHE) Strategic Objectives Action Plan:

- Continuous surveillance of MRSA bacteraemia throughout the WHE
- Prompt identification, isolation and monitoring of MRSA bacteraemia patients
- Review of all Whole Health Economy MRSA bacteraemia cases via a process which gives assurance on stakeholder participation and learning from 'lapses in care'
- Multidisciplinary education and training focusing on Aseptic Non Touch Technique (ANTT) and care of invasive devices
- Management of antibiotics

## Infection Prevention and Control – C difficile

| NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm |  |
|---|---|

Tameside and Glossop Integrated Care NHS Foundation Trust aimed to achieve or better the CDI target of 46 hospital attributable (post 3 day) cases for the year which we achieved in 2017/18 with 22 reported hospital cases with 1 being avoidable which is an improvement on 2016/17. In 2018/19 we aim improve on this positon. In community services in 2017/18 we identified 49 cases (5 avoidable) of C difficile against an NHSE trajectory of 52 which whilst within the target was higher than in 2016/17, however the number of avoidable cases was reduced.




The national benchmarking identifies how the Trust compares nationally for inpatients:

**Rate of C difficile per 100,000 bed days for patient aged 2 years and over**

| | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | Rank in most recent reporting period |
|---|---|---|---|---|---|---|---|
| National rate | 22.3 | 17.4 | 14.7 | 15.0 | 14.9 | 13.2 | n/a |
| Tameside (Trust apportioned) | 53.3 | 21.6 | 32.5 | 24.4 | 12.7 | 20.4 | 145/153 |
| Best performing nationally | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0 | n/a |
| Worst performing nationally | 58.2 | 31.2 | 37.1 | 62.6 | 66.0 | 82.7 | n/a |

Tameside and Glossop Integrated Care NHS Foundation Trust considers that this data is as described because of the assertive Infection Prevention Improvement Plan which has been in place to minimise the potential for harm from Healthcare Associated Infections (HCAI's). The Improvement Plan was agreed with key stakeholders and progress has been monitored by the Trust Board. The

challenges regarding reducing HCAI's have been recognised and being assertively addressed.

Tameside and Glossop Integrated Care NHS Foundation Trust will continue to assertively progress the reduction in HCAI's and will proactively aim to reduce the rate further.

This will be achieved by a number of actions included in the 2016-18 HCAI Whole Health Economy (WHE) Strategic Objectives Action Plan and includes:

- Continuous surveillance of CDI throughout the WHE
- Prompt identification, isolation and monitoring of CDI patients
- Strict Antimicrobial prescribing
- Review of all Whole Health Economy CDI cases via a process which gives assurance on stakeholder participation and learning from 'lapses in care'
- Multidisciplinary education and training focusing on CDI prevention and management
- Instigation of environmental actions (infrastructure and cleaning) to prevent any indirect / direct transmission

Tameside and Glossop Integrated Care NHS Foundation Trust aims to continue to achieve a reduction in the rate of numbers of C difficile infection cases based on the NHSE trajectories

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# Infection Prevention and Control – MSSA and E –Coli bacteraemia

| | |
|---|---|
| NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm | **E Coli**  **MSSA**  |

Tameside and Glossop Integrated Care NHS Foundation Trust aimed to comply with the requirement to monitor MSSA and E Coli Bacteraemia. Although no formal NHSE trajectory is set for these parameters local agreements are that the Trust should aim to reduce the amount of cases from the baseline recorded in 2013/14. It should be noted that E-Coli bacteraemia data is only collected and reported to Public Health England (PHE) for epidemiological purposes.

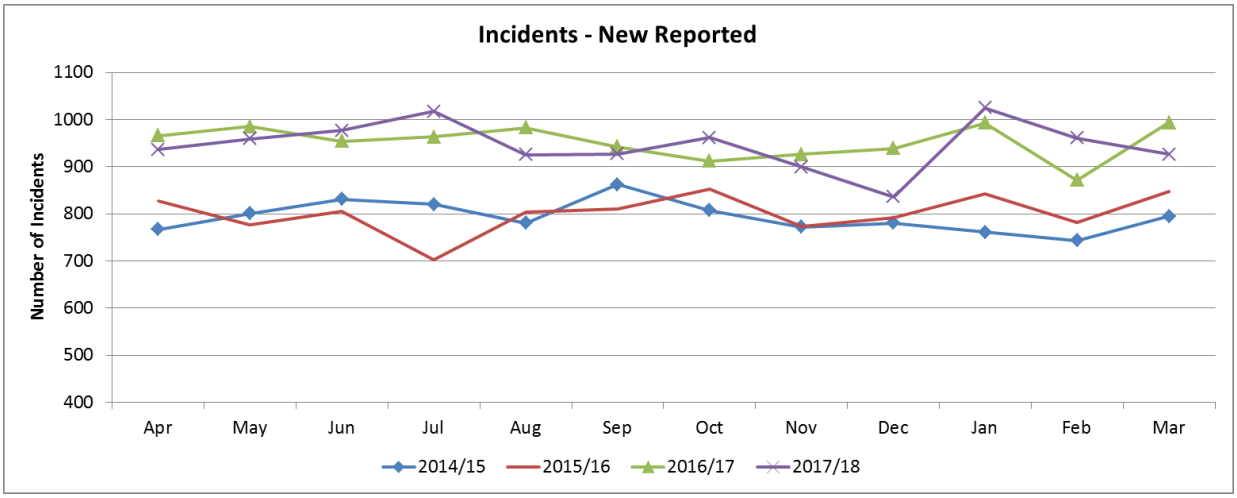
| | 2014/15 | 2015/16 | 2016/17 | | 2017/18 | |
|---|---|---|---|---|---|---|
| | Acute | Acute | Acute | Community | Acute | Community |
| E Coli Bacteraemia: | 27 | 30 | 25 | 144 | 17 | 118 |
| MSSA Bacteraemia: | 6 | 15 | 9 | 30 | 10 | 34 |

In 2017/18 the Trust has reported further reductions in the number of infections for both E Coli in the Acute and community areas from those reported in 2016/17, however there has been a reported increase of 1 for Acute and community MSSA infections compared to 2016/17. The Trust expectation to see a reduction of 10% in MSSA and E-Coli bacteraemia across the whole Trust has only been achieved E coli this year but we will continue to work to reduce further the infection rates by utilising the same actions as those employed to reduce our rates of MRSA bacteraemia (as noted above).

## Incident Reporting

| NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. |  |
|---|---|

We aim to increase the number of reported incidents whilst reducing harm associated with these.




The NRLS identifies that organisations who report high levels of incidents are likely to be safer organisations, since the certainty that incidents will be reported is higher. We therefore pledged to improve patient safety by ensuring incident our reporting rate will increase and result in the Trust and being identified as having a good incident reporting culture.

The National benchmarking data now groups us in with all acute non specialist Trusts and activity is benchmarked per 1000 bed days. We have increased the reported rate of incident to NRLS further in 2017/18 by 9% in the comparable period last year as part of an assertive programme of ensuring incidents are reported. We are now in the top 10% of Trust for incident reporting. The underlying trajectory for this Trust is increasing year on year. This is also reflected in the information published from the NRLS which demonstrates that the percentage of incidents reported with moderate, severe harm or death is decreasing.

| Reporting rate incidents per 1000 bed days published by the NRLS | April - September 2015 | October 2015 – March 2015 | April - September 2016 | October 2016 – March 2017 | April 2017 – September 2017 | Rank in most recent reporting period |
|---|---|---|---|---|---|---|
| Tameside & Glossop Integrated Care NHS Foundation Trust | 50.68 | 51.04 | 57.29 | 38.28 | 62.47 | 5 |
| Highest value for Acute Non specialist Trusts | 74.67 | 75.91 | 71.81 | 68.97 | 111.69 | n/a |
| Lowest rate for Acute Non specialist Trusts | 18.07 | 14.77 | 21.15 | 23.13 | 23.47 | n/a |

| % of incidents with Moderate, Severe and death reported | April to September 2015 | October 2015 – March 2016 | April - September 2016 | October 2016 – March 2017 | April 2017 – September 2017 | Rank in most recent reporting period |
|---|---|---|---|---|---|---|
| Tameside & Glossop Integrated Care NHS Foundation Trust % | 1.4 | 1.3 | 0.9 | 2.2 | 0.1 | 78 |
| Highest % for Acute Non specialist Trusts | 31.1 | 15 | 11.6 | 11.3 | 11.1 | n/a |
| Lowest % for Acute Non specialist Trusts | 0.3 | 0.5 | 0.4 | 0.2 | 0.2 | n/a |
| National Average % | 3.6 | 3.1 | 2.8 | 2.6 | 2.3 | n/a |

Tameside and Glossop Integrated Care NHS Foundation Trust considers that this data is as described because of the assertive action taken to increase the number of incidents reported and the move towards electronic reporting and the use of incident trigger lists to ensure standardised and consistent reporting of issues across all areas of the organisation.

Tameside and Glossop Integrated Care NHS Foundation Trust has taken the following action to improve this indicator and so the quality of its services by the implementation of a Trust wide improvement programme agreed with key stakeholders and progress monitored by the Trust Board. The Trust has as part of this continued to reinforce incident reporting, which will ensure feedback to incident reporters on action taken.

## Other Important Patient Safety and Effectiveness Indicators

| | |
|---|---|
| *NHS Outcome framework 3: Helping people to recover from episodes of ill health or following injury* | **See individual indicators below** |

Tameside and Glossop Integrated Care NHS Foundation Trust made goals regarding other key patient safety indicators, progress of which is identified in the table below and monitored through the Dr Foster intelligence tools used by the Trust.

| Indicator | Observed Rate per 1000 | Expected Rate per 1000 | |
|---|---|---|---|
| Accidental puncture or laceration | 0.7 | 1.3 |  |
| Deaths after Surgery | 74.1 | 78.3 |  |
| Deaths in low-risk diagnosis groups | 0.5 | 0.5 |  |
| Decubitus Ulcer | 52.6 | 52.2 |  |
| Infections associated with central line | 0 | 0 |  |
| Obstetric trauma - caesarean delivery | 0 | 4.2 |  |
| Obstetric trauma – vaginal delivery with instrument | 66.4 | 72.3 |  |
| Obstetric trauma – vaginal delivery without instrument | 24.3 | 31.3 |  |
| Postoperative Haemorrhage or Haematoma | 0.7 | 0.4 |  |
| Postoperative hip fracture | 0.1 | 0.1 |  |
| Postoperative Physiologic and Metabolic Derangement | 0.1 | 0.1 |  |

| Indicator | Observed Rate per 1000 | Expected Rate per 1000 | |
|---|---|---|---|
| Accidental puncture or laceration | 0.7 | 1.3 |  |
| Deaths after Surgery | 74.1 | 78.3 |  |
| Deaths in low-risk diagnosis groups | 0.5 | 0.5 |  |
| Postoperative pulmonary embolism or deep vein thrombosis | 3.2 | 2.1 |  |
| Postoperative respiratory failure | 1.0 | 0.8 |  |
| Postoperative sepsis | 9.8 | 13.4 |  |
| Postoperative wound dehiscence | 0 | 0.9 |  |

As at March 2018

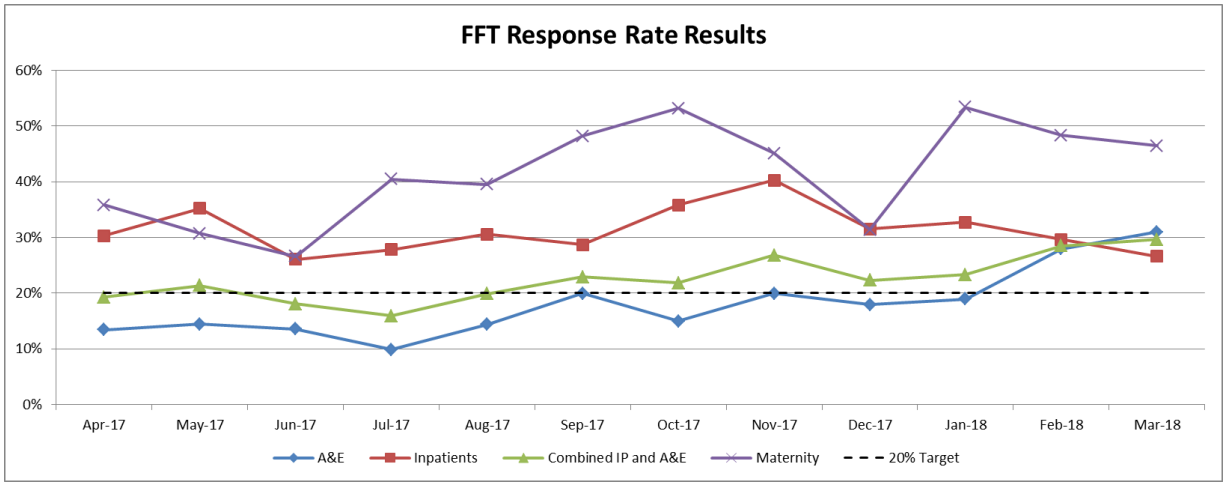
We pledged to Implement and deliver the Trust Safety plan for 2017/18 measuring and monitoring safety objectives across the Trust. The metrics reported in this Quality account are evidence of this achievement.

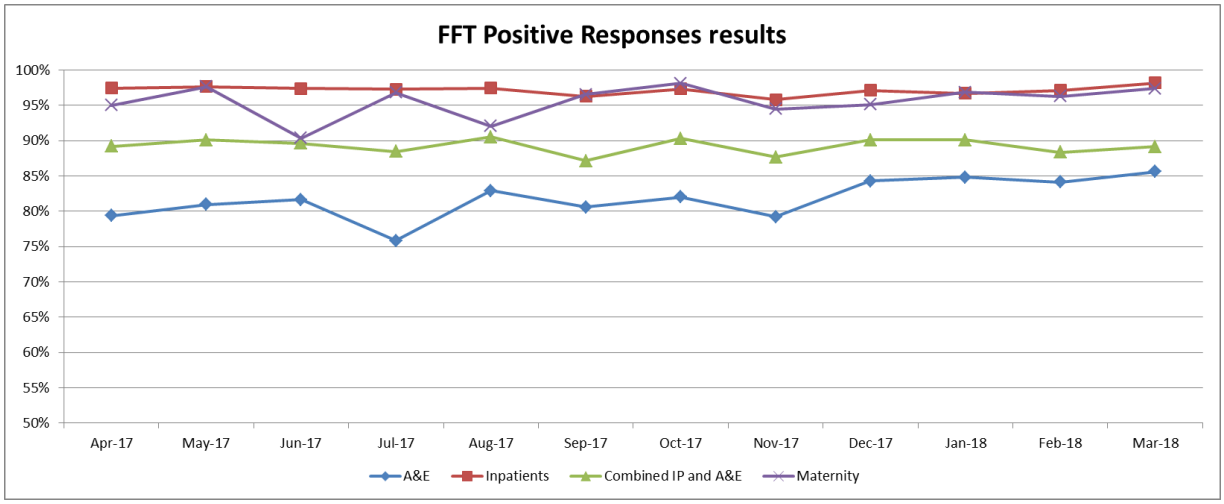
## Patient Experience - Friends & Family Test

| NHS Outcome framework 4: Ensuring that people have a positive experience of care | |
|---|---|

The Friends and Family test has been introduced to collect Patient feedback by asking "How likely are you to recommend our ward, department or service to your friends and family if they needed similar care or treatment?" The Trust performance is reported to the Trust board monthly.

We pledged to ensure that we would improve our Friends & Family Test response rates by a further 5% on the national trajectory.




We pledged in 2017/18 in our revised objectives to achieve the following FFT results

- All in-patient areas to achieve a 30% response rate.
- Maternity to achieve a 30% response rate.
- ED to sustain the 25% response rate.
- Adult community services to achieve a 95% positive response rate.
- Children's community services to achieve a 95% positive response rate.
- Out-patients to achieve a 20% response rate
- All areas to achieve 95% positive response rating.

We have achieved improvement towards these trajectories.

We also pledged to see improvement in patient experience percentage recommended scores improving. We have achieved this for in the Inpatient and Maternity and have seen more recent improvement for A&E which we will aim to maintain. Our objectives for 2018/19 set out our ambition for the coming year.

Our patient experience strategy and revised expectations are identified in the objectives set expectation for all areas to achieve.

National Benchmarking demonstrates

Inpatient Friends and Family test

| Friends and Family Inpatient response rate | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|
| THFT response rate | 40.3% | 31.5% | 33% | 30% | 26% |
| Rank | 25/166 | 45/171 | 44/172 | 64/172 | 79/172 |
| Worst performing trust | 3% | 2.6% | 3% | 3.6% | 0.2% |
| Best performing Trust | 100% | 100% | 100% | 100% | 100% |
| England average | 25.5% | 22.1% | 23.3% | 24.5% | 23.2% |
| Friends and Family Inpatient percentage recommended | | | | | |
| THFT percentage recommended | 96% | 97% | 97% | 97% | 98% |
| Rank | 108/166 | 72/171 | 90/172 | 73/172 | 36/172 |
| Worst performing trust | 73% | 64% | 75% | 82% | 81% |
| Best performing Trust | 100% | 100% | 100% | 100% | 100% |
| England average | 96% | 95.6% | 96% | 96% | 96% |

Accident and Emergency Friends and Family test

| Friends and Family A&E response rate | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|
| THFT response rate | 19.9% | 18% | 19% | 28% | 31% |
| Rank | 29/138 | 33/136 | 28/138 | 7/140 | 4/140 |
| Worst performing trust | 0% | 0% | 0% | 0% | 0% |
| Best performing Trust | 58.7% | 45.4% | 49.1% | 69.7% | 45.1% |
| England average | 12.9% | 11.6% | 12.3% | 13.4% | 12.8% |
| Friends and Family A&E percentage recommended | | | | | |
| THFT percentage recommended | 79% | 84% | 85% | 84% | 86% |
| Rank | 130/138 | 95/136 | 93/138 | 90/140 | 79/140 |
| Worst performing trust | 66% | 57% | 66% | 67% | 64% |
| Best performing Trust | 100% | 100% | 100% | 100% | 100% |
| England average | 87% | 85% | 88% | 85% | 84% |

* = Joint Ranks

Tameside and Glossop Integrated Care NHS Foundation Trust considers that this data is as described because of the assertive improvement programme implemented in place and the Care and Treatment provided by the Trust being provided to the standards expected more consistently and the assertive work of the patient experience team with clinical colleagues to ensure that receipt of feedback is

prioritized.

Tameside and Glossop Integrated Care NHS Foundation Trust has taken the following action to further improve this indicator and so the quality of its services through the continued implementation of its Patient and Service User Strategy and agreed objectives which are reported through to Trust Board.

## Complaints and Concerns Monitoring

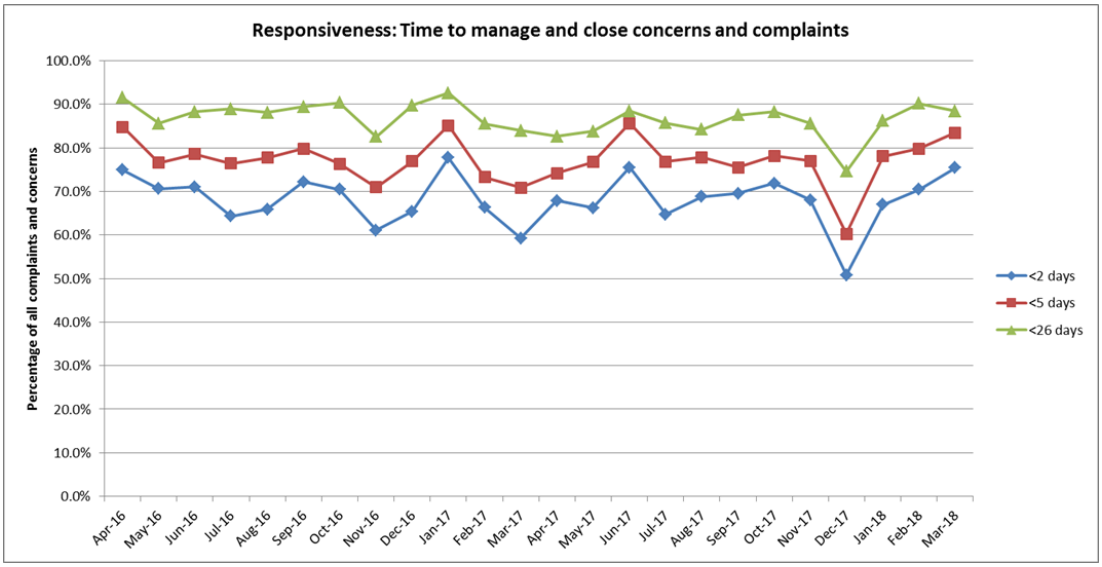
| | |
|---|---|
| NHS Outcome framework 4: Ensuring that people have a positive experience of care |  |

The percentage of total cases closed within an agreed time or negotiated extension of time frame is 94% at the end of March 2018.

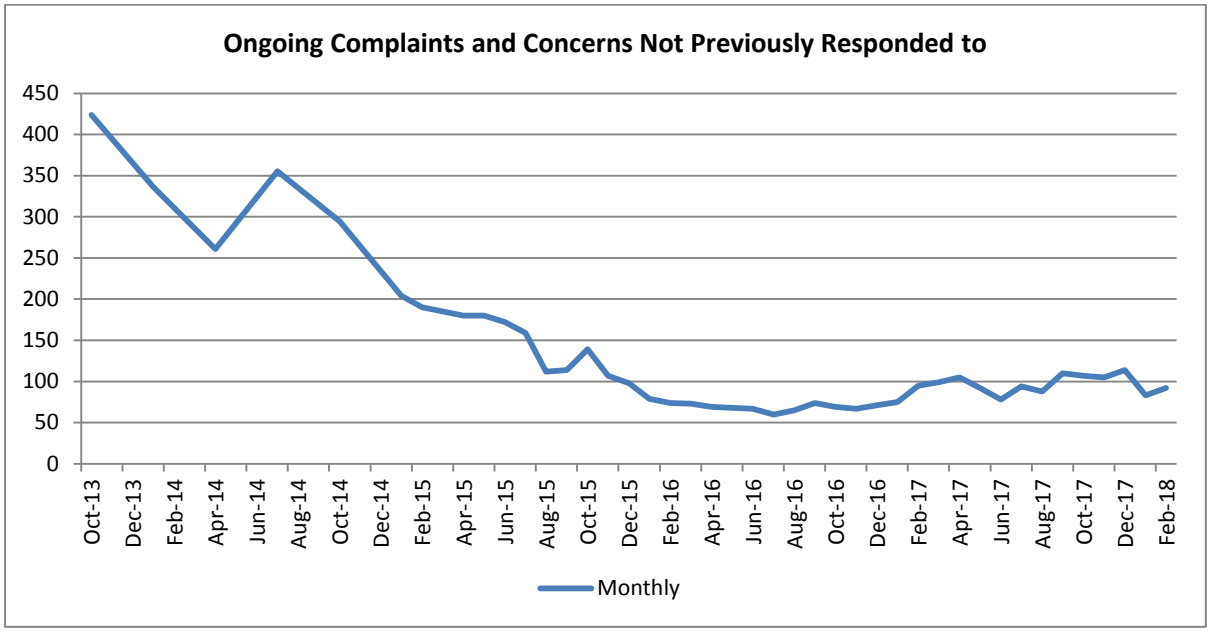
We have continued to refine the way we handle Complaints and PALS cases in order that we become more responsive to patient and carers that raise issues with the complaints and PALS service. The clinical and operational teams have also streamlined their part of the process to ensure that the leadership and infrastructure was strengthened to reinforce divisional engagement rather than a Trust centrally based service.

- We have increased our responsiveness and attempt to ensure real time response management when possible.
- We continue to show openness and Candour in the way we work and our responses which is evident in the responses for cases reviewed by the PHSO
- All complaints are triaged for harm and aligned, if applicable to the Serious Incident and escalated investigation process.
- We continue to recommend and undertake face to face resolution meetings which are recorded and a CD issued as a record of the meeting for complainants to keep.
- We offer apology and appropriate redress for harm in line with the PHSO redress principles.
- We use the learning from complaints to provide our patient stories and inform the organisational development and learning through our Governance Processes across the organisation.

Our responsiveness to concerns and complaints has been maintained but was impacted by some staff absence as demonstrated below




And have managed the backlog of ongoing cases.




The table above shows the average number of ongoing complaints and concerns not yet responded to on a monthly basis. The increase in Quarter 3 2017/18 is due to staff changes and revised skill mix of staff from December 2016. We expect to see less than 80 ongoing cases as our average in 2017-18.

We pledged to reduce the number of KO41 complaints per 1000 patient contacts to below 1.15. We have achieved this in 2016/17. We have seen a small increase in the number of complaints in 2016/17 in line with what was expected as we now provide community services.

| | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|---|
| Number of K041 complaints received | 403 | 450 | 532 | 445 | 450 | 468 |
| Complaints per 1000 patient contacts across the Trust including community services | 1.15 | 0.95 | 1.11 | 0.80 | 0.52 | 0.58 |

| Month | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints per 1000 contacts | 0.62 | 0.46 | 0.56 | 0.66 | 0.76 | 0.53 | 0.59 | 0.57 | 0.39 | 0.52 | 0.68 | 0.61 |

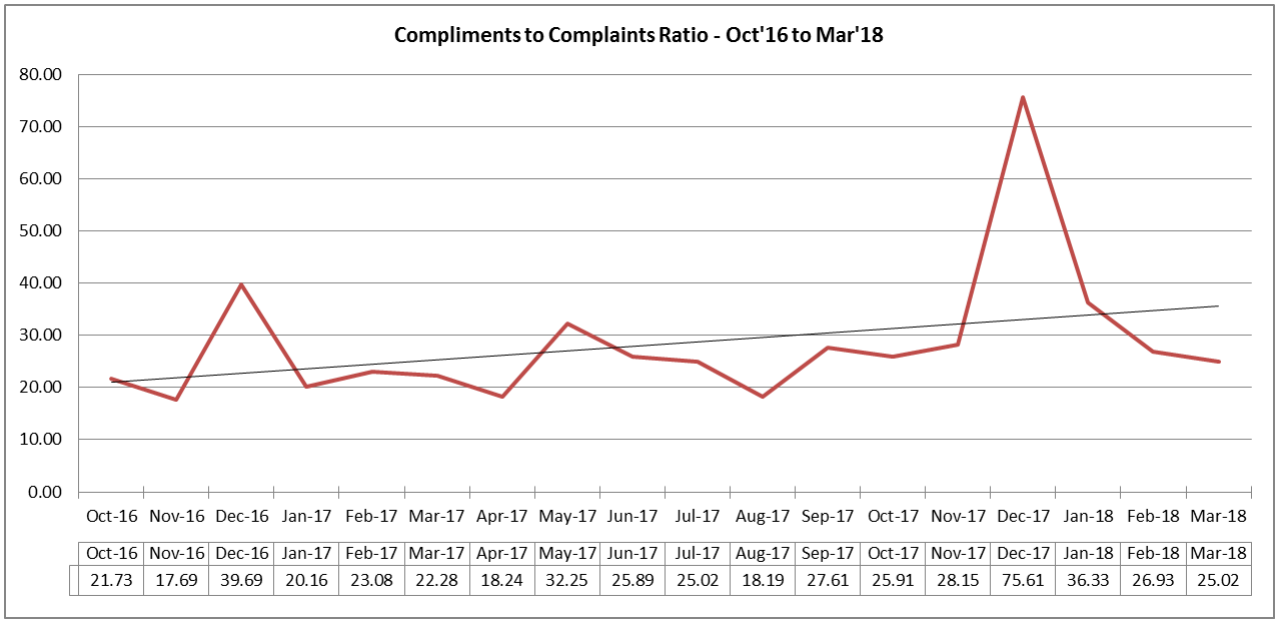
## Compliments

We pledged to increase in the number of recorded compliments per 1000 patient contacts by 25% from the baseline of 4092 in April 2016.

We have in developed and implemented a more robust method of capturing this data and the compliments recorded at ward level have continued to increase on a quarterly basis throughout the year. We have achieved this pledge. In 2017/18 we captured a total of 13307 compliments. This equates to 28.43 compliments for every K041 complaint received. This is an increase of 31% since 16/17.

| | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of compliments received | 693 | 1032 | 958 | 1076 | 946 | 994 | 1114 | 1154 | 1739 | 1417 | 1158 | 1026 |
| Compliments per 1000 patient Trust contacts | 11.27 | 14.86 | 14.52 | 16.50 | 13.85 | 14.72 | 15.19 | 16.08 | 29.21 | 19.00 | 18.30 | 15.39 |
| Compliments to complaints ratio | 18.24 | 32.25 | 25.89 | 25.02 | 18.19 | 27.61 | 25.91 | 28.15 | 75.61 | 36.33 | 26.93 | 25.02 |

In 2018/19 the Trust will aim to reduce further the rate of complaints received and improve the percentage of responses provided within an agreed timeframe whilst maintaining the low rate of comeback letters, and improving the Compliments to complaints ratio.




| Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 21.73 | 17.69 | 39.69 | 20.16 | 23.08 | 22.28 | 18.24 | 32.25 | 25.89 | 25.02 | 18.19 | 27.61 | 25.91 | 28.15 | 75.61 | 36.33 | 26.93 | 25.02 |

## Responsiveness to the patients personal needs

| NHS Outcome framework 4: Ensuring that people have a positive experience of care |  |
|---|---|

The 2017 in patient survey results are not yet available.
The results of the 2016 In-patient Survey are based on responses from patients discharged in August 2016 and January 2017.

| Section | 2014 Survey | 2015 Survey | 2016 Survey | 2017 survey |
|---|---|---|---|---|
| The A&E department | About the same | About the same | About the same | Not available nationally at the time of the publication |
| Waiting list and Planned admissions | About the same | About the same | About the same | |
| Waiting to get a bed on a ward | Worse | Worse | About the same | |
| The Hospital and Ward | About the same | About the same | About the same | |
| Doctors | Worse | Worse | About the same | |
| Nurses | About the same | About the same | About the same | |
| Care and Treatment | About the same | About the same | About the same | |
| Operations and procedures | About the same | About the same | About the same | |
| Leaving Hospital | About the same | About the same | About the same | |
| Overall view and experience | Worse | About the same | About the same | |

We also pledged in our Patient and Service User Experience Strategy to improve the scores in the inpatient survey for

- Reduction in disturbance from noise at night
- Improved levels of support at mealtimes
- Improved involvement in decision making

We will report on the success of these criteria when the results are available (Not available the time of the publication)

### Benchmarking scores

NHS England provides benchmarking scores which are demonstrated below for the Trust.

| | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 |
|---|---|---|---|---|---|---|
| Tameside | 69.3 | 73.7 | 75.2 | 72.2 | 72.6 | 74.2 |
| England Average score | 75.6 | 76.5 | 76.9 | 76.6 | 77.3 | 76.7 |

NHS England provide the following explanation of the scores
The scores are out of 100. A higher score indicates better performance: if patients reported all aspects of their care as "very good" we would expect a score of about 80, a score around 60 indicates "good" patient experience.

The overall score is the average of the domain scores.

Tameside and Glossop Integrated Care NHS Foundation Trust considers that this data is as described because of the feedback received from Patients, and the improvement achieved due to the improvement and patient safety work undertaken.

Tameside and Glossop Integrated Care NHS Foundation Trust has taken the following action to further improve this indicator and so the quality of its services by the implementation of a Trust wide improvement programme agreed with key stakeholders and progress monitored by the Trust board.

| *NHS Outcome framework 3: Helping people to recover from episodes of ill health or following injury* |  |
|---|---|

We pledged to achieve all access standards – we have not achieved all of these.

Performance against the access standards is reported monthly in the Trust board papers. The reported position for March 2018 is shown below.

| Key Performance Indicators | Target 17/18 | Actual YTD | 4-mth Trend | Actual Month | Current Period | 1-mth F'cast |
|---|---|---|---|---|---|---|
| 4-hour wait* | | | | | | |
| Type 1 and Type 3 activity | ≥95% | 89.65% | ↘ | 85.57% | ● | ● |
| Type 1 activity | NA | 83.20% | ↘ | 75.56% | NA | NA |
| Waiting times | | | | | | |
| 18-week incomplete* | ≥92% | 92.61% | → | 92.01% | ● | ● |
| RTT waits- incompletes (>52 weeks) | 0 | 1 | ↗ | 0 | ● | ● |
| A&E | | | | | | |
| HAS compliance | ≥95% | 94.8% | ↗ | 94.8% | ● | ● |
| Notify to Handover (30-60mins) (Feb-18) | ≤30 | 629 | ↘ | 93 | ● | ● |
| Notify to Handover (>60mins) (Feb-18) | ≤10 | 199 | ↘ | 42 | ● | ● |
| Diagnostic test waiting times | | | | | | |
| ≤6 weeks from Referral for a diagnostic test | ≥99% | 99.80% | → | 100% | ● | ● |

**Referral-to-Treatment**

In this year's Quality account we identified our improvement programme to ensure we met the RTT requirements. We implemented this and the Trust met the national Referral-to-Treatment standard in each month from August 2016, and has continued to do this throughout 2017/18.

**Six week Diagnostic target**

We have met the requirement throughout the year and not had a six week diagnostic breeches for the last 4 months of the year.

**The Four-hour Target**

The Trust did not meet the emergency access four-hour standard in any quarter of 2017/18. Performance has been constrained by high levels of bed occupancy and patient acuity, despite the improvement and transformation work which has been implemented as describe earlier. Our performance against the 95% standard has been a challenge all year, and were ranked 46$^{th}$ out of 133 Trusts.

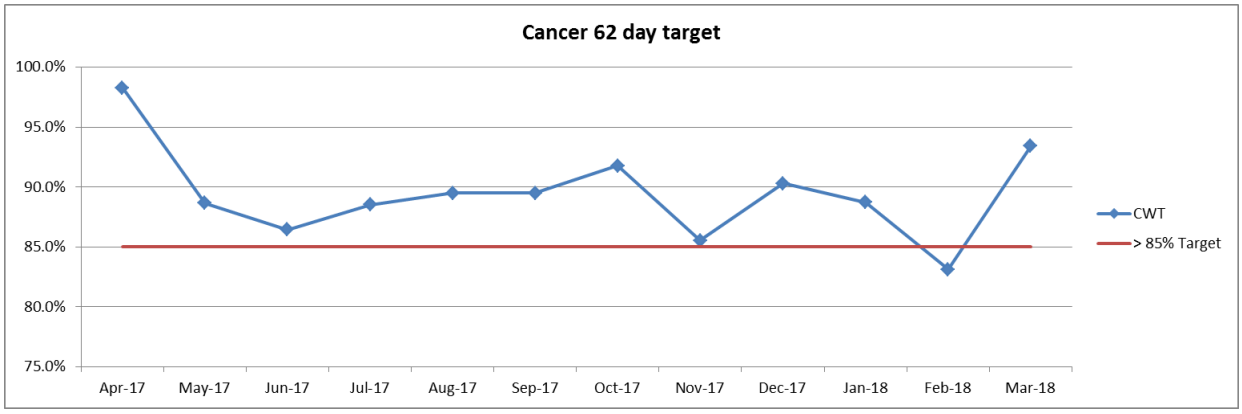
The Trust has engaged with stakeholders and implemented the NHSI best practice guidance to enable admission avoidance and facilitate early discharge, and plans to develop this work further as described in section 2 of the Quality account as part of the service transformation work being undertaken and the health-economy implementation plan.

## Cancer indicators - including 62 Day cancer performance

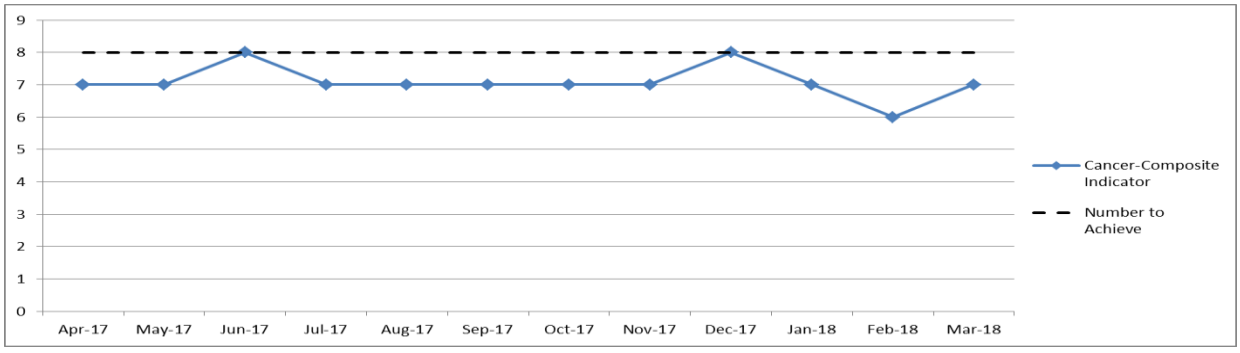
| | |
|---|---|
| NHS Outcome framework indicators:<br>All domains |  |

The monitoring of Cancer performance is undertaken by the Trust board through its routine reporting process. The performance indicators are set to identify best practice minimum standards to ensure that patients receive care and treatment in the most effective way. With respect to the Cancer performance criteria we believe that this has been achieved in 2017/18 and we ranked 19th out of 133 Trusts for these.

| Measure | Target % | YTD % |
|---|---|---|
| Two-week wait | 93 | 97 |
| Breast symptomatic target | 93 | 98.2 |
| 31-day target | 96 | 100 |
| Subsequent 31-day target (Drug treatments) | 98 | 100 |
| Subsequent 31-day target (Surgery) | 94 | 100 |
| 62-day target (CWT) | 85 | 89 |
| Upgrade 62-day target | 85 | 96.3 |
| NHS Cancer Screening Programmes(62-days) | 90 | 100 |




## Cancer composite indicator number achieved out of 8




The Trust aims to maintain compliance with all national and local performance standards as identified in the Trust Objectives for 2018/19.

## Staff Survey Results (including Friends and Family Test)

| NHS Outcome framework 4: Ensuring that people have a positive experience of care |  |
|---|---|

During autumn 2017 the Trust participated in the annual staff survey. The survey was sent out to a random sample of 1250 eligible staff, 503 staff took part in the survey providing a response rate of 40% which was slightly better than last year's response rate of 39%. The average response rate for all Combined Acute and Community NHS Trusts was 43%.

Nationally the Trust was 7th out of 43 Combined Acute and Community Trust remaining in the top 20%.

The results are extremely positive with 21 of the 32 areas classed as better than average when compared to other Combined Acute and Community Trusts, 10 areas are classed as average and only 1 areas are worse than average.

We have maintained 28 of our previous year's scores and have improved on 1 area. We have 3 areas where performance was worse than the previous year; however in each of these three areas the Trusts score is higher than the average score for combined Acute and Community Trusts.

There were also 4 areas where the Trust scored the maximum score of any Combined Acute and Community Trust.

- KF29 – Percentage of staff reporting errors, near misses or incidents witnessed in the last month.
- KF4 – Staff motivation at work
- KF8 – Staff satisfaction with the level of responsibility and involvement
- KF2 – Staff satisfaction with the quality of work and care they are able to deliver

**TOP AND BOTTOM RANKING SCORES**

This highlights the Key findings where the Trust compares most favourably with other combined acute and community trusts (CA&CT) in England

| TOP FIVE RANKING SCORES | Trust Score 2017 | National Average for CA&CT | Trust Score 2016 |
|---|---|---|---|
| **KF2. Staff satisfaction with the quality of work and care they are able to deliver (the higher the score the better, highest is 5)** | **4.16** | **3.90** | **4.11** |
| **KF4. Staff motivation at work (the higher the score the better, highest is 5)** | **4.01** | **3.91** | **4.03** |
| **KF8. Staff satisfaction with level of responsibility and involvement (the higher the score the better, highest is 5)** | **4.05** | **3.89** | **4.06** |
| **KF24. Percentage of staff / colleagues reporting most recent experience of** | **81%** | **67%** | **83%** |

| | | | |
|---|---|---|---|
| **violence (the higher the score the better)** | | | |
| **KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month (the higher the score the better)** | **94%** | **91%** | **96%** |

This highlights the Key findings where the Trust compares least favourably with other acute and community trusts in England

| BOTTOM FOUR RANKING SCORES | Trust Score 2017 | National Average for CA&CT | Trust Score 2016 |
|---|---|---|---|
| **KF20. Percentage of staff experiencing discrimination at work in the last 12 months** | **10%** | **10%** | **8%** |
| **KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (the lower the score the better)** | **14%** | **14%** | **13%** |
| **KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (the lower the score the better)** | **28%** | **27%** | **25%** |
| **KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse (the higher the score the better)** | **47%** | **47%** | **46%** |
| **KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (the lower the score the better)** | **29%** | **29%** | **24%** |

Significant Improvements – this highlights the areas where staff experience has shown a statistical significant improvement since 2016

| Significant Improvements | Trust Score 2017 | Trust Score 2016 |
|---|---|---|
| **KF11. Percentage of staff appraised in last 12 months** | **94%** | **90%** |

Significant deteriorations -

| Significant deterioration | Trust Score 2017 | Trust Score 2016 |
|---|---|---|

| | | |
|---|---|---|
| **KF9. Effective team working (the higher the score the better)** | **3.80** | **3.91** |
| **KF31. Staff confidence and security in reporting unsafe clinical practice (the higher the score the better)** | **3.72** | **3.86** |
| **KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (the higher the score the better)** | **89%** | **93%** |

Overall Staff Engagement - Above better than average

| Trust Score 2017 | Trust Score 2016 | National Average for CA&CT 2017 |
|---|---|---|
| **3.89** | **3.95** | **3.78** |

Although there was a slight drop against last year this was not statistically significant.

Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

| | Your Trust in 2017 | Average (median) for combined acute and community trusts |
|---|---|---|
| Q21a "Care of patients / service users is my organisation's top priority | 82% | 75% |
| Q21b "My organisation acts on concerns raised by patients / service users | 80% | 73% |
| Q21d "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation | 71% | 69% |
| KF1. Staff recommendation of the organisation as a place to work or receive treatment | 3.86 | 3.75 |

The Trust benchmarked performance with others demonstrates

| Staff survey Q21a, 21c and 21d<br>The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|
| Tameside | 3.70 | 3.94 | 3.92 | 3.86 |
| Rank | 61/138 | 16/99 | 7/39 | 7/43 |
| Worst performing trust | 3.00 | 3.30 | 3.32 | 3.06 |

| | | | | |
|---|---|---|---|---|
| Best performing Trust | 4.20 | 4.10 | 4.20 | 4.54 |

Tameside and Glossop Integrated Care NHS Foundation Trust considers that this data is as described because of the assertive improvement programme implemented including staff engagement undertaken in the past year to ensure delivery of Services, Care and Treatment and staff support was enabled and was being consistently provided to the standards required.

Tameside and Glossop Integrated Care NHS Foundation Trust has taken the following action to further improve this indicator and so the quality of its services by the continuation of this a Trust wide improvement programme agreed with key stakeholders and progress monitored by the Trust board. Specifically:

The results of the 2017 survey were disseminated across the whole organisation and all staff groups and shared with the Divisional Teams to ensure they had a full opportunity to review the results for their areas and to agree the core actions that needed to be taken.

**ACTION PLANNING FOR 2018**

The NHS Staff Survey provides an opportunity to build up a picture of staff experience and, with care, to compare and monitor change over time and to identify variations between different staff groups. Obtaining feedback from staff is vital for driving real improvements.

On the whole the survey results are positive, we have high levels of staff job satisfaction and motivation and staff would on the whole recommend the Trust as a place to work or receive treatment.

The results of the 2017 survey will be disseminated through the usual communication mechanisms and Divisional teams. Next steps will be to work with divisional teams to develop bespoke action plans to celebrate some of the very positive results but also to address areas identified where improvements are required.

Divisional action plans and progress against those actions will be reported via the Workforce Committee for oversight and assurance.

Actions already commenced:

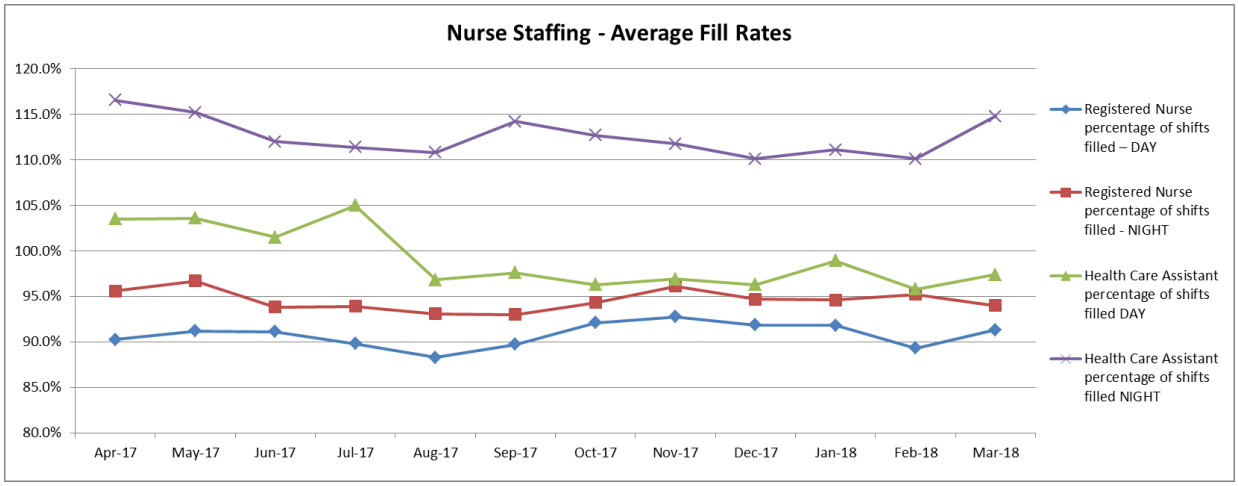
- Medical Staffing team as part of the Medical Staffing retention work stream will be conducting aspiration interviews with Trust Grade Junior and Specialty doctors to understand what support/career development that they would benefit from.
- A programme of resilience training dates have been arranged throughout 2018 so that staff and teams can access some tips and tools to support them to increase their own resilience and develop strategies to reduce levels of stress.
- Mental Health First Aid Training for Managers/Mental Health Champions has been arranged for May 2018, the course will equip the Mental Health champions to support staff experiencing Mental Health issues and create and maintain a healthier workforce.
- In response to feedback from staff in terms of experiencing high levels of violence and aggression during the course of their work last year, Conflict

Resolution De-escalation training has been commissioned. Additional dates are booked in February and March with 20 staff booked on to attend from ward Areas within Medicine and Urgent Care. Further dates, are to be scheduled throughout 2018 for teams identified requiring this support.

- A series of Focus Groups to be held at the end of April with BME staff initially to explore their experiences in the workplace and further understanding of the results.
- Re-design of the Equality and Diversity Training with a greater emphasis on discrimination.
- Focus Groups with staff to further understand the results where we have scored lower than the national average
- Benchmarking with other Trust's that have scored higher on those areas where we require improvement.

## Safe Staffing levels

Safe Staffing levels continue to have a high profile within the organisation and are reported on Monthly to Trust board. The graph and table below demonstrate the data which has been presented throughout the year with Registered Nurse staffing and Care staff achieved fill rates for day and night shifts.




| Percentage | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Registered Nurse percentage of shifts filled – DAY** | 90.2 | 91.2 | 91.1 | 89.8 | 88.3 | 89.7 | 92.1 | 92.7 | 91.9 | 91.8 | 89.3 | 91.3 |
| **Registered Nurse percentage of shifts filled - NIGHT** | 95.6 | 96.7 | 93.8 | 93.9 | 93.1 | 93.0 | 94.3 | 96.1 | 94.7 | 94.6 | 95.2 | 94.0 |
| **Care Staff percentage of shifts filled DAY** | 103.5 | 103.6 | 101.5 | 105.0 | 96.8 | 97.6 | 96.3 | 96.9 | 96.3 | 98.9 | 95.8 | 97.4 |
| **Care Staff percentage of shifts filled NIGHT** | 116.6 | 115.2 | 112.0 | 111.4 | 110.8 | 114.2 | 112.7 | 111.8 | 110.1 | 111.1 | 110.1 | 114.8 |

| NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. |  |
|---|---|

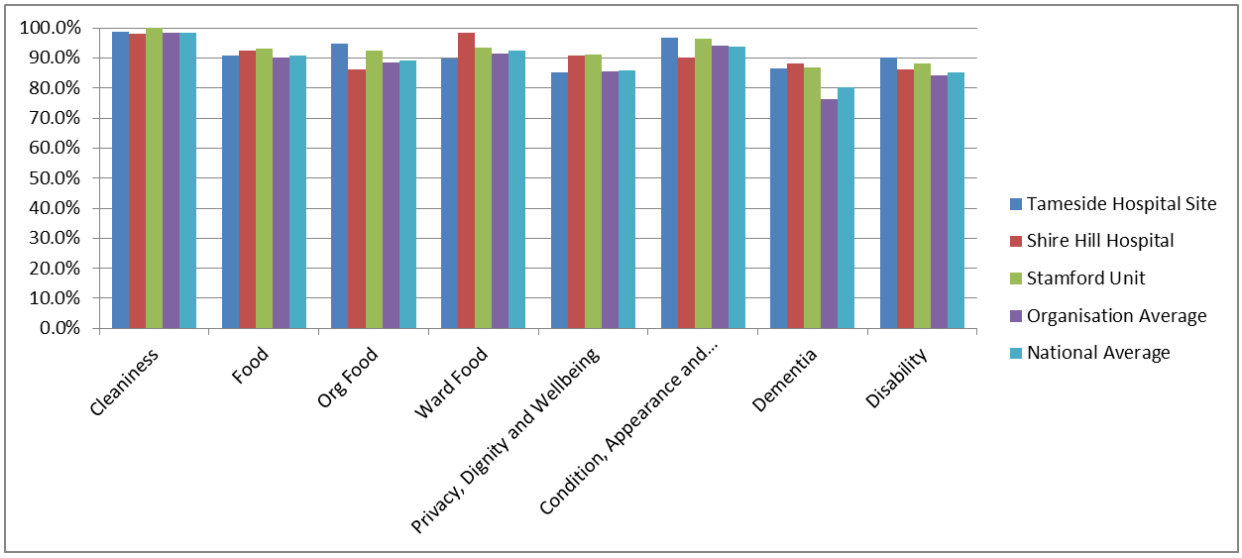
**PLACE inspections**
**(Patient-led assessments of the care environment)**

PLACE is the Patient Led Audit of the Care Environment and covers a number of areas: Environment, Cleanliness, Food, Condition, Appearance and Maintenance, Dementia and Privacy, Dignity and Wellbeing and for the first year Disability was also reviewed. Staff and Volunteers are split into groups and choose which areas to audit. This ensures that as many areas as possible are audited and also means that the audits are led by the volunteers.

In 2017 we had a large number of new volunteers joining us for the PLACE assessments as well as a large number of volunteers who had helped on previous PLACE Audits.

The scores in all areas increased from previous years and in all cases were either very close to or exceeded the national average scores from the previous year and the current year.

The graph demonstrates the Tameside and Glossop Hospital site, Shire Hill Hospital and the Trust Average against the national average. We achieved improved scores in the areas of Cleanliness, Food, Condition and appearance and dementia, but seen a small reduction in Privacy dignity and wellbeing. Disability is a new indicator with which we benchmark at about the national level.



# Patient Outcomes

## PROMS (Patient Reported Outcome Monitoring)

| | |
|---|---|
| NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. |  |

The Trust continues to participate in the Patient Reported Outcome monitoring measures identified below. The information provided demonstrates the Trust Performance compared to the national benchmarking which demonstrates that in the main patients are reporting benefits from the outcome of the procedures reviewed

The information provided below is the nationally published year on year comparison data of our involvement and benchmarked comparison of pre- and post-operative patient questionnaires (a combination of five key criteria concerning patients' self-reported general health called EQ-5D Index' scores). The EQ5D scores are compared to the England average scores in the table below.

A positive number indicates a net health gain being identified and comparison to the England Average is also provided. This is the case for all data reported below. In some areas the data we provide during part of a year is too small to be evaluated separately, but will be included in the national average.

| **Hip Replacement** | **2013/14** | **2014/15** | **2015/16** | **2016/17** |
|---|---|---|---|---|
| TGH EQ5D Adjusted Average Health Gain | 0.369 | 0.415 | 0.398 | 0.460 |
| England average EQ5D index Adjusted Average Health Gain | 0.436 | 0.436 | 0.438 | 0.449 |

| **Knee Replacement** | **2013/14** | **2014/15** | **2015/16** | **2016/17** |
|---|---|---|---|---|
| TGH EQ5D index Adjusted Average Health Gain | 0.261 | 0.319 | 0.284 | 0.303 |
| England average EQ5D index Adjusted Average Health Gain | 0.259 | 0.315 | 0.320 | 0.337 |

Tameside and Glossop Integrated Care NHS Foundation Trust considers that these data are as described because of the improvement programme put in place and the implementation of care pathways being implemented.

Tameside and Glossop Integrated Care NHS Foundation Trust has taken the following action to further improve this indicator and so the quality of its services by the continued implementation of a Trust wide improvement programme agreed with key stakeholders and progress monitored by the Trust board.

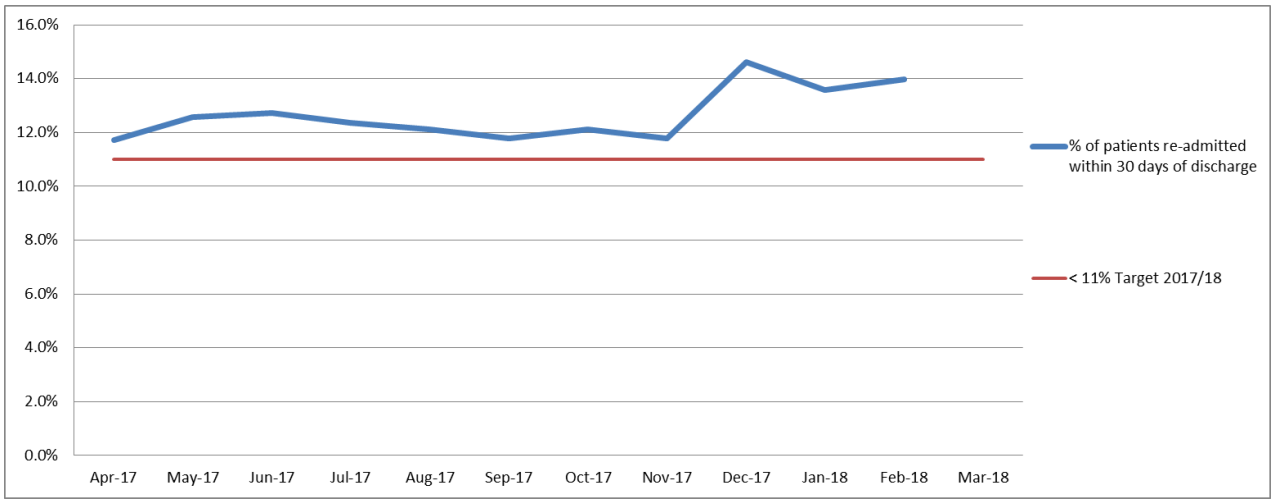
## Readmission Rates

| NHS Outcome framework 3: Treating and caring for people in a safe environment and protecting them from avoidable harm. |  |
|---|---|

The Trust Board monitors readmission rates for patients recently discharged from hospital as a Quality indicator. The Board performance report monitors 30 day readmissions as this is the Quality measure within the contract. The graph below demonstrates the performance this year. We are aiming to reduce readmission rates from both elective and non-elective patients.

We pledged to see a reduction in 30 day re-admission rates. We have not demonstrated further improvement this year. We continue to review readmissions to ensure that these are understood and that these are correctly captured in the context of the work to ensure timely discharge with the appropriate care support packages. We have further work to do to achieve the target rate which is being progressed through the service improvement workstreams.

### Re-admission rates 2017/18




The Quality Account requires us to benchmark 28 day readmissions, and these are set out in the table below but have not been available nationally to report on.

| | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | Comparison v. National | Improvement Banding |
|---|---|---|---|---|---|---|---|---|
| **Age 16+** | | | | | | | | |
| Tameside | 11.84 | 12.47 | Data not available | Data not available | Data not available | Data not available | W | D |
| Best nationally | 7.14 | 0.00 | Data not available | Data not available | Data not available | Data not available | Data not available | Data not available |
| Worst nationally | 12.70 | 15.11 | Data not available | Data not available | Data not available | Data not available | Data not available | Data not available |
| **Age 0-15** | | | | | | | | |
| Tameside | 11.24 | 11.6 | Data not available | Data not available | Data not available | Data not available | A5 | D |
| Best nationally | 6.26 | 0.00 | Data not available | Data not available | Data not available | Data not available | Data not available | Data not available |
| Worst | 12.75 | 14.87 | Data not available | Data not available | Data not available | Data not available | Data not available | Data not available |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| nationally | | | | | | | | |

**Key to The Health and Social Care Information Centre Comparison and improvement bandings**

W = National average lies within expected variation (95% confidence interval);
D = Some deterioration (not significant)
A5 = Significantly poorer than the national average at the 95% level but not at the 99.8% level;

Notes:

- The readmission rate figures are standardised to persons 2006/07
- Indirectly age, sex, method of admission of discharge spell, diagnosis (ICD 10 chapter/selected sub-chapters within medical specialties) and procedure (OPCS 4 chapter / selected sub-chapters within surgical specialties) standardised rates
- Ages 16+
- Best and worse readmission rates selected from Trusts classed as “Small acute” or “Small acute or multi service categories”.
- Source: The Health and Social Care Information Centre

The Trust’s performance on this indicator is reported above for 2017/18 this is an average of 12.7%. This is an internal figure and subject to validation by HSCIC in the future.

Tameside and Glossop Integrated Care NHS Foundation Trust consider that this data is as described because the care and treatment provided by the Trust is still not being consistently provided to the standards required.

Tameside and Glossop Integrated Care NHS Foundation Trust has taken the following action to further improve this indicator and so the quality of its services by continuing to implement and monitor care pathways and ensure they are systematically implemented.

## Improving Hospital Mortality

| | |
|---|---|
| NHS Outcome framework<br>1: Preventing People from dying prematurely<br>2: Enhancing quality of life for people with long-term conditions |  |

We pledged to see reduction in mortality rates and implementation of a systematic review process to levels that are not statistically significant and show a reduction in the raw death rate and the implementation of a systematic review process.

We are continuing to undertake mortality reviews for every death occurring in hospital. The initial reviews within 14 days have systematically been achieved for each month of the year. Where an issue is identified we undertake a comprehensive MDT reviews and further investigation or external review as appropriate. These cases are systematically followed up and results reported through the Mortality Steering Group reporting to the Service Quality and Operational governance group.

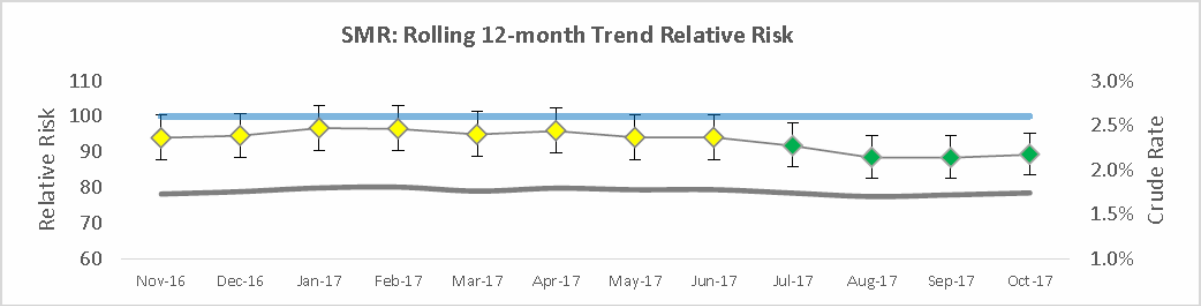
The Hospital Risk adjusted mortality indices HSMR (Hospital Standardised Morality Ratio) and SHMI (Summary Hospital-level Mortality Indicator) are routinely reported in the Trust Board papers available on the Trust website. These indicators are reported retrospectively the HSMR indicator has remained within normal limits during the year and the SHMI indicator score has reduced and has been within the "as expected" banding for the last four reporting periods and we anticipate that this position will be maintained

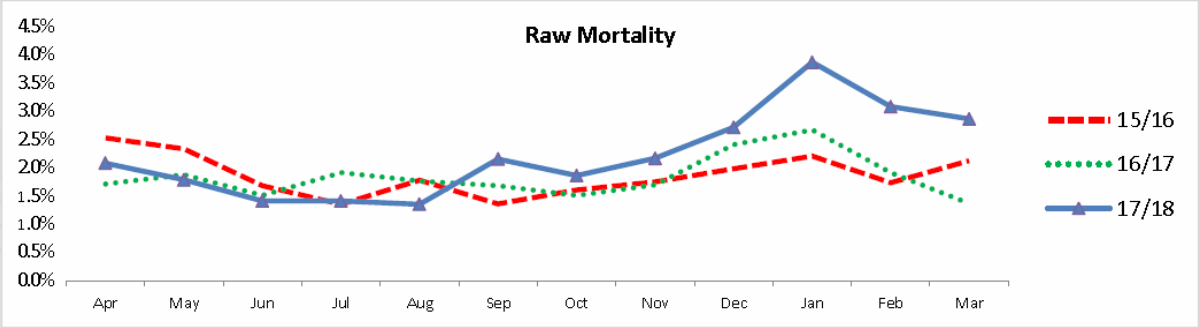
**SHMI – *Summary Hospital-level Mortality Indicator***

| | Jan 15 – Dec 15 | Apr 15 – Mar 16 | Jul 15 – Jun 16 | Oct 15 – Sep 16 | Jan 16 – Dec 16 | Apr 16 - Mar 17 | Jul 16 – Jun 17 | Oct 16 – Sep 17 |
|---|---|---|---|---|---|---|---|---|
| **SHMI** | 115.00 | 114.00 | 110.00 | 111.00 | 109.00 | 109.00 | 108.00 | 108.00 |

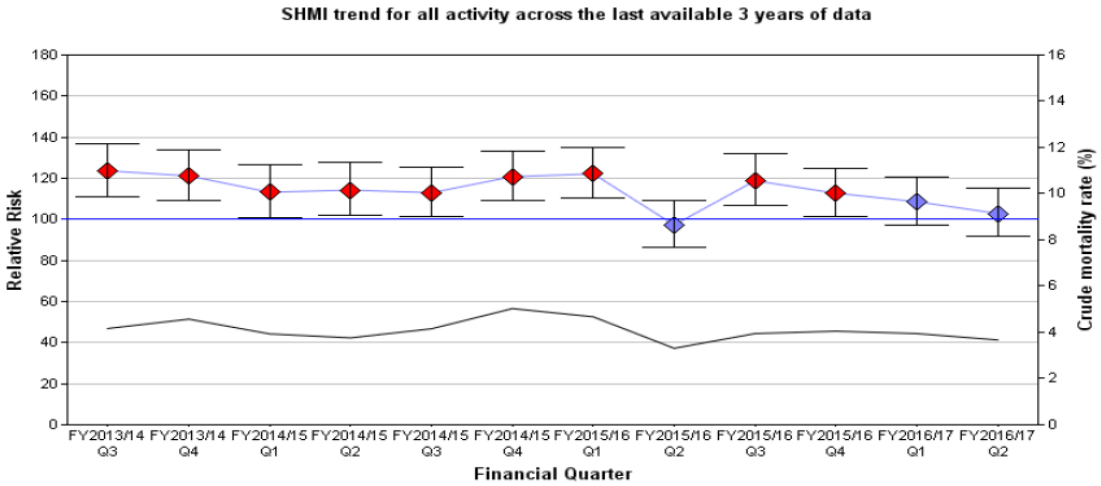
**HSMR – *Mortality Rate All Diagnosis***

| | Apr 16 – Mar 17 | May 16 – Apr 16 | Jun 16 – May 16 | Jul 16 – Jun 16 | Aug 16 - Jul 16 | Sep 16 – Aug 16 | Oct 16 – Sep 16 | Nov 16 – Oct 17 |
|---|---|---|---|---|---|---|---|---|
| **HSMR** | 93.60 | 95.90 | 94.10 | 94.20 | 91.70 | 88.50 | 88.50 | 89.20 |






**SHMI trend for all activity across the last available 3 years of data**




The Trust continues to take the following actions to improve these indicators, and ensure our mortality rates reduce further and are not higher than expected:

We continue to

- Maintain an Executive clinically led mortality steering group to review intelligence available.
- Ensure that we report on our learning from deaths
- Routinely monitor and investigate and understand the areas that alert on the mortality indices.
- Analyse and understand our data and develop the capability of the clinical divisions to review and analyse the mortality data at specialty level in the clinical divisions
- Commission specific reviews/audits of areas of concern when required.
- Develop more care pathways and care bundles to improve standardisation and reliability of care delivery.

Tameside and Glossop Integrated Care NHS Foundation Trust considers that this data is as described because the because of the improvement programme put in place and the implementation of care pathways being implemented.

Tameside and Glossop Integrated Care NHS Foundation Trust is taking the following action to further improve this indicator and so the quality of its services by implementation of the Trust wide improvement programme agreed with key stakeholders and progress monitored by the Trust board, and in addition a work programme including:

The Palliative Care Coding rate compared to the national rate is displayed in the table below.

| Indicator | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|---|
| Tameside Palliative Care coding rate | 4.8% | 3.3% | 3.76% | 3.28% | 3.55% | 3.63% |
| National Palliative Care coding rate | 2.6% | 3.3% | 3.57% | 3.79% | 4.03% | 4.04% |

The percentage of patient deaths with palliative care coded are:-

| | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|---|
| Tameside | 18.7 | 12.3 | 14.5 | 17.3 | 17.9 | 15.9 |
| Highest Nationally | 97.6 | 94.1 | 92.3 | 95 | 96.1 | 93.3 |
| Lowest nationally | 1.7 | 2.4 | 6.4 | 8 | 6.3 | 3.9 |
| National average | 17.6 | 20.7 | 23.3 | 26.2 | 28.6 | 29.7 |

The Table below demonstrates the current SHMI

| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|
| Tameside | 118 | 112 | 118 | 114 | 110 | 108 |
| Best Nationally | 71 | 63 | 60 | 65 | 69 | 73 |
| Worst nationally | 125 | 116 | 120 | 118 | 116 | 125 |

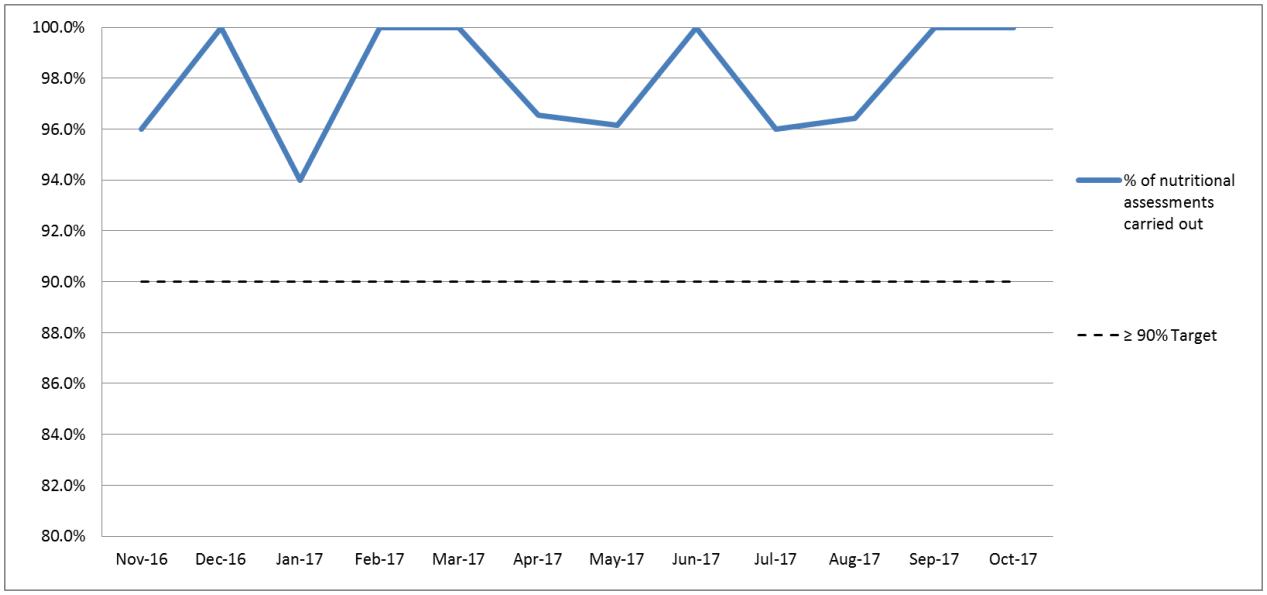
**Improved nutritional care and hydration.**

| | |
|---|---|
| NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. |  |

We pledged to provide improved care in relation to nutrition and hydration

The Trust routinely undertakes a nutritional risk assessment for inpatients and this is reported to the Trust board. We have achieved and exceeded the standard set throughout the year.

**Nutritional Risk Assessments**



**Other Important Patient Safety and Effectiveness Indicators**

| | |
|---|---|
| *NHS Outcome framework 3: Helping people to recover from episodes of ill health or following injury* | **See individual indicators below** |

| Patient Safety Indicator | 2015/16 Performance | 2016/17 Performance | 2017/18 Performance |
|---|---|---|---|
| Failure of the safer-surgery process | 0 | 0 | 0 |
| StEIS Serious Incidents reported | 27 | 38 | 87 |
| Duty of Candour breeches | 0 | 0 | 0 |
| Never events reported | 1 | 0 | 2 |
| Coroners Section 28 letters | 7 | 2 | 5 |

The Trust is aware of why the number of StEIS reported incident has increased. In April 2017 we changed the threshold for reporting of StEIS incidents following dialogue with the commissioners to better align local practice with other Trust as we were seen as an outlier in reporting incident on StEIS. The increased reporting of these cases does not indicate a higher level of harm but that we are making Commissioners and regulators aware of these incidents through the StEIS reporting system. The two reported Never Events related to low harm incident in theatre and have been reported through StEIS. These have been subject to Investigation and Root Cause Analysis to understand why these occurred and prevent recurrence. The learning form these is being implemented.

We have received 5 Coroners regulation 28 letters (PFD). These have all been responded to in detail with either the required additional information by the Coroner which was not heard or provided through Coronial process or our learning and evidence of the action taken by the Trust in response to these. We will continue to build and strengthen our relationship with the Coroner to ensure the process better assists and informs families through this process at a difficult time.

# Trust Corporate Objectives 2018/19

**Objective 1**

To ensure our patients and users receive harm-free care by improving the quality and safety of our services though the delivery of our Quality and Safety programme.

**Objective 2**

To improve our patient and service user experience through the delivery of a personalised, responsive, caring and compassionate approach to the delivery of care.

**Objective 3**

To continue to recruit and retain talented individuals and how to develop our staff and future workforce to support the integration and transformation of our services.

**Objective 4**

To develop and support our five primary care neighbourhood hubs and key partners to enable them to deliver new integrated service models in order to improve user patient outcomes through supporting people:

- to prevent ill-health and live healthy, independent lives where possible;
- to manage any on-going health conditions more effectively in their own homes and communities;
- to facilitate easy access to joined-up services in the most appropriate location.

**Objective 5**

To deliver against the required national regulatory frameworks and agreed local standards, in terms of quality, access and financial performance.

**Objective 6**

To access available technologies and research to improve the outcome for our patients population.

# Annex 1 - Comments from Other Agencies on the 2017/18 Quality Account

## Statement from Tameside and Glossop CCG

Tameside & Glossop Strategic Commission welcome the opportunity to comment on the quality of services provided by Tameside & Glossop Integrated Care Foundation Trust. We welcome the progress the Trust has made in moving towards a more integrated health and care organisation. The commissioners are particularly pleased with the development of integrated neighbourhood provision, which is starting to bring care closer to people, working alongside primary care colleagues to improve outcomes for our population. During this year, the Trust has started to broaden its community scope by contracting for asset base approach services, early intervention in mental health and care navigators to support early intervention and prevention, helping people to self-care.

Over the past year, we have built upon the closer working relationships between commissioners and The Trust to support the delivery of good quality, safe services for our population. Commissioners are pleased to see the ambition from the organisation to become a CQC outstanding provider and will support the Trust in achieving this ambition. The Strategic commission acknowledge the continued improvement journey and the quality improvements that are outlined in this account are commendable.

Tameside & Glossop Strategic Commission have continued to work closely with The Trust to monitor the quality of services provided via contract meetings and monthly meetings focussed on quality and safety. The Strategic Commissions Director of Quality & Safeguarding continues to be invited as a regular participant to the Trusts internal quality and governance forum and participated in a quality visit to the flexible community bed base. The Strategic Commission would like to acknowledge the continued level of transparency and openness demonstrated by the Trust.

**Patient safety**

Within the quality account, the Trust outlines how they continue to work towards improvements in patient safety by the continuation of the Sign up to Safety Campaign. They demonstrate this commitment to safety by the development of a further 30 AQUA Patient Safety Champions across the organisation. The Strategic Commission acknowledges the considerable improvement work the Trust has built upon from the previous year in continuing to drive improvements in pressure ulcer prevention across the health and social care economy. Managing the deteriorating patient, reducing falls and increasing VTE and nutritional assessments. We also commend the continued work on medicines management, antibiotic stewardship and infection prevention that the Trust are now leading for the health and social care economy.

The Strategic Commission would like to specifically acknowledge the continued work the Trust has implemented in learning from mortality and the continued implementation of mortality reviews for people with a learning disability. We also commend the Trusts commitment to safe staffing and care contact time by having a continual focus on recruitment and retention.

**Patient experience**

The Strategic Commission acknowledge that the Trust continues to see significant improvement in patient's experience of services. This can be seen in both response rates for the Friends and Family Test and recommended score particularly in in patient and maternity setting. Where there are areas for improvement such as Accident and Emergency services, there is an improvement plans in place which the Strategic Commission will monitor via the quality, performance and contract meetings.

Commissioners are pleased to see the continued commitment on responding to complaints and the focus on learning from complaints across the organisation.

**Staffing and Culture**

The Trust have again received positive results from the annual staff survey. The results demonstrate that staff feel well trained and able to provide quality care. Where there are areas for improvement such as bullying and harassment and discrimination, in response the Trust has commissioned Conflict Resolution De-escalation training and specific work with its BME staff. The Commissioners will work with the trust in order to drive improvements in staff experience.

**Patient Outcomes**

The Trust has continued to participate in both national and local clinical audits; learning from these audits is implemented in practice and shared with the Strategic Commission.

The Trust continues to participate in the Patient Reported Outcome monitoring measures. The information provided demonstrates that in the main patients are reporting benefits from the outcomes of reviewed procedures carried out in the Trust,

**Areas for improvement 2017/18**

Tameside & Glossop Strategic Commission will continue to work with the Trust to support them in maintaining their overall CQC rating as good and their ambition to become a CQC outstanding organisation.

The Strategic Commission would like to see the Trust continue to deliver good quality, safe care to patients with a focus of delivery in neighbourhoods.

The Strategic Commission would like to see continued improvements in Urgent care performance, length of stay and delayed transfer of care. We acknowledge that they remain a challenge and the Trust have implemented initiatives such as discharge to assess, flexible community bed base and ticket home to assist with flow through the organisation. The Strategic Commission will continue to support these and further initiatives as a system.

The Strategic Commission would like to see further progress on the integration and transformation of community and social care services. Building upon the progress made this year.

The Strategic Commission would like to see greater focus on a patient journey view of quality and safety reflected in quality reporting going forward.

The strategic commission will support the trust in monitoring quality and safety of their commissioned services.

In conclusion the Single Commission are confident the Trust has demonstrated their commitment to quality, experience and safety in their continual improvement journey. We thank The Trust for the honest and open culture fostered within the organisation and their continued focus on putting patients first. We look forward to seeing the further transformation of The Trust on its integration journey and the continued commitment to system quality improvement.

**Steven Pleasant MBE**

**Chief Executive, TMBC and Accountable Officer, CCG**

**Statement from the Healthwatch**

Healthwatch Tameside value our strong partnership work with TGICFT and our ability to input into service improvements. We have strong relationships for this work from the CEO through to an operational level.

The continued openness to our Healthwatch Champions talking to people in any of the outpatients waiting rooms is particularly positive.

Summaries of all the stories and information collected by Healthwatch Tameside about a service or care provided by the TGICFT are shared on a regular basis. This information is then triangulated with Friends and Family and PALS comments received which is a valuable way to process public and patient feedback. This could be further improved by ensuring that Healthwatch Tameside hear feedback about whether any changes have been made as a result of this information. Posts on Care Opinion are responded to well which is excellent, but again where changes are made, this is not usually recorded online.

Regarding our work related to complaints handling we have recently given some detailed feedback on areas for improvement which has been responded to promptly including looking at how to more directly answer the questions raised by patients.

Our staff have attended the Patient Experience Group at the hospital and the staff who attend are committed to improving care and the services provided. There are new initiatives being discussed regularly which is encouraging. It continues to be vital to gather evidence of the difference this work makes which we can feedback to our members and the public.

In conclusion we are very positive about our work with TGICFT and feel that a continued focus on the feedback to Healthwatch Tameside, patients and the public about improvements to services, especially those improvements linked to patient and public engagement, would further strengthen this work.

**Ben Gilchrist**

**Healthwatch Tameside Chief Executive**

## Statement from the Council of Governors

The Governors once again want to acknowledge the significant improvements and changes made in the Trust during the last year.

We also want to acknowledge the hard work, dedication and effort put in by all staff at the Trust.

The continued development with regard to the organisation is very pleasing.

Governors are satisfied to see evidence of the continued focus across many and varied areas ;with ongoing transformation of services, developments in service improvement and transformation within what we now recognise as an Integrated Care Organisation. Across the many highlighted in the Quality Report, we would note –

The home first focus

The neighbourhood development programme.

Community work to prevent people having to attend hospital.

Early signs of progress on digital health.

Development and progress in how intermediate care is to be offered.

The Quality Account continues to recognise that the improvement process is a continuous process, with further work and objectives to improve the health and wellbeing of the community. We remain confident that under the current leadership these will continue to be achieved.

The Council of Governors continue to receive regular updates from the Board on issues related to quality, both at formal meetings and through informal settings.

Designated colleagues also attend the meetings of the Quality and Governance Committee, giving Governors visibility of the more detailed discussions.

Having reviewed the draft, on behalf of Governors I am happy that the Quality Account provides representative and comprehensive coverage of services outlining the improvements during the year; and provides a balanced account of the activities the Trust has undertaken in this area during 2017/18.

**John Phillips**

**Lead Governor**
**Tameside and Glossop**
**Integrated Care NHS Foundation Trust.**

**Statement from TMBC Health and Well being**

Not received at the time of publication. We requested this feedback from TMBC Health and Wellbeing committee on 19th April 2018, which provided the time required for a response to be provided.

# Annex 2 – Statement of Directors Responsibilities on the 2017/18 Quality Account

## 2017/18 Statement of Directors' responsibilities in respect of 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.

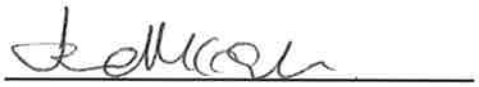
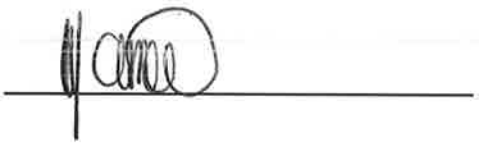
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- 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 March 2018
- papers relating to Quality reported to the board over the period April 2017 to March 2018
- feedback from commissioners dated 10th May 2018
- feedback from governors dated 15th May 2018
- feedback from local Healthwatch organisations dated 11th May 2018
- feedback from Overview and Scrutiny Committee requested on 19th April 2018
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 3rd May 2018
- the 2016 national patient survey 31st May 2017
- the 2017 national staff survey 6th March 2018
- the Head of Internal Audit's annual opinion over the trust's control environment dated 23rd April 2018
- CQC inspection report dated 7th February 2017
- 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 Improvements annual reporting manual (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 have complied with the above requirements in preparing the Quality Report.

By order of the Board

| | Signature | Date |
|---|---|---|
| **Chair** |  | **23rd May 2018** |
| **Chief Executive** |  | **23rd May 2018** |

## INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Tameside and Glossop Integrated Care NHS Foundation Trust to perform an independent assurance engagement in respect of Tameside and Glossop Integrated Care NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

**Scope and subject matter**

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge.

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

**Respective responsibilities of the directors and auditors**

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by 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 *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2017/18* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18.*

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes and papers for the period April 2017 to March 2018;
- papers relating to quality reported to the board over the period April 2017 to March 2018;
- feedback from commissioners, dated 10 May 2018;
- feedback from governors, dated 15 May 2018;
- feedback from local Healthwatch organisations, dated 11 May 2018;
- feedback from Overview and Scrutiny Committee, requested on 19 April 2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 3 May 2018;

- the 2016 national patient survey, dated 31 May 2017;
- the 2017 national staff survey, dated 6 March 2018;
- Care Quality Commission Inspection, dated 7 February 2017;
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated 23 April 2018; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Tameside and Glossop Integrated Care NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Tameside and Glossop Integrated Care NHS Foundation 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 indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; 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 which 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 *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Tameside and Glossop Integrated Care NHS Foundation Trust.

**Conclusion**

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE

24 May 2018

KPMG

# Independent auditor's report

## to the Council of Governors of Tameside and Glossop Integrated Care NHS Foundation Trust

### REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

#### 1. Our opinion is unmodified

We have audited the financial statements of Tameside and Glossop Integrated Care NHS Foundation Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health Group Accounting Manual 2017/18.

Material uncertainty related to going concern

We draw attention to note 1 to the financial statements which indicates that the Trust had a total net liability of £2.5m as at 31 March 2018. The Trust expects this net liability to increase to £28.3m by 31 March 2019, reflecting the planned deficit for 2018/19. In order to meet the Trust's liabilities within the year, the Directors are expecting to draw down a further £25.8m of cash support from the Department of Health and Social Care.

This would bring the Trust's total loan liability to £101.2m. These events and conditions, along with the other matters explained in note 1, constitute a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

| Overview | |
|---|---|
| **Materiality:** financial statements as a whole | £4.0m (2016/17: £3.25m)<br>1.88% (2016/17: 1.53%) of total revenue |

| Risks of material misstatement | | vs 201X |
|---|---|---|
| **Recurring risks** | Estimation of NHS income and receivables | ◄► |
| | Valuation of land and buildings | ◄► |

## 2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows (unchanged from 2016/17):

| | The risk | Our response |
|---|---|---|
| **Estimation of NHS income and receivables**<br><br>Income from patient care activities (£198.3 million; 2016/17: £188.2 million)<br><br>*Refer to Audit Committee Report, note 1.2 (accounting policies) and note 3.1 (financial disclosures)* | **Subjective estimate**<br><br>The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners. There is a significant risk of material misstatement in respect of this income recognition, since this includes a number of significant estimates.<br><br>The Trust participates in the national Agreement of Balances (AoB) exercise for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department of Health's resource accounts. The AoB exercise identifies mismatches between income and expenditure and receivable and payable balances recognised by the Trust and its commissioners, which will be resolved after the date of approval of these financial statements.<br><br>Mis-matches can occur for a number of reasons, but the most significant arise were:<br><br>— the Trust and Commissioners record different accruals for completed periods of healthcare which have not yet been invoiced; or<br>— income relating to partially completed period of healthcare is apportioned across the financial years and the Commissioners and the Trust make different apportionment assumptions.<br><br>Where there is a lack of agreement, mis-matches can also be classified as formal disputes as set out in the relevant contract. | Our procedures included:<br><br>— **Tests of details:** We compared the actual income for the Trust's most significant commissioners against the block contracts agreed at the start of the year and checked the validity of any significant variations between the actual income and the contract via agreement to appropriate third party confirmations; and<br><br>— **Tests of details:** We inspected confirmations of balances provided by the Department of Health as part of the AoB exercise and compared the relevant income and receivables recorded in the Trust's financial statements to the expenditure and payable balances recorded within the accounts of commissioners. Where applicable, we investigated and reviewed correspondence to assess the reasonableness of the Trust's approach to recognising income from commissioners. |

## 2. Key audit matters: our assessment of risks of material misstatement (continued)

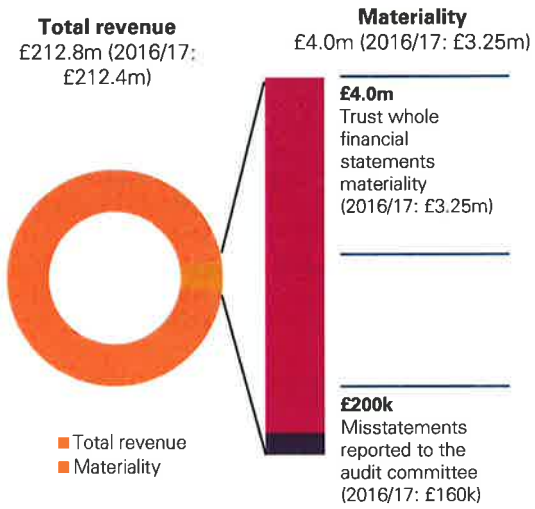
| | The risk | Our response |
|---|---|---|
| **Valuation of land and buildings**<br><br>(£127.7 million; 2016/17: £113.6 million)<br><br>*Refer to Audit Committee Report, note 1.5 (accounting policies) and page 12 (financial disclosures)* | **Subjective valuation**<br><br>Land and buildings are initially recognised at cost. Non-specialised property assets in operational use are subsequently recognised at current value in existing use (EUV). Specialised assets (such as hospitals) where a market value is not readily ascertainable, are subsequently recognised at the depreciated replacement cost of a modern equivalent asset that has the same service potential as the existing property (DRC). A review is carried out each year to test assets for potential impairment or revaluation.<br><br>There is significant judgment involved in determining the appropriate basis (EUV or DRC) for each asset according to the degree of specialization, as well as over the assumptions made in arriving at the valuation.<br><br>In 2017/18, the Trust commissioned a desktop valuation from an external valuer as at 31 March 2018. As a result, the value of land and building assets was increased by £14.1 million. Given the materiality and the judgement involved in determining the carrying amounts of land and buildings, this has been identified as a key audit risk. | Our procedures included:<br><br>— **Assessing valuer's credentials:** We assessed the competence, capability, objectivity and independence of the Trust's external valuer and considered the terms of engagement of, and the instructions issued to, the valuer to confirm consistency with the requirements of Department of Health Group Accounting Manual 2017/18.<br><br>— **Methodology choice:** We tested the completeness of the estate covered by the valuation to the Trust's underlying records of the estate held, including additions to land and buildings during the year.<br><br>— **Tests of details:** We critically assessed the Trust's formal consideration of indications of impairment within its estate, including the process undertaken and the adequacy of the judgements made by management in determining whether assets are impaired or surplus to requirements.<br><br>— **Tests of details:** We agreed movements in asset valuation per the Trust's Fixed Asset Register to the reports provided by the valuer; and<br><br>— **Tests of details:** We undertook work to understand the basis upon which movements in the valuation of land and buildings as per the Fixed Asset Register have been identified and treated in the financial statements and determined whether they have complied with the requirements of the Department of Health Group Accounting Manual 2017/18. |

## 3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £4.0 million (2016/17: £3.25 million), determined with reference to a benchmark of total revenue, of which it represents approximately 1.88% (2016/17: 1.53%). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £200k (2016/17: £160k), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was all performed at the Trust's headquarters in Tameside.




## 4. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

### Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

### Corporate governance disclosures

We are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or
- the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

## 5. Respective responsibilities

### Accounting Officer's responsibilities

As explained more fully in the statement set out on page 63, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; 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 they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity

### Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

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## REPORT ON OTHER LEGAL AND REGULATORY MATTERS

### We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

### Our conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources is qualified

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

#### Qualified conclusion

Subject to the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects Tameside and Glossop Integrated Care NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

#### Basis for qualified conclusion

The Trust's outturn position for 2017/18 was a deficit of £23.7 million. During the year, the Trust received £20.6 million of cash support from the Department of Health and Social Care (DHSC).

The Trust's financial plans for 2018/19 show a forecast deficit of £25.7 million. This also includes an assumption of further DHSC cash support of £25.8m in the second half of the financial year. Without this cash support, the Trust would not be able to continue to operate. At present, there are no viable means for the Trust to repay its existing DHSC support loans, or any new ones which are received during 2018/19.

Whilst the Trust and its local health economy partners have identified efficiency schemes that will support the achievement of the Trust's short-term financial plans, its long-term plans are not yet sufficiently progressed to achieve a break-even position in the foreseeable future or an ability to repay the loans from the DHSC.

These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of the Trust's strategic priorities.

#### Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

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

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources .

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 the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether 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. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

#### Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out overleaf, together with the findings from the work we carried out on each area.

| Significant Risk | Description | Work carried out and judgements |
|---|---|---|
| **Working with partners and third parties** | **The Care Together Programme**<br><br>The Care Together Programme incorporates the Trust, Tameside Metropolitan Borough Council and Tameside and Glossop Clinical Commissioning Group.<br><br>This Programme has been formed to deliver integrated health and social care services across Tameside and Glossop. During 2017/18, the economy was forecasting a deficit of £11m at the year-end.<br><br>Effective working arrangements with key partners in the local health economy is integral to the Trust achieving economy, efficiency and effectiveness in its use of resources. | Our work included:<br><br>— Assessing the governance arrangements in place, within the Trust, to deliver this programme;<br><br>— Evaluating the influence of the Trust on the programme; and<br><br>— Reviewing the arrangements the Trust has in place to achieve the aims of the programme, including resources to deliver and prioritisation of the key aims.<br><br>**Our findings on this risk area:**<br><br>We concluded that the governance arrangements in respect of the Tameside and Glossop Care Together programme were adequate. The Trust has a leading role in Care Together and has appropriate influence over, and engagement with, the programme. During 2017/18, the Trust put in place adequate arrangements to achieve the aims of the Care Together Programme. Overall, we did not identified any findings in respect of this risk which would indicate that a qualification to our VFM conclusion was appropriate. |
| **Sustainable resource deployment** | **Financial sustainability (including delivery of the Trust Efficiency Programme and management of the Trust's cash position)**<br><br>The Trust did not agree a control total with NHSI this year and consequently forecasted a deficit of £24.5m for 2017/18, with longer term forecasts identifying continued deficits and a requirement for additional loan financing from NHSI.<br><br>There is therefore a risk that the Trust is not currently able to articulate and deliver a financially sustainable long-term strategy. | Our work included reviewing the Trust's arrangements for:<br><br>— Managing working capital, including the processes for forecasting and monitoring cash flows and delivering cash savings;<br><br>— Forecasting the level of cash and loan support required by the Trust from NHSI and access to this funding;<br><br>— Delivering recurrent cost improvements, including identifying savings plans, monitoring in-year performance and addressing any slippage;<br><br>— Identifying a long term financially sustainable plan for the Trust; and<br><br>— Monitoring the day-to-day spend against budget.<br><br>**Our findings on this risk area:**<br><br>We were satisfied that the Trust has appropriate arrangements in place to:<br><br>— Manage working capital, including forecasting cash flow requirements on a rolling 13 week basis;<br><br>— Monitor cash flow against forecasts to identify any unexpected variances;<br><br>— Forecast and communicate the level of required cash flow, such that DHSC cash can be accessed in a way that enables the Trust to continue to meet its obligations as they fall due; and<br><br>— Produce accurate and complete monthly Finance reports for Trust Board and the Finance Committee;<br><br>However, the Trust's current 2018/19 financial plans show a forecast deficit of £25.7 million. This includes the assumption of further DHSC cash support of £25.8m in the second half of the financial year. Without this cash support, the Trust would not be able to continue to operate. At present, there are no viable means for the Trust to repay its existing DHSC support loans, or any new ones which are received during 2018/19.<br><br>Whilst the Trust and its local health economy partners have identified efficiency schemes that will support the achievement of the Trust's short-term financial plans, its long-term plans are not yet sufficiently progressed to achieve a break-even position in the foreseeable future or an ability to repay the loans from the DHSC.<br><br>These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of the Trust's strategic priorities. |

## THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

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

## CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Tameside and Glossop Integrated Care NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Amanda Latham

**Amanda Latham**
**for and on behalf of KPMG LLP (Statutory Auditor)**

*Chartered Accountants*
1 St Peter's Square
Manchester
M2 3AE

24 May 2018

KPMG

**Foreword to the accounts**

These accounts, for the year ended 31 March 2018, have been prepared by Tameside and Glossop Integrated Care NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

| | |
|---|---|
| **Signed** |  |
| **Name** | **Karen James** |
| **Position** | **Chief Executive** |
| **Date** | **23-May-18** |

# Statement of Comprehensive Income

| | Note | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|---|
| Operating income from patient care activities | 3.1 | 198,304 | 188,196 |
| Other operating income | 3.4 | 14,454 | 24,227 |
| **Total operating income from continuing operations** | | **212,758** | **212,423** |
| Operating expenses | 4 | (230,912) | (222,494) |
| **Operating surplus/(deficit) from continuing operations** | | **(18,154)** | **(10,071)** |
| Finance income | 9 | 28 | 22 |
| Finance expenses | 10 | (4,315) | (3,926) |
| Finance expenses - unwinding of discount | 19 | (2) | (7) |
| PDC dividends payable | | (1) | 0 |
| **Net finance costs** | | **(4,290)** | **(3,911)** |
| Gains/(losses) of disposal of assets | | 0 | (11) |
| **Surplus/(deficit) for the year** | | **(22,444)** | **(13,993)** |
| **Other comprehensive income** | | | |
| **Will not be reclassified to income and expenditure:** | | | |
| Impairments | 12 | (138) | (4,904) |
| Revaluations | 12 | 14,407 | 11,944 |
| Other recognised gains and losses | | 0 | 0 |
| Other reserve movements | | 0 | 0 |
| **May be reclassified to income and expenditure when certain conditions are met:** | | | |
| Fair value gains/(losses) on available-for-sale financial investments | | 0 | 0 |
| Recycling gains/(losses) on available-for-sale financial investments | | 0 | 0 |
| **Total comprehensive income/(expense) for the period** | | **(8,175)** | **(6,953)** |

| ***Financial Performance for the year - Memorandum only, does not form part of the accounts** | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **(Deficit)/Surplus for the year*** | **(22,444)** | (13,993) |
| Net impairments | **(50)** | 561 |
| Loss on asset disposals | **0** | 11 |
| Donations received for PPE & intangible assets, total | **(1,488)** | (67) |
| Depreciation - Donated assets | **256** | 167 |
| **Operating Deficit for the year** | **(23,726)** | **(13,321)** |

## Statement of Financial Position

| | Note | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|---|
| Intangible assets | 11 | 413 | 0 |
| Property, plant and equipment | 12 | 135,212 | 120,401 |
| Trade and other receivables | 14 | 5,735 | 5,014 |
| **Total non-current assets** | | **141,360** | **125,415** |
| **Current assets** | | | |
| Inventories | 13 | 1,671 | 1,430 |
| Trade and other receivables | 14 | 7,047 | 13,356 |
| Cash and cash equivalents | 15 | 1,415 | 2,945 |
| **Total current assets** | | **10,133** | **17,731** |
| **Current liabilities** | | | |
| Trade and other payables | 16 | (22,514) | (24,666) |
| Other liabilities | 17 | (1,584) | (2,342) |
| Borrowings | 18 | (21,692) | (1,337) |
| Provisions | 19 | (151) | (151) |
| **Total current liabilities** | | **(45,941)** | **(28,496)** |
| **Total assets less current liabilities** | | **105,552** | **114,650** |
| **Non-current liabilities** | | | |
| Other liabilities | 17 | 0 | 0 |
| Borrowings | 18 | (107,302) | (108,394) |
| Provisions | 19 | (701) | (693) |
| **Total non-current liabilities** | | **(108,003)** | **(109,087)** |
| **Total assets employed** | | **(2,451)** | **5,563** |
| **Financed by** | | | |
| Public dividend capital | SoCIE | 53,446 | 53,285 |
| Revaluation reserve | SoCIE | 48,011 | 35,291 |
| Income and expenditure reserve | SoCIE | (103,908) | (83,013) |
| **Total taxpayers' equity** | | **(2,451)** | **5,563** |

The notes on pages 5 to 34 form part of these accounts.

Signed 

Name **Karen James**

Position **Chief Executive**

Date **23 May 2018**

## Statement of Changes in Equity for the year ended 31 March 2018

| | Public Dividend Capital | Revaluation reserve | Income and Expenditure reserve | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Taxpayers' and others' equity at 1 April 2017 - brought forward** | **53,285** | **35,291** | **(83,013)** | **5,563** |
| Surplus/(deficit) for the year | **0** | **0** | (22,444) | **(22,444)** |
| Public dividend capital received | **161** | **0** | **0** | **161** |
| Impairments | **0** | **(138)** | **0** | **(138)** |
| Revaluations | **0** | **14,407** | **0** | **14,407** |
| Other reserve movements | **0** | **(1,549)** | **1,549** | **0** |
| **Taxpayers' and others' equity at 31 March 2018** | **53,446** | **48,011** | **(103,908)** | **(2,451)** |

| **Statement of Changes in Equity for the year ended 31 March 2017** | Public Dividend Capital | Revaluation reserve | Income and Expenditure reserve | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Taxpayers' and others' equity at 1 April 2016 - brought forward** | **53,285** | **29,301** | **(70,070)** | **12,516** |
| Prior period adjustment | 0 | 0 | 0 | **0** |
| **Taxpayers' and others' equity at 1 April 2016 - restated** | **53,285** | **29,301** | **(70,070)** | **12,516** |
| Surplus/(deficit) for the year | 0 | 0 | (13,993) | **(13,993)** |
| Revaluations | 0 | 0 | 0 | **0** |
| Net impairments | 0 | (4,904) | 0 | **(4,904)** |
| Revaluations - property, plant and equipment | 0 | 11,944 | 0 | **11,944** |
| Other reserve movements | 0 | (1,050) | 1,050 | **0** |
| **Taxpayers' and others' equity at 31 March 2017** | **53,285** | **35,291** | **(83,013)** | **5,563** |

# Statement of Cash Flows

| | Note | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| Operating surplus/(deficit) | SOCI | (18,154) | (10,071) |
| **Non-cash income and expense:** | | | |
| Depreciation and amortisation | 4 | 5,411 | 4,766 |
| Impairments and reversals of impairments | 4 | (50) | 561 |
| (Gain)/loss on disposal of non-current assets | | 0 | 0 |
| Income recognised in respect of capital donations | 3.4 | (1,488) | (67) |
| (Increase)/decrease in receivables and other assets | 14 | 5,588 | (9,226) |
| (Increase)/decrease in inventories | 13 | (241) | 274 |
| Increase/(decrease) in payables and other liabilities | 16 | (2,165) | 3,675 |
| Increase/(decrease) in other liabilities | 17 | (758) | (98) |
| Increase/(decrease) in provisions | 19 | 6 | (50) |
| **Net cash generated from/(used in) operating activities** | | **(11,851)** | **(10,236)** |
| **Cash flows from investing activities** | | | |
| Interest received | 9 | 28 | 22 |
| Purchase of intangible assets | 11 | (413) | 0 |
| Purchase of property, plant, equipment and investment property | 12 | (6,044) | (2,764) |
| Receipt of cash donations to purchase capital assets | | 1,488 | 0 |
| Sales of property, plant, equipment and investment property | | 0 | 0 |
| **Net cash generated from/(used in) investing activities** | | **(4,941)** | **(2,742)** |
| **Cash flows from financing activities** | | | |
| Public dividend capital received | | 161 | 0 |
| Public dividend capital repaid | | 0 | 0 |
| Movement on loans from the Department of Health | | 20,600 | 19,850 |
| Capital element of PFI, LIFT and other service concession payments | | (1,337) | (1,282) |
| Interest paid on PFI, LIFT and other service concession obligations | | (3,243) | (3,155) |
| Interest paid on Loans from Department of Health | | (907) | (770) |
| PDC dividend (paid)/received | | (1) | 65 |
| Cash flows from (used in) other financing activities | | (11) | 0 |
| | | **15,262** | **14,708** |
| **Increase/(decrease) in cash and cash equivalents** | | **(1,530)** | **1,730** |
| **Cash and cash equivalents at 1 April** | | **2,945** | **1,215** |
| **Cash and cash equivalents at start of period for new FTs** | | **0** | **0** |
| Cash and cash equivalents transferred under absorption accounting | | 0 | 0 |
| **Cash and cash equivalents at 31 March** | 15 | **1,415** | **2,945** |

**Notes to the Accounts**

**Note 1 Accounting policies and other information**
**Basis of preparation**

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.

**Going concern**

IAS 1 requires management to assess, as part of the accounts preparation process, the NHS Foundation Trust's ability to continue as a going concern. The financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS Foundation Trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

Having given careful consideration to all information in their possession, the Directors have concluded that there is a reasonable expectation that Tameside and Glossop Integrated Care NHS Foundation Trust has adequate resources to continue in operational existence.

The Directors are aware there is material uncertainty related to events or conditions that may cast significant doubt on the entity's ability to continue as a going concern and that it may therefore be unable to realise its assets and discharge its liabilities in the normal course of business;

The Trust is planning for an income and expenditure deficit of £25.8m in 2018/19. As at the 31st March 2018, the Trust had net liabilities of £2.5m and anticipates this will increase to £28.3m net liabilities by the 31st March 2019, reflecting the planned deficit for 2018/19. In order to deliver the agreed financial plan, the Trust will have to achieve efficiency savings of at least £12.8m within the year.

In order to meet the Trust's liabilities within the year, the Directors anticipate seeking a further £25.8m from the Department of Health (DH) in loan support. This would bring the total Trust loan liability to £101.2m. The Directors have cause to believe that DH will provide the required loans as NHS Improvement have indicated that they will approve a final financial plan for the year predicated on those loans becoming available, The Directors have also had regard to the guidance issued by the Secretary of State under Section 42A of the National Health Service Act 2006, regarding his policy on granting loan support to NHS provider organisations.

If loan support is not provided, the Trust would not be able to meet its debts as they fell due. The Trust would need to enter discussions with Commissioners and regulators regarding the future of provision, particularly Commissioner-Requested Services under Condition CoS 7 of the Trust's Provider Licence,

The financial statements are prepared on a going concern basis which the directors believe to be appropriate for the following reasons.

- The level and basis of expected income for 2018/19, supported by fully signed off contracts and agreed activity levels,
- Contractual agreement with its main commissioner (Tameside & Glossop Clinical Commissioning Group) to the Trust's overall service strategy, including full agreement of future commissioning intentions;
- Robust assessment of the impact of the block contract agreed with the main commissioner, specifically for 2018/19 but looking to the medium-term,
- Robust assessment of the impact of Payment by Results tariffs for secondary commissioner contracts, specifically in 2018/19 but looking to the medium-term,
- Full identification of potential risks and opportunities incorporated into the financial plan for 2018/19, including the potential impact of planned demand management initiatives.
- The announced intention of Her Majesty's Government to bring forward a long-term (covering 10 years) financial settlement for the NHS in the autumn of 2018;
- Prior Board agreement to apply to DH for loan funding as required during the course of the 2018-19 year, up to a total of £25.8 million.
- The capital expenditure programme for 2018/19, as agreed by the Board, has been risk assessed to reflect the requirements of the Trust to ensure delivery of Commissioner-Requested Services.

Based on these indications the directors believe that it remains appropriate to prepare the financial statements on a going concern basis. However, the matters referred to above represent a material uncertainty that may cast significant doubt on the Trust's future to continue as a going concern. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

**Note 1.1 Accounting convention**

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

**Note 1.2 Income**

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Where income is received for a specific activity which is to be delivered in future financial years, that income is deferred.

The NHS Foundation Trust receives income under the NHS Injury Cost Recovery Scheme (CRU), designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS Foundation Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit (CRU) 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.

**Revenue grants and other contributions to expenditure**

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

**Note 1.3 Expenditure on employee benefits**

**Note 1.3.1 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 annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

**Note 1.3.2 Pension costs**

*NHS Pension Scheme*

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. The schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

**Note 1.4 Expenditure on other goods and services**

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

**Note 1.5 Property, plant and equipment**

**Note 1.5.1 Recognition**
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

**Note 1.5.2 Valuation**
All land and buildings are stated at their revalued amount. Plant and equipment assets are stated at their depreciated replacement costs. Upon initial recognition, all tangible assets are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. The carrying values of property, plant and equipment are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

All land and buildings are revalued using professional valuations in accordance with IAS16 at least every five years. A three yearly desktop interim valuation is also carried out, as a minimum. The NHS Foundation Trust may also consider additional valuations due to significant changes in external environmental factors. In addition the Trust carries out an annual verification exercise that identifies whether the asset is still in existence and in use. Valuations are carried out by professionally qualified valuers, District Valuer Servcies, in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisals and Valuation Manual.

Valuations are normally carried out on the basis of depreciated replacement cost at the Modern Equivalent Asset (MEA) valuation for specialised operational property, this is in accordance with the requirements of RICS Appraisal and Valuation Manual. The Modern Equivalent Asset valuation is the cost of replacing an existing building at current cost, using modern building equipment, structures and technology. Non-Specialised operational property is valued at existing use. This is in line with Department of Health guidance. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.
During 2017/18, the NHS Foundation Trust had a desk top site valuation. The valuation resulted in the land and building increasing in value by £13.5m. The net impairment reversal after charging to the revaluation reserve resulted in a £0.05m income to the Statement of Comprehensive Expenditure.
Properties in the course of construction are valued at cost and are valued by professional valuers as part of the five and three-yearly valuation or, for new buildings, when they are brought into use.

**Note 1.5.3 Subsequent expenditure**
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset, when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

**Note 1.5.4 Depreciation**
Items of property, plant and equipment are depreciated over their remaining useful economic lives on a straight line basis. Freehold land is considered to have an infinite life and is not depreciated.
Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Assets in the course of construction are not depreciated until the asset is brought into operational use.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the District Valuer. Leaseholds are depreciated over the primary lease term.

Assets held under finance leases are depreciated over their estimated useful lives.

***Useful Economic lives of property, plant and equipment***

| | Min life Years | Max life Years |
|---|---|---|
| Land | 0 | |
| Buildings, excluding dwellings | 3 | 75 |
| Dwellings | 47 | |
| Plant & machinery | 0 | |
| Transport equipment | 0 | |
| Information technology | 0 | |
| Furniture & fittings | 0 | |

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

**Property, plant and equipment (continued)**

**Note 1.5.5 Revaluation gains and losses**

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

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

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

**Note 1.5.6 Impairments**

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

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

**Note 1.5.7 De-recognition**

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable i.e.:

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

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

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

**Note 1.6 Revenue government and other grants**

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

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

**Note 1.7 Private Initiative (PFI) transactions**

PFI transactions which meet the IFRIC 12 - Service Concessions Arrangements, definition of a service concession, as interpreted in HM Treasury's Financial Reporting Manual, are accounted for as 'on-Statement of Financial Position' by the NHS Foundation Trust. The underlying assets are recognised as Property, Plant and Equipment at their fair value as determined in the operators' model. An equivalent financial liability is recognised in accordance with IAS 17 - Leases.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme.

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

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

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

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operators' planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

**Note 1.8 Intangible assets**

**Note 1.8.1Recognition**

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

- it is probable that future economic benefit will flow to the NHS Foundation Trust;
- the cost of the asset can be measured reliably;
- the cost is at least £5,000; and
- the NHS Foundation Trust can measure reliably the expenses attributable to the asset during development.

**Note 1.8.2 Software**

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

**Note 1.8.3 Measurement**

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

**Note 1.8.4 Amortisation**

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

**Useful economic life of intangible assets**

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are

| | Min life Years | Max life Years |
|---|---|---|
| **Intangible assets - internally generated** | | |
| Information technology | | 0 |
| Development expenditure | | 0 |
| Other | | 0 |
| **Intangible assets - purchased** | | |
| Software | | 5 |
| Licences & trademarks | | 5 |
| Patents | | 0 |
| Other | | 0 |
| Goodwill | | 0 |

**Note 1.8.5 Valuation**

All Intangible Assets are stated at their valuation amount, which is reviewed by management on an annual basis.

**Note 1.9 Inventories**
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. Pharmacy stock is measured at a weighted average cost.

**Note 1.10 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 Tameside & Glossop Intergrated Care NHS Foundation Trusts cash management. Cash, bank and overdraft balances are recorded at current values.

**Note 1.11 Financial instruments and financial liabilities**

**Note 1.11.1 Recognition**
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.
All other financial assets and financial liabilities are recognised when the NHS Foundation Trust becomes a party to the contractual provisions of the instrument.

**Note 1.11.2 De-recognition**
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.
Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

**Note 1.11.3 Classification and measurement**
Financial assets are categorised as 'Fair Value through Income and Expenditure', 'Loans and receivables' or 'Available for Sale' financial assets.
Financial liabilities are classified as 'Fair value through Income and Expenditure' or as 'Other financial liabilities'.

**Note 1.11.4 Financial assets and financial liabilities at 'fair value through income and expenditure'**

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term.

**Note 1.12 Loans and receivables**
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.
The NHS Foundation Trust's loans and receivables comprise: Cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

**Note 1.13 Available-for-sale financial assets**
The NHS Foundation Trust recognises assets as Available for Sale when the NHS Foundation Trust has made a strategic decision to sell a Financial Asset.

**Note 1.14 Other financial liabilities**
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.
They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.
Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs.
Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

**Note 1.15 Determination of fair value**
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined by reference to quoted market prices, independent appraisals or discounted cash flow analysis.

**Note 1.16 Impairment of financial assets**
At the Statement of Financial Position date, the NHS Foundation Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.
For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

**Note 1.17 Leases**
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

**Note 1.17.1 Finance leases**
Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.
The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.
The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income.
The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

**Note 1.17.2 Operating leases**
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Operating lease incentives are added to the lease rentals and charged to operating expenses over the life of the lease.

**Note 1.17.3 Contingent rentals**
Contingent rentals are recognised as an expense in the period in which they are incurred.

**Note 1.17.4 Leases for land and buildings**
Where a lease is for land and buildings, the land and building components are separated. Leased land is treated as an operating lease. Leased buildings are assessed as to whether they are operating or finance leases.

**Note 1.17.5 The Trust as lessor**
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

**Note 1.18 Provisions**
The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

**Note 1.19 Clinical Negligence Costs**
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 19.1 but is not recognised in the NHS Foundation Trust's accounts.

**Note 1.20 Non-clinical risk pooling**

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

**Note 1.21 Contingencies**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the control of the NHS Foundation 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.

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets. Contingent liabilities are not recognised, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Contingent Liabilities are not recognised, but are disclosed in note 20, unless the probability of a transfer of economic benefits is remote.

**Note 1.22 Public dividend capital**

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

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

**Note 1.23 Value Added Tax**

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

**Note 1.24 Foreign exchange**

The functional and presentational currencies of the trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March

• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and

• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

**Note 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 NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

**Note 1.26 Losses and special payments**

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

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

**Note 1.27 Early adoption of standards, amendments and interpretations**

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

**Note 1.28 Critical accounting estimates and judgements**

**Note 1.28.1 Critical accounting judgments and key sources of estimation uncertainty**

In the application of the NHS Foundation 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.

**Note 1.28.2 Critical judgments and key sources of estimation uncertainty in applying accounting policies**

The following are the key estimations that management has made in the process of applying the Trust's accounting policies that have the most significant effect on the amounts recognised in the financial statements.

**Partially Completed Spells**

The calculation is to establish a value, and therefore recognise the value of "work in progress" in line with accounting standards. The calculation is based on the total number of inpatients as at 31st March 2018, taking into account our current average length of stay and average income per patient based on the current years tariff package calculating the income due for their care in the current financial year.

**Maternity Pathway**

Under the current national tariff system Antenatal Care is paid for by Commissioners at the time of booking, a single payment covers all aspects of the care, outpatient inpatient and community care up until the point the pregnancy ends. Given that this care is delivered over a number of months it is necessary to only recognise in the Trusts Accounts the actual value of income reflective of the care the patient has received up to 31st March 2018. The calculation is based on the number of patients booked per month and their expected delivery month in the following financial year.

**Bad Debt Provisions**

Within the bad debt provision is an amount for Compensation Recovery Unit and has this is under statute and not a contract a percentage of 22.94% is recommended by DHSC as a provision amount. All other provisions relate to invoices that have been raised and all avenues have been followed to try and collect this debt. The debt is mainly over 90 days old.

**Valuation of Land and Buildings**

See 1.5.2 -Valuations are carried out by professionally qualified valuers, District Valuers Services, in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisals and Valuation Manual and this includes external factors including

**Note 1.29 Standards, amendments and interpretations in issue but not yet effective or adopted**

The Treasury Financial Reporting Manual does not require the following Standards to be applied in 2017/18:

### 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 14 Regulatory Deferral Accounts

Not yet EU-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DH group bodies.

### 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.

### IFRS 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.

The application of the Standards as revised would not have a material impact on the accounts of the NHS Foundation Trust for 2017/18, were they applied in that year.

* Work has commenced to understand the impact of these new standards for future periods, and prepare for the changes to the accounts and disclosures that will result.

**Note 2 Operating Segments**

All activity for Tameside and Glossop Integrated Care NHS Foundation Trust is healthcare related. As the operating segments have similar characteristics there is no requirement to report segmentally.

Whilst the Foundation Trust has a divisional structure in place the services that are provided are essentially all the same (patient care) and the majority of risks faced by each division are fundamentally the same.

**Note 3 Operating income from patient care activities**

**Note 3.1 Income from patient care activities**

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| **Acute services** | **£000** | **£000** |
| Elective income | 23,601 | 23,398 |
| Non elective income | 59,531 | 52,816 |
| First outpatient income | 13,452 | 12,876 |
| Follow up outpatient income | 11,905 | 14,522 |
| A & E income | 10,917 | 9,619 |
| High cost drugs income from commissioners (excluding pass-through costs) | 5,224 | 5,556 |
| Other NHS clinical income | 42,988 | 37,058 |
| **All other services** | | |
| Community services | 28,194 | 30,844 |
| Private patient income | 9 | 14 |
| Overseas Visitors | 185 | 57 |
| NHS injury scheme (was RTA) | 879 | 834 |
| Prescription Inccome | 135 | 36 |
| Other clinical income | 1,284 | 566 |
| **Total income from activities** | **198,304** | **188,196** |

**Note 3.2 Income from patient care activities**

| **Income from patient care activities received from:** | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | **£000** | **£000** |
| NHS England | 8,558 | 8,076 |
| CCGs | 180,023 | 171,172 |
| Local Authorities | 8,047 | 7,198 |
| NHS Foundation Trusts | 244 | 229 |
| NHS trusts | 14 | 14 |
| NHS other (including Public Health England) | 14 | 0 |
| Non-NHS: private patients | 9 | 14 |
| Non-NHS: overseas patients (chargeable to patient) | 185 | 57 |
| NHS injury scheme (was RTA) | 879 | 834 |
| Non NHS: other | 331 | 602 |
| **Total income from activities** | **198,304** | **188,196** |
| **Of which:** | | |
| Related to continuing operations | 198,304 | 188,196 |
| Related to discontinued operations | 0 | 0 |

**Note 3.3 Overseas visitors (relating to patients charged directly by the provider)**

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| Income recognised this year | 185 | 57 |
| Cash payments received in-year | 81 | 12 |
| Amounts added to provision for impairment of receivables | 91 | 41 |
| Amounts written off in-year | 6 | 16 |

**Note 3.4 Other operating income**

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000 | £000 |
| Research and development | 351 | 400 |
| Education and training | 5,095 | 4,580 |
| Education and training - notional income from apprenticeship fund | 25 | 0 |
| Receipt of capital grants and donations | 0 | 67 |
| Cash grants for the purchase of capital assets - received from other bodies | 1,488 | 0 |
| Charitable and other contributions to expenditure | 104 | 110 |
| Non-patient care services to other bodies | 4,664 | 7,050 |
| Sustainability and Transformation Fund income * | 0 | 9,428 |
| Profit on disposal of non-current assets* | 0 | 0 |
| Reversal of impairments | 0 | 0 |
| Rental revenue from operating leases | 24 | 35 |
| Income in respect of staff costs where accounted on gross basis | 207 | 204 |
| Other income ** | 2,496 | 2,353 |
| **Total other operating income** | **14,454** | **24,227** |
| **Of which:** | | |
| Related to continuing operations | 14,454 | 24,227 |
| Related to discontinued operations | 0 | 0 |

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| **Other Income **** | **£000** | **£000** |
| Car Parking | 1,097 | 1,177 |
| Staff Accommodation rentals | 71 | 57 |
| Catering | 343 | 398 |
| Clinical Excellence Awards | 46 | 45 |
| Other | 939 | 676 |
| | **2,496** | **2,353** |

**Note 4 Operating expenses**

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000 | £000 |
| Purchase of healthcare from NHS and DHSC bodies | 5,655 | 5,245 |
| Purchase of healthcare from non-NHS and non-DHSC bodies | 1,333 | 2,117 |
| Employee expenses - executive directors | 1,070 | 1,018 |
| Remuneration of non-executive directors | 115 | 111 |
| Employee expenses - staff | 158,022 | 146,546 |
| Supplies and services - clinical | 14,369 | 17,251 |
| Supplies and services - general | 2,888 | 4,562 |
| Establishment | 1,448 | 1,493 |
| Research and development | 245 | 283 |
| Transport | 745 | 912 |
| Premises | 12,226 | 12,959 |
| Increase/(decrease) in provision for impairment of receivables | 97 | 167 |
| Change in provisions discount rate(s) | 9 | 73 |
| Inventories consumed | 10,084 | 9,504 |
| Rentals under operating leases | 2,475 | 739 |
| Depreciation on property, plant and equipment | 5,411 | 4,766 |
| Net impairments of property, plant and equipment | (50) | 561 |
| Audit fees payable to the external auditor; | | |
| audit services- statutory audit | 62 | 62 |
| other auditor remuneration (external auditor only) | 12 | 12 |
| Clinical negligence | 11,994 | 10,903 |
| Loss on disposal of non-current assets | 0 | 0 |
| Legal fees | 349 | 567 |
| Consultancy costs | 147 | 400 |
| Internal audit costs | 83 | 87 |
| Education and training - non-staff | 434 | 543 |
| Education and Training - staff | 605 | 543 |
| Education and training - notional expenditure funded from apprenticeship fund | 25 | |
| Patient travel | | |
| Redundancy | 23 | 14 |
| Hospitality | 5 | 22 |
| Insurance | 252 | 231 |
| Losses, ex gratia & special payments | 131 | 11 |
| Other | 648 | 792 |
| **Total** | **230,912** | **222,494** |
| **Of which:** | | |
| Related to continuing operations | 230,912 | 222,494 |
| Related to discontinued operations | 0 | 0 |

The clinical negligence insurance cost has increased to £11.9m, resulting in additional expenditure to the Trust of £1.0m from the 2016/17 expenditure which is due to an increase in historical claims. In 2018/19 the cost has reduced to £8.8m.

**Note 4.1 Other auditor remuneration**

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| Other auditor remuneration paid to the external auditor: | | |
| 1. Audit of accounts of any associate of the trust | 0 | 0 |
| 2. Audit-related assurance services | 12 | 12 |
| 3. Taxation compliance services | 0 | 0 |
| 4. All taxation advisory services not falling within item 3 above | 0 | 0 |
| 5. Internal audit services | 0 | 0 |
| 6. All assurance services not falling within items 1 to 5 | 0 | 0 |
| 7. Corporate finance transaction services not falling within items 1 to 6 above | 0 | 0 |
| 8. Other non-audit services not falling within items 2 to 7 above | 0 | 0 |
| **Total** | **12** | **12** |

**Note 4.2 Limitation on auditor's liability**

The External Auditors Liability is limited to £2m. The scope of work for the External Auditors is to provide a Statutory Audit to the NHS Foundation Trust. This will be conducted in accordance with the Audit Code for NHS Foundation Trusts (the Audit Code) issued by Monitor in accordance with paragraph 24 of schedule 7 of the Act. The scope of the work is for the External Auditors to be satisfied that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The External Auditors are to provide their opinion on the financial statements.

**Note 5 Impairment of assets**

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **Net impairments charged to operating surplus / deficit resulting from:** | | |
| Changes in market price | (50) | 561 |
| Other | 0 | 0 |
| **Total net impairments charged to operating surplus / deficit** | **(50)** | **561** |
| Impairments charged to the revaluation reserve | 138 | 4,904 |
| **Total net impairments** | **88** | **5,465** |

**Note 6 Employee benefits**

| | 31 March 2018 Total £000 | 31 March 2017 Total £000 |
|---|---|---|
| Salaries and wages * | **118,201** | 106,956 |
| Social security costs | **10,914** | 9,940 |
| Apprenticeship levy | **539** | 0 |
| Employer's contributions to NHS pensions | **13,139** | 12,210 |
| Temporary staff - external bank | **6,809** | 6,939 |
| Temporary staff - agency/contract staff | **10,772** | 12,692 |
| | **160,374** | **148,737** |
| Recoveries in respect of seconded staff | **(409)** | (347) |
| **Total staff costs** | **159,965** | **148,390** |
| **Of which** | | |
| Costs capitalised as part of assets | **0** | 0 |

* Increase is due to creation of internal bank, implementation of IR35, transfer of Grange View, Transformation, pay award and incremental drift.

Average number of employees (WTE basis) is on page 31 of the Annual Report

**Note 6.1 Retirements due to ill-health**

During 2017/18 there is 1 early retirement from the NHS Foundation Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2017). The estimated additional pension liability of this ill-health retirements is £66k (£457k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

**Note 6.2 Directors' remuneration**

The aggregate amounts payable to directors were:

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| Salary | 884 | 901 |
| Taxable benefits | 0 | 1 |
| Performance related bonuses | 0 | 0 |
| Employer's pension contributions | 339 | 395 |
| **Total** | **1,223** | **1,297** |

Further details of directors' remuneration can be found in the remuneration report on page 26 of the Annual Report.

**Note 7 Pension costs**

The NHS Foundation Trust offers Retirement Benefits to its employees from the NHS Pension Scheme.

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

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

**a) Accounting valuation**

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

**b) Full actuarial (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The 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 employee and employer representatives as deemed appropriate.

**Note 8 Operating leases**

**Lessor**

This note discloses income generated in operating lease agreements where Tameside and Glossop Integrated Care NHS Foundation Trust is the lessor.

The Foundation Trust has two lessors, relating to the PFI building and the renting of two shops for the length of the contract.

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| **Operating lease revenue** | **£000** | **£000** |
| Minimum lease receipts | 24 | 35 |
| **Total** | **24** | **35** |

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | **£000** | **£000** |
| **Future minimum lease receipts due:** | | |
| - not later than one year; | 24 | 32 |
| - later than one year and not later than five years; | 97 | 129 |
| - later than five years. | 447 | 418 |
| **Total** | **568** | **579** |

**Lessee**

This note discloses costs and commitments incurred in operating lease arrangements where Tameside and Glossop Integrated Care NHS Foundation Trust is the lessee.

The NHS Foundation Trust has two significant leases, one with London and Manchester Healthcare Ltd (L&M Ltd) for Darnton House, and with Olympus Keymed Ltd for a managed clinical equipment service.

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | **£000** | **£000** |
| **Operating lease expense** | | |
| Minimum lease payments | 2,475 | 739 |
| **Total** | **2,475** | **739** |

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | **£000** | **£000** |
| **Future minimum lease payments due:** | | |
| - not later than one year; | 2,456 | 2,474 |
| - later than one year and not later than five years; | 6,136 | 8,384 |
| - later than five years. | 80 | 80 |
| **Total** | **8,672** | **10,938** |

**Note 9 Finance income**

Finance income represents interest received on assets and investments in the period.

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| Interest on bank accounts | 28 | 22 |
| **Total** | **28** | **22** |

The NHS Foundation Trust received interest from cash deposited with HM Treasury, and the Government Banking

**Note 10 Finance expenditure**

Finance expenditure represents interest and other charges involved in the borrowing of money.

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **Interest expense:** | | |
| Loans from the Department of Health | 1,062 | 770 |
| Interest on late payment of commercial debt | 10 | 2 |
| Main finance costs on PFI and LIFT schemes obligations | 2,274 | 2,328 |
| Contingent finance costs on PFI and LIFT scheme obligations | 969 | 826 |
| **Total** | **4,315** | **3,926** |

The interest charge on the Interim Revenue Support loans was £1,062k in 2017/18. The NHS Foundation Trust is expecting to receive additional Interim Revenue Support loans of £25.7m in 2018/19, which will also incur interest of 3.5%.

**Note 11 Intangible assets - 2017/18**

| | Software Licences | Licenses & Trademarks | Other | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Valuation/gross cost at 1 April 2017 - brought forward** | **0** | **0** | **0** | **0** |
| **Valuation/gross cost at start of period for new FTs** | **0** | **0** | **0** | **0** |
| Additions | 413 | 0 | 0 | **413** |
| Impairments | 0 | 0 | 0 | **0** |
| Disposals / derecognition | 0 | 0 | 0 | **0** |
| **Gross cost at 31 March 2018** | **413** | **0** | **0** | **413** |
| **Amortisation at 1 April 2017 - brought forward** | **0** | **0** | **0** | **0** |
| **Amortisation at start of period for new FTs** | **0** | **0** | **0** | **0** |
| Provided during the year | 0 | 0 | 0 | **0** |
| Impairments | 0 | 0 | 0 | **0** |
| Disposals / derecognition | 0 | 0 | 0 | **0** |
| **Amortisation at 31 March 2018** | **0** | **0** | **0** | **0** |
| **Net book value at 31 March 2018** | **413** | **0** | **0** | **413** |
| **Net book value at 1 April 2017** | **0** | **0** | **0** | **0** |

**Note 11.1 Intangible assets - 2016/17**

| | Software licences | Licenses & Trademarks | Other | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Valuation/gross cost at 1 April 2016 - as previously stated** | **0** | **0** | **0** | **0** |
| Prior period adjustments | 0 | 0 | 0 | **0** |
| **Gross cost at 1 April 2016 - restated** | **0** | **0** | **0** | **0** |
| **Gross cost at start of period for new FTs** | **0** | **0** | **0** | **0** |
| Additions | 0 | 0 | 0 | **0** |
| Impairments | 0 | 0 | 0 | **0** |
| Disposals / derecognition | 0 | 0 | 0 | **0** |
| **Valuation/gross cost at 31 March 2017** | **0** | **0** | **0** | **0** |
| **Amortisation at 1 April 2016 - as previously stated** | **0** | **0** | **0** | **0** |
| Prior period adjustments | 0 | 0 | 0 | **0** |
| **Amortisation at 1 April 2016 - restated** | **0** | **0** | **0** | **0** |
| **Amortisation at start of period for new FTs** | **0** | **0** | **0** | **0** |
| Provided during the year | 0 | 0 | 0 | **0** |
| Impairments | 0 | 0 | 0 | **0** |
| Disposals / derecognition | 0 | 0 | 0 | **0** |
| **Amortisation at 31 March 2017** | **0** | **0** | **0** | **0** |
| **Net book value at 31 March 2017** | **0** | **0** | **0** | **0** |
| **Net book value at 1 April 2016** | **0** | **0** | **0** | **0** |

**Note 12 Property, plant and equipment - 2017/18**

| | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation/gross cost at 1 April 2017 - brought forward** | **13,668** | **99,490** | **482** | **720** | **15,586** | **91** | **6,341** | **114** | **136,492** |
| Additions | 0 | 0 | 0 | 2,602 | 1,615 | 0 | 192 | 6 | **4,415** |
| Additions - Donantions | 0 | 1,488 | 0 | 0 | 0 | 0 | 0 | 0 | **1,488** |
| Impairments | (15) | (94) | (29) | 0 | 0 | 0 | 0 | 0 | **(138)** |
| Reclassifications | 0 | 1,798 | 0 | (2,584) | 0 | 0 | 786 | 0 | **-** |
| Revaluations | 828 | 10,024 | 27 | 0 | 0 | 0 | 0 | 0 | **10,879** |
| Disposals / derecognition | 0 | 0 | 0 | 0 | (738) | 0 | (15) | 0 | **(753)** |
| **Valuation/gross cost at 31 March 2018** | **14,481** | **112,706** | **480** | **738** | **16,463** | **91** | **7,304** | **120** | **152,383** |
| **Accumulated depreciation at 1 April 2017 - brought forward** | **0** | **0** | **0** | **0** | **11,109** | **83** | **4,803** | **96** | **16,091** |
| **Depreciation at start of period as FT** | | | | | | | | | |
| Provided during the year | 0 | 3,578 | 11 | 0 | 1,160 | 8 | 643 | 11 | **5,411** |
| Impairments | 0 | 184 | 0 | 0 | 0 | 0 | 0 | 0 | **184** |
| Revaluations | 0 | (3,528) | 0 | 0 | 0 | 0 | 0 | 0 | **(3,528)** |
| Reversals of impairments | 0 | (234) | 0 | 0 | 0 | 0 | 0 | 0 | **(234)** |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Disposals/ derecognition | 0 | 0 | 0 | 0 | (738) | 0 | (15) | 0 | **(753)** |
| **Accumulated depreciation at 31 March 2018** | **0** | **0** | **11** | **0** | **11,531** | **91** | **5,431** | **107** | **17,171** |
| **Net book value at 31 March 2018** | **14,481** | **112,706** | **469** | **738** | **4,932** | **0** | **1,873** | **13** | **135,212** |
| **Net book value at 1 April 2017** | **13,668** | **99,490** | **482** | **720** | **4,477** | **8** | **1,538** | **18** | **120,401** |
| Total Revaluation | 828 | 13,552 | 27 | 0 | 0 | 0 | 0 | 0 | 14,407 |
| Total Impairment | (15) | (278) | (29) | 0 | 0 | 0 | 0 | 0 | (322) |
| | **813** | **13,274** | **(2)** | **0** | **0** | **0** | **0** | **0** | **14,085** |

**Note 12.1 Property, plant and equipment - 2016/17**

| | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation/gross cost at 1 April 2016 - as previously stated** | **15,168** | **93,290** | **482** | **408** | **16,234** | **106** | **5,916** | **128** | **131,732** |
| **Valuation/gross cost at start of period as FT** | 0 | 0 | 0 | 1,783 | 847 | 0 | 307 | 0 | **2,937** |
| Additions - purchased/ leased/ grants/ donations | 0 | 0 | 0 | 0 | 67 | 0 | 0 | 0 | **67** |
| Reversals of impairments | (1,500) | (3,404) | 0 | 0 | 0 | 0 | 0 | 0 | **(4,904)** |
| Reclassifications | 0 | 1,261 | 0 | (1,471) | 0 | 0 | 210 | 0 | **0** |
| Revaluations | 0 | 8,343 | 0 | 0 | 0 | 0 | 0 | 0 | **8,343** |
| Disposals / derecognition | 0 | 0 | 0 | 0 | (1,562) | (15) | (92) | (14) | **(1,683)** |
| **Valuation/gross cost at 31 March 2017** | **13,668** | **99,490** | **482** | **720** | **15,586** | **91** | **6,341** | **114** | **136,492** |
| **Accumulated depreciation at 1 April 2016 - as previously stated** | **0** | **0** | **0** | **0** | **11,586** | **88** | **4,263** | **99** | **16,036** |
| **Depreciation at start of period as FT** | | | | | | | | | |
| Provided during the year | 0 | 3,030 | 10 | 0 | 1,073 | 10 | 632 | 11 | **4,766** |
| Impairments | 0 | 561 | 0 | 0 | 0 | 0 | 0 | 0 | **561** |
| Reversals of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Revaluations | 0 | (3,591) | (10) | 0 | 0 | 0 | 0 | 0 | **(3,601)** |
| Transfers to/ from assets held for sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Disposals / derecognition | 0 | 0 | 0 | 0 | (1,550) | (15) | (92) | (14) | **(1,671)** |
| **Accumulated depreciation at 31 March 2017** | **0** | **0** | **0** | **0** | **11,109** | **83** | **4,803** | **96** | **16,091** |
| **Net book value at 31 March 2017** | **13,668** | **99,490** | **482** | **720** | **4,477** | **8** | **1,538** | **18** | **120,401** |
| **Net book value at 1 April 2016** | **15,168** | **93,290** | **482** | **408** | **4,648** | **18** | **1,653** | **29** | **115,696** |
| Total Revaluation | 0 | 11,934 | 10 | 0 | 0 | 0 | 0 | 0 | 11,944 |
| Total Impairment | (1,500) | (3,965) | 0 | 0 | 0 | 0 | 0 | 0 | (5,465) |
| | **(1,500)** | **7,969** | **10** | **0** | **0** | **0** | **0** | **0** | **6,479** |

**Note 12.2 Property, plant and equipment financing - 2017/18**

| | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Net book value at 31 March 2018** | | | | | | | | | |
| Owned | 14,481 | 70,251 | 469 | 738 | 4,647 | 0 | 1,873 | 13 | **92,472** |
| On-SoFP PFI contracts and other service concession arrangements | 0 | 40,929 | 0 | 0 | 0 | 0 | 0 | 0 | **40,929** |
| Donated | 0 | 1,526 | 0 | 0 | 285 | 0 | 0 | 0 | **1,811** |
| **NBV total at 31 March 2018** | **14,481** | **112,706** | **469** | **738** | **4,932** | **0** | **1,873** | **13** | **135,212** |

**Note 12.3 Property, plant and equipment financing - 2016/17**

| | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Net book value at 31 March 2017** | | | | | | | | | |
| Owned | 11,668 | 62,573 | 482 | 720 | 4,040 | 8 | 1,538 | 18 | **81,047** |
| On-SoFP PFI contracts and other service concession arrangements | 2,000 | 36,666 | 0 | 0 | 0 | 0 | 0 | 0 | **38,666** |
| Donated | 0 | 251 | 0 | 0 | 437 | 0 | 0 | 0 | **688** |
| **NBV total at 31 March 2017** | **13,668** | **99,490** | **482** | **720** | **4,477** | **8** | **1,538** | **18** | **120,401** |

**Note 13 Inventories**

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| Drugs | 782 | 656 |
| Work In progress | 0 | 0 |
| Consumables | 858 | 741 |
| Energy | 31 | 33 |
| Other | 0 | 0 |
| **Total inventories** | **1,671** | **1,430** |

**Note 14 Trade receivables and other receivables**

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **Current** | | |
| Trade receivables due from NHS bodies | 2,355 | 3,665 |
| Trade receivables due from Non NHS bodies | 851 | 2,237 |
| Provision for impaired receivables | (367) | (286) |
| Prepayments (non-PFI) | 1,803 | 1,287 |
| Accrued income * | 1,372 | 5,813 |
| Accrued Income (CRU) | 667 | 626 |
| Provision for impaired CRU | (324) | (308) |
| PDC dividend receivable | 0 | 0 |
| VAT receivable | 540 | 119 |
| Other receivables | 150 | 203 |
| **Total current trade and other receivables** | **7,047** | **13,356** |
| **Non-current** | | |
| PFI prepayments: | | |
| Lifecycle replacements | 4,983 | 4,289 |
| Other receivables (CRU) | 752 | 725 |
| **Total non-current trade and other receivables** | **5,735** | **5,014** |

* The decrease is due to Sustainibility and Transforamtion funding not being owed from the Department of Health and Social Care.

The NHS Foundation Trust receives income under the NHS Injury Cost Recovery Scheme (CRU), designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS Foundation Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit (CRU) 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.

| Note 14.1 Provision for impairment of receivables | | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|---|
| **At 1 April as previously stated** | | **594** | **427** |
| Prior period adjustments | | 0 | 0 |
| **At 1 April - restated** | | **594** | **427** |
| **At start of period for new FTs** | | **0** | **0** |
| Increase in provision | | 97 | 167 |
| Amounts utilised | | 0 | 0 |
| Unused amounts reversed | | 0 | 0 |
| **At 31 March** | * | **691** | **594** |

| Note 14.2 Analysis of impaired receivables | | Trade receivables & other receivables 31 March 2018 £000 | Trade receivables & other receivables 31 March 2017 £000 |
|---|---|---|---|
| **Ageing of impaired receivables** | | | |
| 0 - 30 days | | 0 | 14 |
| 30-60 Days | | 0 | 14 |
| 60-90 days | | 0 | 14 |
| 90- 180 days | | 47 | 109 |
| Over 180 days | | 320 | 443 |
| **Total** | * | **367** | **594** |

*Difference relates to Provision on doubtful debt of CRU £324k as this does not fall into the critera of a financial asset.

| **Ageing of non-impaired receivables past their due date** | | |
|---|---|---|
| 0 - 30 days | 957 | 4,187 |
| 30-60 Days | 715 | 860 |
| 60-90 days | 243 | 25 |
| 90- 180 days | 506 | 244 |
| Over 180 days | 418 | 300 |
| **Total** | **2,839** | **5,616** |

**Note 15 Cash and cash equivalents movements**

Cash and cash equivalents comprise of cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **At 1 April** | **2,945** | **1,215** |
| Prior period adjustments | 0 | 0 |
| **At 1 April (restated)** | **2,945** | **1,215** |
| **At start of period for new FTs** | **0** | **0** |
| Transfers by absorption | 0 | 0 |
| Net change in year | (1,530) | 1,730 |
| **At 31 March** | **1,415** | **2,945** |
| **Broken down into:** | | |
| Cash at commercial banks and in hand | 87 | 65 |
| Cash with the Government Banking Service | 1,328 | 2,880 |
| Deposits with the National Loan Fund | 0 | 0 |
| Other current investments | 0 | 0 |
| **Total cash and cash equivalents as in SoFP** | **1,415** | **2,945** |
| Bank overdrafts (GBS and commercial banks) | 0 | 0 |
| Drawdown in committed facility | 0 | 0 |
| **Total cash and cash equivalents as in SoCF** | **1,415** | **2,945** |

**Note 15.1 Third party assets held by the NHS Foundation Trust**

Tameside and Glossop Integrated Care NHS Foundation Trust hold cash and cash equivalents which relate to monies held by the NHS Foundation Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| Bank balances | 5 | 4 |
| Monies on deposit | 0 | 0 |
| **Total third party assets** | **5** | **4** |

| Note 16 Trade and other payables | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **Current** | | |
| NHS trade payables | 1,689 | 1,899 |
| Amounts due to other related parties | 0 | 0 |
| Other trade payables | 4,118 | 3,612 |
| Capital payables | 563 | 704 |
| Social security costs | 1,653 | 1,461 |
| Other taxes payable | 1,339 | 1,173 |
| Other payables | 4,383 | 4,358 |
| Accruals | 8,769 | 11,459 |
| PDC dividend payable | 0 | 0 |
| **Total current trade and other payables** | **22,514** | **24,666** |
| **Non-current** | | |
| **Total non-current trade and other payables** | **0** | **0** |

| Note 17 Other liabilities | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **Current** | | |
| Other deferred income | 1,584 | 2,342 |
| **Total other current liabilities** | **1,584** | **2,342** |
| **Non-current** | | |
| Other deferred income | 0 | 0 |
| **Total other non-current liabilities** | **0** | **0** |

| Note 18 Borrowings | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **Current** | | |
| Loans from the Department of Health | 20,300 | 0 |
| Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle) | 1,392 | 1,337 |
| **Total current borrowings** | **21,692** | **1,337** |
| **Non-current** | | |
| Loans from the Department of Health | 55,100 | 54,800 |
| Obligations under PFI, LIFT or other service concession contracts | 52,202 | 53,594 |
| **Total non-current borrowings** | **107,302** | **108,394** |

**Note 19 Provisions for liabilities and charges analysis**

| | Pensions - former directors | Pensions - other staff | Other legal claims | Other | Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **At 1 April 2017** | 0 | 604 | 240 | 0 | **844** |
| **At start of period for new FTs** | 0 | 0 | 0 | 0 | **-** |
| Change in the discount rate | 0 | 9 | 0 | 0 | **9** |
| Arising during the year | 0 | 0 | 189 | 0 | **189** |
| Utilised during the year | 0 | (30) | (47) | 0 | **(77)** |
| Reclassified to liabilities held in disposal groups | 0 | 0 | 0 | 0 | **-** |
| Reversed unused | 0 | 0 | (115) | 0 | **(115)** |
| Unwinding of discount | 0 | 2 | 0 | 0 | **2** |
| **At 31 March 2018** | **0** | **585** | **267** | **0** | **852** |
| **Expected timing of cash flows:** | | | | | |
| - not later than one year; | 0 | 36 | 115 | 0 | 151 |
| - later than one year and not later than five years; | 0 | 144 | 152 | 0 | 296 |
| - later than five years. | 0 | 405 | 0 | 0 | 405 |
| **Total** | **0** | **585** | **267** | **0** | **852** |

The above provisions are subject to uncertainties relating to the estimated costs and expected timings of the settlement. The cost and timing of the provision for employer's and occupier's liability has been calculated using the information provided by the NHS Litigation Authority. The injury benefits provision is an amount that is payable for the remaining life of an individual. The provision has been calculated based on the historic annual payment and the expected remaining life of the individual.

Below is a table detailing a breakdown of the above provisions:

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000 | £000 |
| Employer's Liabilities - NHS Litigation Authority | **233** | **222** |
| Public Liabilities - NHS Litigation Authority | **34** | **18** |
| **Total Legal Claims** | **267** | **240** |
| Injury Benefits - NHS Business Services Authority - Pensions Division | **585** | **604** |
| **Total Pensions** | **585** | **604** |
| Other Provisions - Industrial tribunal claims | **0** | **0** |
| Other Provisions - VAT costs | **0** | **0** |
| Other Provisions - Probable repayment of income liabilities | **0** | **0** |
| Other Provisions - Business rates | **0** | **0** |
| **Total Other Provisions** | **0** | **0** |
| **Total Provisions** | **852** | **844** |

**Note 19.1 Clinical negligence liabilities**

The NHS Litigation Authority at the 31 March 2018 has a provision of £178,815m in respect of the clinical negligence liabilities of the NHS Foundation Trust (31 March 2017, £137,952m).

The NHS Foundation Trust has no contingent liabilities in 2017/18, which relate to the Employer's and Occupier's Liability. This is the difference between the provision which the NHS Foundation Trust has made for the claim and the actual excess which the NHS Foundation Trust could be liable to pay against the claim.

**Note 20 Contractual capital commitments**

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| Property, plant and equipment | 493 | 192 |
| Intangible assets | 0 | 0 |
| **Total** | **493** | **192** |

**Note 21 Private Finance Initiative contracts**

**Note 21.1 PFI scheme off-Statement of Financial Position**
The NHS Foundation Trust does not have any PFI scheme off-Statement of Financial Position.

**Note 21.2 PFI scheme on-Statement of Financial Position**
In 2011 extensive new acute facilities were built through PFI investment by Consort Healthcare.

The contract with Consort Healthcare expires at the end of the contract term (28th August 2041) and there is no provision within the contract to re-price or re-negotiate the prices and dates. There is however the facility for variations to the contract and the NHS Foundation Trust has procedures to manage those variations in line with Standing Financial Instructions. The Annual Service Payment will be inflated each April based on the preceding February RPI.

The NHS Foundation Trust has the right to use the buildings, however Consort Healthcare have the responsibility for maintaining the buildings to an agreed standard. All lifecycle replacement is also the responsibility of Consort Healthcare.

A key feature of the PFI scheme is that the operator is responsible for ensuring that the property is maintained to an agreed standard for the entire life of the contract. These are known as lifecycle costs. The cost which the operator expects to incur in doing this is reflected in the unitary payment and reflects two elements:

- maintenance (planned and reactive); and
- replacement of components as they wear out during the contract – this is known as capital lifecycle.

After the expiry of the contract, the license with Consort Healthcare to operate out of these buildings will expire and the NHS Foundation Trust will become responsible for the maintenance and lifecycle costs of those buildings.

The building is valued within the cycle of the Trust Land & Building valuation exercise. The building was valued exclusive of VAT in 2016/17. This is allowable as the VAT is recovered on all payments relating to a fully managed and serviced building under a PFI.

**Note 21.3 On-SoFP PFI, LIFT or other service concession arrangements**

The NHS Foundation Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **Gross PFI, LIFT or other service concession liabilities** | **84,356** | **87,966** |
| - not later than one year; | 3,610 | 3,610 |
| - later than one year and not later than five years; | 14,437 | 14,437 |
| - later than five years. | 66,309 | 69,919 |
| Finance charges allocated to future periods | **(30,762)** | **(33,035)** |
| **Net PFI, LIFT or other service concession arrangement obligation** | **53,594** | **54,931** |
| - not later than one year; | 1,392 | 1,337 |
| - later than one year and not later than five years; | 6,178 | 5,928 |
| - later than five years. | 46,024 | 47,666 |
| | **53,594** | **54,931** |

**Note 21.4 Total on-SoFP PFI, LIFT and other service concession arrangement commitments**

The Trust's total future obligations under these on-SoFP schemes are as follows:

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| Total future payments committed in respect of the PFI, LIFT or other service concession arrangements | **280,685** | **286,318** |
| **Of which liabilities are due:** | | |
| - not later than one year; | 8,960 | 8,648 |
| - later than one year and not later than five years; | 38,137 | 36,809 |
| - later than five years. | 233,588 | 240,861 |
| | **280,685** | **286,318** |

**Note 21.5 Analysis of amounts payable to service concession operator**

This note provides an analysis of the trust's expenditure in 2017/18:

| | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| Unitary payment payable to service concession operator | 8,647 | 8,376 |
| **Consisting of:** | | |
| - Interest charge | 2,274 | 2,328 |
| - Repayment of finance lease liability | 1,336 | 1,282 |
| - Service element | 3,373 | 3,267 |
| - Contingent rent | 969 | 826 |
| - Addition to lifecycle prepayment | 695 | 673 |
| **Total amount paid to service concession operator** | **8,647** | **8,376** |

**Note 22 Financial instruments**

**Note 22.1 Liquidity Risk**

The NHS Foundation Trust's net operating costs are incurred under annual service contracts with local Clinical Commissioning Groups (CCG's), which are financed from resources voted annually by Parliament. The NHS Foundation Trust has agreed a block contract with Tameside and Glossop CCG, the main commissioner for the organisation. The NHS Foundation Trust receives cash each month based on the profiling of the contract value. The Trust financial plan and budgets are based on this contract value. This means that in periods of significant over-spend on budgets, there can be a significant cash flow impact. Wherever possible this is mitigated by rephrasing income payments with Commissioners. As the NHS Foundation Trust has a deficit financial plan, there is also a reliance on a revenue support loan from the DH to provide the cash to support financial obligations.

The NHS Foundation Trust presently finances its capital expenditure from internally generated funds or funds made available from Government, in the form of additional Public Dividend Capital, under an agreed limit. In addition, the NHS Foundation Trust can borrow, both from the Department of Health Financing Facility and commercially, to finance capital schemes. Although given current Department of Health loan conditions this is only possible with NHSI approval. Financing would be drawn down to match the capital spend profile of the scheme concerned and the NHS Foundation Trust would not therefore be exposed to significant liquidity risks in this area; the NHS Foundation Trust did not borrow under any of these arrangements in the year 2017/18.

**Note 22.2 Interest-Rate Risk**

All of the NHS Foundation Trust's financial assets and liabilities carry nil or fixed rates of interest. The NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk. The only risk is therefore regarding the level of interest generated on the NHS Foundation Trust's investment which may be higher or lower than planned at the start of the year, due to fluctuating interest rates on National Loan Fund investments. The value of interest generated in 2017/18 was £28k (2016/17 was £22k).

**Note 22.3 Credit Risk**

The main source of income for the NHS Foundation Trust is from NHS Commissioners in respect of healthcare services provided under local agreements and NHS Contracts. Non NHS customers do not represent a large proportion of income, the majority of this relates to other public sector bodies which are considered low risk. The NHS Foundation Trust is therefore, not exposed to significant credit risk.

**Note 22.4 Treasury Management Arrangements**

The NHS Foundation Trust operates within an agreed Treasury Management policy that governs the nature of the cash investments. The financial performance of the NHS Foundation Trust's cash investments is reviewed quarterly by the NHS Foundation Trust's Finance and Performance Committee. The credit risk to the NHS Foundation Trust is minimal for the investments. Investments are limited to a maximum amount of £3m with each commercial bank and a maximum period of 95 days. Investments can only be placed with commercial banks who have a Fitch credit rating of AA+. The NHS Foundation Trust is also able to place investments with HM Treasury in the National Loans Fund Account (NLF). The Treasury Management policy states an unlimited value can be placed with the NLF.

The NHS Foundation Trust also has an Interim Revenue Support Loan from the DH. The Trust is required to repay the 3.5% interest element on the loan every six months, with the principle of the loan being required to be repaid at the end of the 2 year loan period. If required, the NHS Foundation Trust is able to apply for an extension on this loan for a further 3 year period, extending the loan to 5 years, when the principle would be expected to be repaid in full. Total loan liability for the Trust is £75.4m. DH are reveiwing their loans policy in 2018/19.

**Note 22.5 Currency Risk**

The NHS Foundation Trust does not have any overseas foreign transactions or balances. There is no currency or translation risk to the NHS Foundation Trust.

| Note 22.6 Financial assets | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **Assets as per SoFP as at 31 March 2018** | | |
| Trade and other receivables (excluding non financial assets) - with NHS and DH bodies | 2,355 | 1,654 |
| Trade and other receivables (excluding non financial assets) - with other bodies | 2,373 | 9,045 |
| Cash and cash equivalents at bank and in hand (at 31 March 2018) | 1,415 | 2,945 |
| | **6,143** | **13,644** |

| Note 22.7 Financial liabilities | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| **Liabilities as per SoFP as at 31 March 2018** | | |
| Borrowings excluding finance lease and PFI liabilities | 75,400 | 54,800 |
| Obligations under PFI, LIFT and other service concession contracts | 53,594 | 54,931 |
| Trade and other payables (excluding non financial liabilities) - with NHS and DH bodies | 1,689 | 714 |
| Trade and other payables (excluding non financial liabilities) - with other bodies | 16,027 | 20,722 |
| **Total at 31 March 2018** | **146,710** | **131,167** |

| Note 22.8 Maturity of financial liabilities | 31 March 2018 £000 | 31 March 2017 £000 |
|---|---|---|
| In one year or less | 39,409 | 22,772 |
| In more than one year but not more than two years | 56,547 | 21,693 |
| In more than two years but not more than five years | 4,730 | 39,036 |
| In more than five years | 46,024 | 47,666 |
| **Total** | **146,710** | **131,167** |

**Note 23 Losses and special payments**

| | 31 March 2018 | | 31 March 2017 | |
|---|---|---|---|---|
| | Total number of cases | Total value of cases | Total number of cases | Total value of cases |
| | Number | £000 | Number | £000 |
| **Losses** | | | | |
| Bad debts and claims abandoned | 15 | 16 | 8 | 16 |
| Stores losses and damage to property | 1 | 49 | 1 | 51 |
| **Total losses** | **16** | **65** | **9** | **67** |
| **Special payments** | | | | |
| *Ex gratia payments in respect of:* | | | | |
| loss of personal effects | 18 | 9 | 21 | 9 |
| personal injury with advice | 3 | 3 | 14 | **(71)** |
| other negligence and injury | 9 | 40 | 11 | 6 |
| other | 3 | 13 | 0 | 0 |
| **Total special payments** | **33** | **65** | **46** | **(56)** |
| **Total losses and special payments** | **49** | **130** | **55** | **11** |
| Compensation payments received | | 0 | | 0 |

There were no cases exceeding £250,000 in either the current or prior year.

Note: The amounts are reported on an accruals basis but exlude provisions for future losses.

**Note 24 Events after the reporting date**

The Foundation Trust has no events after the reporting date to report.

**Note 25 Related parties**

Tameside and Glossop Integrated Care NHS Foundation Trust is a public benefit body authorised by NHS Improvement, the independent Regulator of NHS Foundation Trusts.

During the period there has been no material transactions with any member of the Board or members of key management staff or parties related to them, with Tameside Hospital NHS Foundation Trust.

The Department of Health is regarded as a related party. During the year Tameside Hospital NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below, along with details of Income and Expenditure and the Debtor and Creditor balances.

| | Receivables | | Payables | |
|---|---|---|---|---|
| | 31 March 2018 £000 | 31 March 2017 £000 | 31 March 2018 £000 | 31 March 2017 £000 |
| Stockport NHS Foundation Trust | 613 | 309 | 72 | 81 |
| NHS Tameside and Glossop CCG | 586 | 2,330 | 1,400 | 1,467 |
| HM Revenue & Customs | 540 | 119 | 2,992 | 2,634 |
| Pennine Care NHS Foundation Trust | 469 | 340 | 196 | 60 |
| Manchester University NHS Foundation Trust * | 458 | 261 | 1,123 | 1,411 |
| Tameside Metropolitan Borough Council | 447 | 1,679 | 115 | 1,222 |
| Other CCGS | 298 | 254 | 100 | 25 |
| Stockport Metropolitan Borough Council | 278 | 0 | 0 | 0 |
| Salford Royal NHS Foundation Trust | 202 | 169 | 185 | 137 |
| Other NHS Bodies (including Welsh Health Bodies) | 106 | 178 | 102 | 127 |
| Pennine Acute Hospitals NHS Trust | 99 | 40 | 238 | 35 |
| The Christie NHS Foundation Trust | 48 | 49 | 314 | 103 |
| NHS Heywood, Middleton and Rochdale CCG | 10 | 0 | 1 | 135 |
| NHS Property Services | 3 | 6 | 0 | 0 |
| Community Health Partnerships | 1 | 1 | 0 | 880 |
| Other Local Authorities | 1 | 0 | 0 | 0 |
| NHS England - Core | 0 | 4,252 | 0 | 0 |
| NHS England - North West Commissioning Hub | 0 | 585 | 0 | 0 |
| NHS England - Greater Manchester Local Office | 0 | 539 | 110 | 0 |
| NHS England - Cheshire and Merseyside Local Office | 0 | 0 | 174 | 0 |
| NHS Manchester CCG ^ | 0 | 12 | 543 | 309 |
| Department of Health | 0 | 0 | 0 | 44 |
| NHS Oldham CCG | 0 | 0 | 770 | 217 |
| NHS Pension Scheme | 0 | 0 | 1,806 | 1,685 |
| NHS Professionals | 0 | 0 | 441 | 1,177 |
| Public Health England (PHE) | 0 | 0 | 1 | 112 |
| **Total** | **4,159** | **11,123** | **10,683** | **11,861** |

| | Income | | Expenditure | |
|---|---|---|---|---|
| | 2018 £000 | 2017 £000 | 2018 £000 | 2017 £000 |
| NHS Tameside and Glossop CCG | 164,704 | 159,010 | 2,121 | 2,187 |
| Tameside Metropolitan Borough Council | 7,386 | 7,198 | 1,068 | 2,167 |
| NHS Oldham CCG | 6,120 | 6,354 | 51 | 42 |
| NHS England - North West Specialised Commissioning Hub | 5,936 | 6,248 | 0 | 0 |
| NHS Manchester CCG ^ | 5,799 | 5,865 | 0 | 0 |
| Health Education England | 4,774 | 4,510 | 0 | 5 |
| Other CCGS | 1,485 | 1,343 | 0 | 0 |
| Pennine Care NHS Foundation Trust | 1,442 | 1,596 | 649 | 566 |
| NHS England - Core | 1,389 | 9,428 | 0 | 0 |
| NHS England - Greater Manchester Local Office | 1,268 | 2,101 | 0 | 0 |
| NHS Stockport CCG | 1,211 | 1,247 | 0 | 0 |
| Stockport Metropolitan Borough Council | 661 | 0 | 0 | 0 |
| NHS Heywood, Middleton and Rochdale CCG | 632 | 531 | 0 | 0 |
| Central Manchester University Hospitals NHS Foundation Trust * | 596 | 988 | 995 | 1,595 |
| Manchester University NHS Foundation Trust * | 379 | 0 | 1,788 | 0 |
| Salford Royal NHS Foundation Trust | 282 | 293 | 251 | 103 |
| Pennine Acute Hospitals NHS Trust | 254 | 294 | 42 | 25 |
| Stockport NHS Foundation Trust | 178 | 405 | 307 | 430 |
| Other NHS Bodies (including Welsh Health Bodies) | 116 | 268 | 588 | 509 |
| NHS Property Services | 94 | 70 | 0 | 0 |
| The Christie NHS Foundation Trust | 91 | 32 | 580 | 350 |
| University Hospital of South Manchester NHS Foundation Trust * | 2 | 39 | 647 | 1,434 |
| Other Local Authorities | 1 | 0 | 0 | 0 |
| NHS England - Cheshire and Merseyside Local Office | 0 | 34 | 0 | 0 |
| Department of Health | 0 | 0 | 5 | 44 |
| Environment Agency | 0 | 0 | 0 | 1 |
| HM Revenue & Customs | 0 | 0 | 11,453 | 9,940 |
| NHS Blood and Transplant | 0 | 0 | 615 | 567 |
| NHS Resolution | 0 | 0 | 12,122 | 11,033 |
| NHS Pension Scheme | 0 | 0 | 13,139 | 12,210 |
| NHS Professionals | 0 | 0 | 9,322 | 11,008 |
| Northumbria Healthcare NHS Foundation Trust | 0 | 0 | 138 | 145 |
| Public Health England (PHE) | 0 | 0 | 34 | 191 |
| Royal Liverpool and Broadgreen University Hospitals NHS Trust | 0 | 0 | 116 | 120 |
| **Total** | **204,800** | **207,854** | **56,031** | **54,672** |

* created on 1 October 2017 from the merger of Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust

^ created on 1 April 2017 from the merger of Central, North and South Manchester CCG's