The Pennine Acute Hospitals NHS Trust

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Annual Report and Accounts

1 April 2018 to 31 March 2019

Saving *lives*, Improving *lives*

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Performance report

Performance overview

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

An introduction to The Pennine Acute Hospitals NHS Trust

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

Pennine operates from four main sites in North Manchester, Bury, Oldham and Rochdale, together with the Floyd Unit at Birch Hill Hospital. Our team of over 9,000 staff provides a wide range of acute, specialist and community services to over 800,000 people across the North East of Greater Manchester, in Bury, North Manchester, Middleton, Heywood, Oldham and Rochdale, and parts of East Lancashire.

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

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

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

From the 1 April 2017, the Northern Care Alliance NHS Group (NCA) was launched, bringing together over 17,000 staff, 2000 beds and serving a population of over 1 million. Whilst Pennine and Salford Royal remain statutory bodies, the respective Trust Boards delegated the exercise of their functions to a Group Committees in Common (Group CiC), effectively managing both Trusts.

Four 'Care Organisations' have been established within the NCA; Oldham, Bury & Rochdale and North Manchester (incorporating the main sites from which Pennine operates), alongside Salford, with responsibility for providing high quality and reliable care to the local communities they serve

The Care Organisations are supported by an NCA Diagnostics and Pharmacy Group Business Unit and Corporate Functions. Each Care Organisation and hospital site has its own Director Leadership Team, led by a Chief Officer, and consisting of a Managing Director, Medical Director, Director of Nursing, and Finance Director. Together they are accountable to the Group CiC for the day to day running of the hospital services and, as applicable, primary, community, mental health and social care services of the respective Care Organisation. These new local arrangements place the emphasis for operational management where it matters - in each hospital and locality.

Northern Care Alliance NHS Group vision and objectives

Our Mission Statement that binds us all together is:

Saving *lives,*
Improving *lives*

Northern Care Alliance NHS Group vision and objectives *continued*

Our Priorities 2018/2019

NHS
Bury & Rochdale
Care Organisation
Northern Care Alliance NHS Group

Saving *lives*, Improving *lives*

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

Bury & Rochdale Care Organisation Priorities

1) We will demonstrate continuous improvement towards our goal of being the safest health and social care organisations in England

This means
- Reductions in core patient and/user harms each year
- Improvements in mortality indices each year
- Achieving CQC rating of Good or Outstanding.

In order to achieve this we will:
- Deliver a series of projects to improve patient care including reducing pressure ulcers and falls
- Continue to embed shared learning to recognise and respond early to patients who are at risk of deterioration
- Use quality improvement techniques to ensure reliable and safe care including a focus on bed-side handover.

2) We will improve patient and care pathways to deliver improved prevention, earlier diagnosis, earlier treatment and earlier discharge

This means
- Our patients will access our hospitals less and go home sooner
- We will contribute to health and wellbeing in our locality
- Work closer with partner organisations.

In order to achieve this we will:
- Look at patient flow and implement changes to make it better for patients
- Start internships for students with learning difficulties
- Undertake further homeless events
- Continue to develop trusting relationships with partners and commissioners, playing an active role in local care alliances.

3) We will continuously improve our efficiency and productivity and work with partners to deliver sustainable financial plans

This means
- Improved financial performance year on year
- Operational efficiency and workforce productivity metrics are met each year.

In order to achieve this we will:
- Continue to deliver better care with lower cost
- Implement robust financial governance systems and processes including sickness and absence planning
- Enhance the critical care workforce model for Fairfield General Hospital.

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

This means
- More people will recommend us as a 'Place to work' and 'Place for Care' each year
- We will deliver training, coaching and talent development plans.

In order to achieve this we will:
- Create a staff led health and well being committee
- Support staff development
- Increase staff survey engagement scores
- Lead and support feedback with staff at all levels.

5) We will ensure good operational planning & execution to deliver our agreed plans & standardise processes across the Northern Care Alliance

This means
- Delivering urgent, planned and cancer care improvements to achieve our targets
- Developing and implementing Standard Operating Models to eliminate unwarranted variation.

In order to achieve this we will:
- Reduce waiting times and improve patient experience for mental health re-attenders
- Ensure robust plans are in place to maintain quality service provision and urgent care access performance through high periods of demand
- Implement standard ways of working to ensure reliability and performance improvements.

6) We will embed changes resulting from Northern Care Alliance strategies and deliver new ways of working through excellence in change management

This means
- Reliably delivering our plans so that benefits can be achieved in agreed timescales.

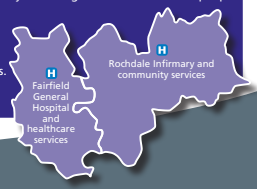
In order to achieve this we will:
- Develop good working relationships with shared services within the Northern Care Alliance NHS Group (NCA)
- Engage and implement best practice recommendations from external reviewers.

Our Alliance Priorities:

1. Pursue quality improvement to ensure safe, reliable and compassionate care
2. Improve care and services through integration, collaboration and growth
3. Deliver the financial plan to assure sustainability
4. Support our staff to deliver high performance and continuous improvement
5. Deliver operational excellence
6. Develop and implement our Service Development Strategy and the Northern Care Alliance enabling strategies

Our services will be:

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



Northern Care Alliance NHS Group vision and objectives *continued*

Our Priorities 2018/2019

NHS
Oldham Care Organisation
Northern Care Alliance NHS Group

Saving lives, Improving lives

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

Oldham Care Organisation Priorities

1) We will demonstrate continuous improvement towards our goal of being the safest health and social care organisations in England

This means
- Reductions in core patient and / user harms each year
- Improvements in mortality indices each year
- Achieving CQC rating of Good or Outstanding.

In order to achieve this we will:
- Deliver the quality improvement (QI) strategy
- Implement streamlined venous thromboembolism (VTE) assessment
- Develop and embed safe surgery process
- Deliver the CQUIN programme
- Develop mortality review and reporting process
- Deliver reliable sepsis indicators and processes
- Implement Deteriorating Patient Collaborative
- Deliver continuous improvement plan to support CQC actions and requirements
- Develop awareness and training programme with quality improvement team.

2) We will improve patient and care pathways to deliver improved prevention, earlier diagnosis, earlier treatment and earlier discharge

This means
- Our patients will access our hospitals less and go home sooner
- We will contribute to health and wellbeing in our locality
- Work closer with partner organisations.

In order to achieve this we will:
- Develop care pathways for adults and children in association with key partners (CCGs & Councils)
- Implement reliable systems to improve patient flow
- Participate in the integrated children's boards
- Participate in the local Health and Wellbeing Board
- Provide clear leadership to the LCO development group
- Lead the Northern Care Alliance NHS Group (NCA) redesign programme for critical care services in collaboration with GM's Healthier Together.

3) We will continuously improve our efficiency and productivity and work with partners to deliver sustainable financial plans

This means
- Improved financial performance year on year
- Operational efficiency and workforce productivity metrics are met each year.

In order to achieve this we will:
- Develop effective theatre utilisation plans
- Deploy robust job /workforce planning processes
- Participate in the booking and scheduling review
- Establish group to improve performance against metrics available in the Model Hospital
- Deliver reliable and effective medical and nursing rotas
- Implement robust booking and approval process for agency usage
- Develop effective absence management systems.

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

This means
- More people will recommend us as a 'Place to work' and 'Place for Care' each year
- We will deliver training, coaching and talent development plans.

In order to achieve this we will:
- Implement the Contribution Framework
- Implement the Northern Care Alliance NHS Group (NCA) Recruitment and Retention strategy
- Deliver a programme of engagement sessions for all staff
- Implement the NCA talent management and medical engagement programme
- Access the Band 6 and 7 development programme.

5) We will ensure good operational planning & execution to deliver our agreed plans & standardise processes across the Northern Care Alliance

This means
- Delivering urgent, planned and cancer care improvements to achieve our targets
- Developing and implementing Standard Operating Models to eliminate unwarranted variation.

In order to achieve this we will:
- Deliver cancer improvement work
- Deliver a digestive diseases improvement plan
- Deliver an urgent care improvement plan and workstreams, supported by quality improvement (QI)
- Implement Gooroo modelling tool and act on findings
- Participate in the Urgent Care Alliance Board and develop pathways
- Implement standard operating models as developed and remove variation in care.

6) We will embed changes resulting from NCA strategies and deliver new ways of working through excellence in change management

This means
- Reliably delivering our plans so that benefits can be achieved in agreed timescales.

In order to achieve this we will:
- Participate in the development of clinical services and enabling strategies across the Northern Care Alliance NHS Group (NCA)
- Work with partners to implement agreed NCA strategies across the Care Organisation
- Establish Care Organisation change programme boards, ensuring a robust change management process using quality improvement methodology.

Our Alliance Priorities:

1. Pursue quality improvement to ensure safe, reliable and compassionate care
2. Improve care and services through integration, collaboration and growth
3. Deliver the financial plan to assure sustainability
4. Support our staff to deliver high performance and continuous improvement
5. Deliver operational excellence
6. Develop and implement our Service Development Strategy and the Northern Care Alliance enabling strategies

Our services will be:

- **Evidence based** and of the **highest quality**
- **Highly reliable:** high quality whatever the day of the week or hour of the day
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- **Trusted:** providing safe, effective and compassionate service
- **Connected:** seamlessly delivering what matters most to people and communities
- **Pioneering:** continuously innovating and improving services.

Northern Care Alliance NHS Group vision and objectives *continued*

The Pennine Acute Hospitals NHS Trust Head Office is at:

Chief Executive's Office
North Manchester General Hospital
Delaunays Road
Crumpsall, M8 5RB

Tel: **0161 624 04020**
Email: **enquiries@pat.nhs.uk**

Performance overview from the Chairman and Chief Executive

This report provides us with the opportunity to highlight Pennine Acute Hospitals NHS Trust's (Pennine) main developments to services and the improvements we have made to care over the past year, whilst also reporting on how Pennine have performed against key national and locally determined clinical standards, waiting times and our key quality improvement priorities.

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

2018/19 was an extremely proud year for Pennine.

On 1 March 2018, the CQC published its latest report and findings following the unannounced inspection of services across Pennine in October and November 2017. The CQC found significant improvements across every hospital run by Pennine, with 70% of the aspects of the services inspected now rated as either 'Good' or 'Outstanding'.

During 2018/19 continued improvement has been made addressing the 'must-do' and 'should do' actions identified during the inspection.

We marked another key milestone throughout the year: the 10 year anniversary of the introduction of our pioneering Nursing Assessment and Accreditation System (NAAS). Nursing colleagues from across all of our Care Organisations took the opportunity to recognise what the scheme has brought to Pennine, its staff and our patients by appearing in ten short clips to explore different aspects of the scheme, for example, how the scheme has been successfully shared from Salford Royal to Pennine and a focus on some of wards who have achieved or are close to achieving SCaPe (Safe, Clean and Personal everytime) status.

2018/19 ended with a change of leadership at Pennine and the NCA. Sir David Dalton retired from the organisation on 31 March after leading Pennine for three years, and Salford Royal for 18, leading to the formation of the NCA. Sir David's tremendous contribution to Pennine and the NCA was paid tribute to, along with the significant impact and influence he has had on the NHS both regionally and nationally.

Raj Jain succeeded Sir David as the NCA and Pennine's new Chief Executive and, as the previous Group Chief Strategy and Organisational Development Officer, stepped into his new role on 1 April 2019.

Demand for our services

Over the last year, Pennine, like the rest of the NHS, has experienced increasing pressure and demand on services. Patient attendances to its Emergency Departments and hospital occupancy rates have been high.

Staff have worked incredibly hard to ensure patients are getting timely access to care, however, Pennine was unable to achieve key access standards in 2018/19 including the 95% Emergency Department standard for treating patients within 4 hours, with an overall performance for Pennine of 84.01%.

Further information regarding Care Organisation performance is included in the Performance Analysis section.

Pennine's financial position for 2018/19 was an operating deficit of £65.4m.

2018/19 Highlights

Global Digital Exemplar progress

Pennine has been given the go ahead to deliver an exciting new programme of digital health technology and electronic patient pathways by NHS England by partnering with Salford Royal to become Manchester's first Global Digital Exemplar (GDE) Fast Follower organisation. The NHS Global Digital Exemplar (GDE) programme is a national initiative which aims to improve digital maturity across the NHS.

Stroke SSNAP

Stroke services at Fairfield General Hospital in Bury were ranked as amongst the very best in the country according to official data compiled by the Royal College of Physicians for its Sentinel Stroke National Audit Programme audit.

CQC Maternity

A Care Quality Commission (CQC) survey of women who gave birth at The Royal Oldham Hospital and North Manchester General Hospital in 2018 revealed a marked improvement in their experience when compared to the same survey carried out in 2017. Overall, the CQC survey showed 12 questions with improved scores when compared to 2017's results.

Significant risks

The Board Assurance Framework (BAF) is a tool for the Group CiC and Care Organisations to assure themselves (gain confidence, based on evidence) about the successful delivery of governing objectives. The risks identified in the BAF are based on a collective assessment by the Directors of the environment in which the organisation operates. It is also informed by high-scoring risks identified locally through the day to day operation of the Care Organisations and that may impact on the achievement of objectives.

The key risks to which the NCA and the North East sector Care Organisations were exposed in 2018/19 largely reflected those faced in 2017/18 and were in relation to the following areas:

- Planned income levels and expenditure controls
- Developing and delivering an effective productivity improvement and cost reduction strategy
- Remodelling the workforce to deliver new models of care
- Compliance with access standards
- IM&T clinical systems and technical infrastructure
- Estate investment to remedy safety risks identified in North East Sector Care Organisations

The BAF was maintained by the Group CiC and Care Organisation leaders throughout 2018/19, enabling the identification, analysis and management of risks to the delivery of principal objectives in-year. Controls and assurances were assessed and action plans were developed and implemented appropriately. This has provided clear sight of significant risks and ensured action was prioritised appropriately.

Going concern assessment

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

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

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

Finally, we are pleased to confirm that the Board of Directors has reviewed this 2018/19 Annual Report and Quality Report and confirm that it is an accurate and fair reflection of our performance. We hope that this Annual Report provides you with a clear picture of how important quality improvement, safety and service user and carer experience are to us at Pennine and across the NCA.

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

Raj Jain
Chief Executive
Date: 24 May 2019

James J Potter
Chairman
Date: 24 May 2019

Performance analysis

Priorities, governing objectives and outcomes are developed collectively by Group CiC, and provide a common framework for all Care Organisations and Corporate functions to work within. This ensures that the Northern Care Alliance NHS Group (NCA) and Pennine both delivers its mission to "Save Lives, Improve Lives by delivering highly reliable services at scale, which are trusted, connected and pioneering", and fulfils its statutory duties. Key Performance Indicators (KPIs) are set appropriately at an NCA and/or Care Organisation level to provide assurance that national, regional and local performance standards are being attained and strategic and transformation programmes delivered and coordinated at all levels.

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

An integrated reporting approach is used by the Group CiC to ensure that the impact on all areas of the NCA and its Care Organisations is understood, including patient, clinical, staffing, financial and regulatory perspectives. A 'High Level Performance Dashboard' of the most important metrics and risks, including historical trend analysis and external benchmarks where available, is reviewed on a monthly basis by the Group CiC.

The dashboard is supported by a suite of granular reports and assurance flows, including the Chief Executive's Report, Cost Improvement Programme, Finance and Activity and Strategic Programmes. A quarterly Quality Improvement Dashboard and Learning from Deaths Report, alongside a six-monthly Learning from Experience Report (including incident management and complaints) and Patient and Service User Experience Report are reviewed. Most recent a quarterly People Report has been considered by Group CiC; this will continue throughout 2019/20.

The performance of Care Organisations is reviewed through the Group Single Oversight Framework, which identifies where Care Organisations will benefit from improvement support and intervention across the five areas highlighted below; a sixth cross cutting theme of Leadership, Behaviours and Culture will be included during 2019/20:

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

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

This section of the Performance Report provides a detailed analysis of the NCA, specifically including North East sector (Pennine) Care Organisations' performance where appropriate, in relation to each priority and objective. It conveys achievements, challenges and any actions taken to address these.

Delivery of the 2018/19 Annual Plan

THEME 1

Pursue Quality Improvement to assure safe, reliable and compassionate care

Key priorities and objectives

1 Demonstrate continuous improvement towards our goal of being the safest health and social care organisation in England

One of Pennine's fundamental aims is reducing avoidable mortality. Headlines regarding progress in achieving this in each of the North East Sector Care Organisations are highlighted below. Further detail, including the achievements in all quality improvement work, can be found in the Quality Report section of the Annual Report.

Bury & Rochdale Care Organisation

Hospital Standardised Mortality Rate (HSMR) for 2018/19 for the Bury & Rochdale Care Organisation is statistically better than the expected level. The Standardised Hospital Mortality Index (SHMI) for Fairfield General Hospital is worse than expected, although showing signs of improvement, whilst SHMI for Rochdale Infirmary is better than expected.

In April 2018 Bury and Rochdale Care Organisation set a target to reduce 'no and low' harm falls by 10% during the year. During Quarter 3 and 4 2018/19, a 21% reduction in 'actual falls' was achieved in comparison to Quarter 3 and 4 2017/18. There has also been a 6% reduction in falls by patients with a cognitive impairment compared to the previous year.

Oldham Care Organisation

HSMR for the Oldham Care Organisation saw an increase during 2018/19, although this was still statistically below the expected level. SHMI for Oldham Care Organisation has remained consistent during 2018/19 and is at the expected level.

Much work has taken place within the Oldham Care Organisation to reduce pressure ulcers and *C-Difficile*. Despite this focus *C-Difficile* infections increased slightly from 18 in 2017/18 to 20 in 2018/19. There has also been a small increase in pressure ulcers from a total of 77 in 2017/18 to 84 in 2018/19. A detailed update can be found in the Infection Control Collaborative and Pressure Ulcer Collaborative project pages in the Quality Report.

During 2018/19, Oldham Care Organisation developed plans to embed the World Health Organisation (WHO) checklist (for safer surgery) in general theatres and a parallel process for maternity theatres. Between April 2018 and March 2019, 96.8% of surgical sessions at Royal Oldham Hospital included a WHO briefing and 100% included a WHO debriefing.

North Manchester Care Organisation

HSMR for North Manchester Care Organisation improved during 2018/19 and is now statistically better than the expected level. SHMI is also better than the expected level.

In addition, there have been positive reductions in *C-Difficile*, pressure ulcers, and falls leading to moderate/severe harm. *C-Difficile* reduced from 43 during 2017/18 to 34 during 2018/19, with pressure ulcers reducing from a total of 91 in 2017/18 to 78 in 2018/19.

Arrangements for monitoring improvements in the quality of healthcare, and progress on action plans from Care Quality Commission assessments

In March 2018 the Care Quality Commission (CQC) published their most recent report in relation to the quality of care and management of Pennine following a comprehensive inspection in October/November 2017. The outcome of the inspection found that Pennine had improved across all services and hospitals with 70% of services rated as 'Good' or 'Outstanding'.

Ratings for the whole Trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↑ Feb 2018	Requires improvement →← Feb 2018	Good →← Feb 2018	Requires improvement →← Feb 2018	Good ↑↑ Feb 2018	Requires improvement ↑ Feb 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
North Manchester General Hospital	Requires improvement ↑ Feb 2018	Requires improvement →← Feb 2018	Good →← Feb 2018	Requires improvement →← Feb 2018	Good ↑↑ Feb 2018	Requires improvement ↑ Feb 2018
The Royal Oldham Hospital	Requires improvement ↑ Feb 2018	Requires improvement →← Feb 2018	Good →← Feb 2018	Requires improvement →← Feb 2018	Requires improvement ↑ Feb 2018	Requires improvement ↑ Feb 2018
Fairfield General Hospital	Requires improvement →← Feb 2018	Good ↑ Feb 2018	Good →← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Rochdale Infirmary	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016

Since the publication of the report comprehensive improvement plans have been developed, to address the recommendations made by the CQC at this time. Each Care Organisation across Pennine has developed strong systems to monitor progress against the CQC 'Must' and 'Should' do requirements identified in the report, with regular monthly assurance meetings to ensure progress is being made.

An overarching NCA CQC Action Plan is reviewed quarterly via the Group CiC to ensure the Executive and Non-Executive Directors are assured of progress and aware of identified risks to implementation and completion.

Significant progress has been made across all three Care Organisations in addressing the 'Must' and 'Should' do requirements.

North Manchester Care Organisation

At North Manchester Care Organisation, the CQC inspected:

- Urgent and emergency care
- Medical services
- Maternity and services for children and young people
- Surgical services

Key successes of the Improvement Plan

- A strengthened response to the workforce challenges with innovative approaches to recrutiment including overseas recruitment events and joint appointments in hard to recruit specialties
- A reduction in agency spend
- Achievement of trajectories for key areas of harm, including infection control, pressure ulcers and falls
- Successful implementation of E-Observations
- Successful implementation of the Nursing Assessment and Accreditation System (NAAS), with 60% of wards rated as 'Green' or 'SCaPe' status
- A theatre working group to support improvements in compliance and processes with the WHO (World Health Organisation) checklist *and*
- Mortality Reduction

Oldham Care Organisation

At Oldham Care Organisation, the CQC inspected:

- Urgent and emergency care
- Medical services
- Surgical services and critical care
- Services for children and young people

Key successes of the Improvement Plan

- Strengthening systems to address the workforce challenges, with on-going recruitment events and improved recruitment processes, including development of additional roles such as the Trainee Nurse Associate, and improved nursing retention rates
- Improvement in paediatric pathways within the Emergency Department
- A theatre working group to support improvements in compliance and processes with the WHO (World Health Organisation) checklist
- Further improvement to risk processes, in particular incident reporting and management, risk assessment and registers, and effective management of complaints *and*
- Engagement of staff in quality improvement projects across the organisation including the management of deteriorating patients, pressure ulcer reduction and ending PJ paralysis

Bury & Rochdale Care Organisation

At Bury & Rochdale Care Organisation, the CQC inspected:

- Urgent and emergency care
- Medical services
- Surgical services

Key successes of the Improvement Plan

- Statistically significant reduction in avoidable falls
- Implementation of revised and improved paediatric assessment documentation in the Emergency Department
- Safeguarding Improvement Board – Evidence based improvements focussed on the Emergency Department
- Improved storage and documentation of medicines
- Overall improvements in Registered Nurse staffing levels
- Improvements to the viewing room for recently deceased patients at Fairfield General Hospital *and*
- Enhanced privacy in the Emergency Department triage area at Fairfield General Hospital

Pennine participated in the following special review undertaken by the CQC in September 2018:

- Reviewing of Safeguarding in the Emergency Department at Fairfield Hospital as part of the CQC health economy wide *'Children looked after and safeguarding reviews'*

Further details and actions taken to address improvements can be found in the Quality Report within the Annual Report.

Concerns, complaints and compliments

The Patient Responsiveness Team at Salford Royal and Pennine came together under one management structure during 2017/18. Demonstrable benefits of this joint working have been seen during 2018/19, not only in economies of scale by operating as one team but more importantly in the efficient way in which we are now able to resolve concerns received from patients, relatives and carers. The NCA Patient Responsiveness Team has allocated dedicated Complaints Case Handlers to work alongside and support each Care Organisation. By working directly with Care Organisation Divisional Teams, the investigation of concerns and compilation of meaningful responses can be undertaken within improved timescales.

Learning is captured from every complaint or concern, and is fed back to Care Organisations through the monthly Patient Responsiveness Report, along with a newly developed C.A.R.E training package (C=Compassion, A=Attitude, R=Responsive, E=Evidence) which is delivered to staff at ward and department level. The Patient Responsiveness Team is able to gather the views of a large diverse, cross-section of the population served.

This rich feedback is useful when developing or planning services. In addition, compliments are gathered on every ward and department, via the PALS Service or the NCA website. These are an important source of feedback from our patients and service users and are distributed to the relevant ward or department to celebrate successes.

Performance during 1 April 2018 to 31 March 2019 for Pennine:

1068	Total number of complaints received during the year
3525	Total number of PALS cases received during the year
1157	Total number of compliments received
69%	% of complaints acknowledged against the 3 working day target
72%	% of complaints responded to within the agreed deadline

Patient and Carer Experience and Service Improvements

Delivering 'What Matters Most' to the people that use our services, their carers and families

Evidencing that we are a caring and responsive organisation is a key priority for the NCA. It is part of the vision of quality improvement to deliver the safest and highest quality health and social care and is reflected within our values. We aim to achieve this vision by being a listening and learning organisation and to provide user driven care focussing on 'What Matters Most' to the people that access the services we deliver.

How do we gather feedback?

To ensure we are continually improving patient and service users' experience, we use a variety of ways to monitor performance and progress, and to obtain feedback. These include local and national surveys, comments from the Friends and Family test, Patient Stories, NHS Choices, engagement events, internal assessment processes and quality improvement projects. We take the approach that improving experience is everyone's responsibility, therefore we aim to embed this approach across all the services we deliver.

During 2018/19 we have continued to implement some fantastic examples of locally developed feedback, such as: 'Tops & Pants', to enable children and young people to feedback their experiences); and Feedback Trees and Glimpses of Brilliance, where staff or patients can nominate staff who they believe have delivered great care and treatment.

We work in partnership with a variety of key stakeholders, for example Healthwatch and Carers groups, to identify areas for improvement, and have a number of on-going joint programmes of work. A number of services support their own patient/service user groups which support us in developing new services and providing peer to peer support. A great example of this is North Manchester Maternity Voices group, which has worked in partnership with the Maternity Experience Lead Midwife to improve experiences of care.

During 2018/19, North East Sector Care Organisations piloted the Observe & Act scheme, a real-time feedback tool adopted from Shropshire Community Health Trust, that enables the independent capture of feedback through the eyes of patients and carers. It focuses on a number of non-clinical outcomes such as wayfinding, the environment, dignity and respect, food and drink, and direct feedback from services users/carers. This model will be developed further during 2019/10.

In addition, the Patient Responsiveness Team regularly conduct ward walk arounds across the Care Organisations to inspect the 'Open & Honest Care Boards' and ensure that the 'You said, We did' approach is being implemented.

What does this tell us about patient & service experience?

National Inpatient Survey

Headlines from the 2017 National Inpatient Survey Results (results are scored either; 'worse', 'about the same' or 'better' compared with most other Trust's in the survey) include:

- Of 8 out of the 11 section scores, Pennine performed 'about the same' when compared to most other Trusts that took part in the survey and 'worse' in 3 section scores
- Staff were invited to attend action planning sessions, where they undertook a 'deep dive' of their results and identified key areas for improvement based on historical and average scores and areas of good performance
- These results have been reviewed by each Care Organisation to align this information to existing and emerging quality improvement programmes of work

HealthWatch reports

Pennine welcomes its close partnership work with local Healthwatch organisations and the rich feedback it gains through their 'Enter and View' reports. In 2018/19, we received a number of reports across various services, including Maternity Services (North Manchester & Oldham), Haematology Day Unit F11 (Oldham) and Antenatal Services (Oldham), which identified areas of good practice and key areas for improvement. Reports are shared directly with the services to enable them to develop action plans and discuss the outcomes with staff. Specifically as a result of engagement with HealthWatch organisations, a working group will be set up by the Estates and Facilities division to develop a joint approach to wayfinding and signage solutions.

Listening and acting on feedback: You Said, We Did

While gathering a variety of feedback is essential, using this feedback to drive improvements is at the very heart of us demonstrating that we are a listening and learning organisation. Across Pennine we are in the process of setting up locally focussed patient and service user experience committees to ensure that they can evidence locally driven examples of 'you said, we did'.

Some examples of patient experience improvements:

- There were no wheelchairs available at North Manchester main entrance - The Estates team has purchased a new set of wheelchairs which have been identified for use in this area
- Lack of support and information for carers. Through joint working with Manchester Gaddum (an independent voluntary sector organisation) a number of support training sessions are being piloted at North Manchester, and carers information boards have been installed
- Improved ways to give feedback - Four wards at Bury & Rochdale Care Organisation are trialling the use of patient/visitors comments books
- Long waits in the haematology department at Oldham - The unit has undertaken a number of improvements from this feedback through a recent HealthWatch Report, including the purchase of new comfortable chairs and more reading materials

Working with women, children and young people

Over recent years, a number of opportunities for joint working have been identified with local school children. These were delivered in 2018, and included art work in the maternity department and the development on the labour ward at the Oldham Care Organisation of a dedicated butterfly bereavement suite to provide a quite area for women and their families who have lost a child in childbirth. The students from North Chadderton High School in Oldham have created artwork to complement the butterfly theme.

Other examples of you said, we did include:

- Water dispensing machines installed in Children's Outpatients
- Families of children with complex needs found it difficult to care for their children in existing rooms in the Children's Department - the service undertook a review of the unit and identified a dedicated space for these families with additional support facilities

Improving and stabilising IM&T infrastructure

The current IM&T infrastructure across Pennine is limiting the ability to optimise the patients' journeys, and properly manage and inform population health. At the beginning of the year, the Group CiC prioritised and committed an initial investment of £17m in IM&T to provide the much needed technology refresh. In the short term this would improve access to clinical systems whilst reducing service outages and improve patient safety by the avoidance of cancellations or diversions caused by IM&T system failures. By improving core infrastructure, Pennine will then be able to drive plans to implement a new Electronic Patient Record and improve informatics data central to improving services for patients. In addition, this will allow the Care Organisations to play a more pivotal role in being able to share and transfer data across the Greater Manchester health economy, providing a more cohesive and coordinated service for the local population.

In September 2018, Pennine experienced a major IT network failure which resulted in the cancellation of around 600 operations and 50 non-urgent operations. The failure was the result of a core Local Area Network (LAN) fault and resulted in Business Continuity Plans being activated. Wards and departments reverted to paper based business continuity plans throughout the course of the subsequent days to assure patient safety. Immediate action was taken to ensure the exact issue would not happen again, and support contracts have been established to reduce the impact of any further hardware incidents. Not withstanding progress towards planned improvements in the range of IM&T communications, in November 2018, the Group CiC supported the acceleration of this work, specifically enabling the most impactful LAN elements of the infrastructure to be replaced in January 2019. The implementation will now run across three financial years due to its complexity and scale.

Implementing and adhering to the new General Data Protection Regulation (GDPR)

GDPR was introduced in spring 2018 as part of the reimagined Data Protection Act 2018. Many of the standards are similar to the previous Act but the requirements have been intensified. The NCA has a Privacy Notice for all staff and patients, with a plan to gradually produce these for specialist areas, such as Research & Development. The work of combining Salford Royal and Pennine governance polices into group-wide NCA policies has commenced to ensure that the governance standards are the same wherever an individual interacts with the NCA. Our 'Subject Access Teams' at Salford Royal and Pennine have also started to work together more closely, with plans for integration in 2019/20, thus bringing a single access route for patients and staff to access their own records. The NCA has a Data Protection Officer in post and this individual is also providing the role for the Greater Manchester integrated record.

THEME 2

Improve care and services through integration, collaboration and growth

Key priorities and objectives

1. **We will develop Group Shared Services functions to deliver scale, resilience, operational excellence and transformation for our Care Organisations and partners**
2. **We will grow and strengthen the Northern Care Alliance to ensure a sustainable future for our populations served**
3. **We will offer leadership, scale and technology to improve care and deliver the goals of our Care Organisations and their locality plans**

Diagnostics & Pharmacy services

Since its formation in September 2018, the NCA Diagnostics (Radiology and Pathology) and Pharmacy Group Business Unit have been progressing plans to transform the future of Diagnostics and Pharmacy services. A series of staff engagement sessions were held in November 2018 to help shape the future of the Business Unit, with colleagues in each specialty now working towards a single service vision, with a standardised operating model providing high quality patient services across all of our Care Organisations and beyond.

A key function of the group-wide service is to develop new ways of addressing the workforce challenges facing the three services of Pathology, Radiology and Pharmacy. Each of the services has its own transformation programme in place, with deep staff involvement to support new ways of working.

During 2019/20 we will be launching an NCA Radiology Academy, and have already introduced new clinical scientist roles in Pathology.

The NCA Diagnostics and Pharmacy Group Business Unit has commenced standardising processes, in particular risk management and equipment replacement plans, which will enable the organisation to take advantage of the opportunities of scale. In addition, the NCA Diagnostics and Pharmacy Group Business Unit continues to take advantage of new technologies through the exploration of digital pathology, artificial intelligence in radiology and robotics in Pharmacy. This includes the pilot of 'Pilltime', the automated dispensing of medications into pouches using a state of the art digital robotic system.

Through partnership working with the Care Organisations, the NCA Pathology and Radiology Services have supported the 18 week referral to treatment pathways, cancer pathways and urgent care targets by fulfilling efficient turnaround times. The challenge in these areas has been both an increasing level of demand, particularly in Radiology, and a demand for faster turnaround times due to greater numbers of urgent and cancer pathway cases. There will be a focus on the development of Rapid Diagnostics services in 2019/20, particularly to support cancer diagnosis.

Elective access transformation

In 2018/19 we launched a programme across our hospital sites to improve the quality of non-emergency care, so that patients can have a better experience accessing our services. Our vision is "to enhance digital and technology solutions to facilitate the transformation of elective access across the NCA to deliver improved outcomes, patient experience and maximise value for our population."

During 2018/19, we identified and analysed key issues across elective access, and categorised these into projects which are now underway at Pennine, including:

- Rollout of a 'Vacant Slot Report' to support full utilisation of available clinic slots; *and*
- Work in collaboration with services across all Care Organisation sites to find ways of increasing clinic utilisation across Elective Access

Procurement

The Procurement Team is now operating as a single procurement function across the whole of the NCA. The Procurement Team had a number of ambitious objectives in 2018/19, including: a savings target of £4m; implementation of standardised systems and processes to drive operational efficiency; and delivery of a joint strategic contracting process.

The Procurement Team exceeded the savings targets, with a total of £4.3m in year, as well as implementing standardised systems across the organisation, including eProcurement, eCatalogue and eTendering systems. Additionally, the national benchmarking system 'Purchase Price Index Benchmarking' (PPIB) was utilised to help drive further efficiencies ahead of negotiations with our suppliers.

Organisational development

During the latter half of 2018/19, the NCA began to explore the value and construct of a Learning Academy. An NCA Learning Academy for Health and Social Care would offer a structured educational framework, utilising innovative solutions to attract, train and retain its staff, and would become a professional leader in workforce development and transformation.

It is envisaged that the Learning Academy will support a workforce 'pipeline' that is agile enough to respond to changing models of care delivery, while delivering high value education and training that underpins the provision of safe, caring, and exemplary quality care. The outcomes from this initial discovery phase will now inform a full business case to develop this exciting new model.

- **We will ensure a safe and sustainable future for the Care Organisations of Salford, Bury, Rochdale, and Oldham, and collaborate with the City of Manchester and NHSi to secure transition of North Manchester**

Building on the quality and safety improvements we have delivered as the NCA since April 2017, good progress has been made during 2018/19 to progress the NHS Improvement (NHSI) transaction process, overseeing the preferred acquisition of the Oldham, Rochdale and Bury Care Organisations by Salford Royal, and the preferred acquisition of North Manchester Care Organisation by Manchester Foundation Trust (MFT).

As planned this year, Salford Royal's Board of Directors approved and submitted a strategic case to NHSI outlining how we intend to bring additional benefit to the patients and populations of Salford, Oldham, Bury and Rochdale. We firmly believe that the acquisition of Oldham, Bury and Rochdale by Salford Royal will enable us to develop and strengthen our clinical services, improve patient experience through digital technology, provide opportunities for staff and reduce the cost of back-office support services.

Moving on to the next phase of the process, Salford Royal is now developing a full business case as part of a transaction process. The business case will plan for and deliver significant, accelerated benefits across the populations of Salford, Bury, Rochdale and Oldham. At the same time we are working closely with our partners to ensure the safe transition of North Manchester Care Organisation to MFT. The transaction process is expected to conclude in the second half of financial year 2019/20.

- **Improve patient and care pathways to deliver improved prevention, earlier diagnosis, earlier treatment, and earlier discharge across the system (including care at home or in a supportive environment)**

Work has continued with commissioners and partners throughout 2018/19 to plan for the transfer of community health services from Pennine Care NHS Foundation Trust (PCFT) to the NCA in the first half of 2019/20, with shadow management arrangements in place from April 2019. Services will be deployed into the appropriate Care Organisation for operational management and governance. Headlines regarding Local Care Organisation (LCO) development across the localities is as follows:

Bury

Towards the latter end of 2018/19 a Mutually Binding Agreement was signed by all partners across the Bury LCO, which includes the NCA, Pennine Care NHS Foundation Trust, Bury Metropolitan Borough Council, Bardoc, the GP Federation and the Voluntary Sector. The agreement outlines how those services which are 'in scope' will be managed through single line-management arrangements within the LCO, with effect from April 2019.

It has been agreed that the NCA will host the LCO for the duration of 2019/20. The Bury LCO will be prioritising prevention and transformation of urgent care, and developing integrated health and social care teams.

Rochdale

Rochdale LCO arrangements continue to operate under the brand of One Rochdale Health and Care. In 2018/19 Rochdale LCO has continued with its oversight of transformation funded service initiatives, and successfully launched an innovative Primary Care Academy. Throughout 2019/20 priority work areas will include further development of integrated neighbourhood working, integrated and improved mental health and wellbeing, along with extending the contract scope of current LCO arrangements.

Oldham

Oldham Care Organisation continues to be an active member of several boards, including: the Oldham Care Alliance Board, which oversees implementation of Integrated Care in Oldham; the Health & Wellbeing Board; and the Integrated Children's Board. Engagement in all of these forums enables us to work together with primary care, community and social care services. Oldham Care Organisation, alongside commissioners, have planned and delivered urgent care workshops to make improvements to emergency and urgent care services, and the Oldham Care Organisation Senior Leadership Team has also attended clinical strategy workshops to create a 'shared hospital service.'

North Manchester

The North Manchester Community Services successfully transacted over to the Manchester Local Care Organisation in April 2018 with community staff formally transferring over on 1 July 2018. North Manchester Care Organisation has continued in its support of the transition throughout 2018/19, including the provision of back office support to the fledgling organisation. This support will continue in 2019/20.

THEME 3

Deliver the financial plan to assure sustainability

Key priorities and objectives

1. **We will demonstrate continuous improvement in operational and workforce productivity and efficiency**
2. **We work with partners to ensure financial plans are sustainable and deliver on our annual income and expenditure budgets**

Summary of financial performance 2018/19

The main headlines of financial performance for Pennine in 2018/19 were:

- The deficit used for measuring NHS performance i.e. excluding impairments and donated assets adjustment is £65.4m which is £3.5m better than plan
- The overall income and expenditure position shows a deficit of £128.2m but this is after accounting for a number of non-operational items. These are set out in the table on page 27
- The financial risk rating (Use of Resources rating - UoR) using NHS Improvement's methodology to assess the level of financial risk based on the position at the end of March 2019 is a 3, the maximum rating for a Trust in deficit and which indicates that mandated and targeted support is required

Statement of comprehensive income position

This statement within the annual accounts shows the total value of income and expenditure for the year ended 31 March 2019. The following table summarises the actual income and expenditure performance as at 31 March 2019.

	Actual results £000's
Income	660.4
Expenditure	(695.2)
Earnings before interest, tax, depreciation and amortisation	**(34.8)**
Exceptional Income / costs and impairments	(63.0)
Depreciation and amortisation	(23.0)
Total interest receivable / (payable)	(2.7)
PDC dividends	(4.7)
Net deficit (per annual accounts)	**(128.2)**
Normalising Adjustments	0.2
Net impairments and accelerated depreciation of non-current assets	62.6
Operating surplus	**(65.4)**

Income

Income from patient care activities has increased by £11.2m from 2017/18. This is primarily driven by a growth in demand for urgent and unplanned clinical activity.

Expenditure

Operating expenses have increased by £35.8m (excluding the impact of impairments of property, plant and equipment) when compared to 2017/18. The increase in operating expenses is driven by inflationary increases in pay and non pay expenditure, new contracts with Commissioners and growth in demand for urgent and unplanned clinical activity.

Pay costs for Pennine have increased by £25.1m from 2017/18. The majority of which is related to the 2018/19 inflationary pay award to staff and new contracts with Commissioners. Pennine continues to experience financial pressures arising from the use of temporary staff due to the difficulties recruiting frontline clinical staff and in particular medical staff.

Capital expenditure 2018/19

In 2018/19 Pennine spent £35.1m in maintaining and improving the physical estate of our hospitals and to develop frontline clinical services. The table below summarises the capital investment during 2018/19.

Heading	Capital Investment £ million
Supporting enhanced Clinical Service Delivery and hospital infrastructure	8.8
Replacing our medical and scientific equipment including new scanners, theatre equipment and mammography machines	10.3
Enhancing our IM&T infrastructure to better support efficient and effective service delivery	11.7
Maintaining and upgrading our estate and buildings	4.3

Accounting policies

Pennine reviews its accounting policies on a regular basis, following the requirements of the International Reporting Standards and the Department of Health and Social Care Group Accounting Manual. These policies are reviewed and approved by the Audit Committee and reflect the changing nature of the guidance and the external environment within which the Trust functions.

Pennine's key accounting policies are set out in the annual accounts included in this report. The accounts have been prepared on a Going Concern basis for accounting purposes in line with Department of Health and Social Care (DHSC) guidance. Further details are provided in the annual accounts.

There were a small number of changes made to the accounting policies in 2018/19 particularly with regard to updates for IFRS9 Financial instruments (superseding IAS 39) and IFRS15 Revenue from contracts with customers (superseding IAS 11 and IAS 18).

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

Post balance sheet events

There are no significant post balance sheet events.

A look forward

Pennine continues to operate in a very challenging financial environment and is working with its healthcare partners, in particular the local North East Sector Commissioners and the Greater Manchester Health and Social Care Partnership, to plan for the future. Pennine's financial plan for 2019/20 was submitted to NHS Improvement in May 2019.

The financial plan for 2019/20 is a deficit of £24.5m in line with the control total proposed by NHSI. The financial plan reflects national planning guidance in addition to:

- A stretching cost improvement target of £19.7m (2.9% of turnover)
- Continued investment to improve quality and address recommendations from the CQC report
- Contracts signed with commissioners
- The impact of CCG locality plans regarding anticipated population growth, along with schemes to treat more patients in the community in order to address the growing demand on acute hospital services

Achieving financial efficiency through the Better Care at Lower Cost Programme is increasingly challenging given the increasing demand for our services and the required investment in improving the quality of service delivery. There will be a strong focus in 2019/20 on delivering the planned savings of £19.7m which relate to improving quality and productivity.

Investment will continue in Pennine's asset base, with an investment of £46.3m. Investment is planned in the completion of the Intermediate Care Facility on the NMGH site, replacing essential medical and IT equipment and in the maintenance and upkeep of our buildings.

THEME 4

Support our staff to deliver high performance and continuous improvement

Key priorities and objectives

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

In June 2018, the Group CiC adopted a People Strategy, which is driven by, and aims to contribute to, the achievement of the objectives of the NCA and Care Organisations through strategies for Leadership and Culture, Contribution Framework 2.0, Talent Management, Learning & Organisational Development and HR Policies & Sourcing.

At the heart of the People Strategy is the aim to embed an inclusive culture based on the NCA's core values and behaviours and characteristics of a high reliability organisation.

Leadership and culture

During 2018/19 an NCA wide Leadership Model was developed, defining the key areas of delivery, along with the mindset, skills and behaviours our leaders need.

The Leadership Wheel (Figure 1) aligns to our NCA Values (Figure 2) and was presented to 150 senior managers at a Leadership Summit held in November 2018.

The Organisational Development team is now embarking on wider staff engagement to ensure buy in to the NCA values and leadership behavioural frameworks, through:

- Pilot of a leading-edge social media platform (NCAexplore) which provides opportunities for extensive online engagement with 500 staff (including generally hard to reach staff) about our values. NCAexplore is also hosting a 'Let's Talk Leadership' online forum to engage leaders around our mindset, skills and behaviours
- Additional non-digital programme of engagement to ensure wider reach, including the promotion of NCA values in all new staff induction programmes, roving reporters gathering stories, and focus groups being held with different staff groups *and*
- Developing a structured process for stakeholder communications and engagement with Care Organisations, Corporate Functions, Staff Side and other key staff groups, to ensure the models and frameworks developed are embedded across the organisation

Figure 1. NCA Leadership Wheel

Figure 2. NCA Values

Our four NCA values are being brought to life through a programme of communications and engagement that will mean the mindset, skills, and behaviours described in our behavioural frameworks deliver our vision of Saving Lives and Improving Lives for patients and communities as well as resonating with staff throughout the NCA.

Contribution Framework 2

2018/19 saw the launch of Contribution Framework 2.0 (CF2) across Pennine. This is a culture change programme supporting leaders to:

- Create team and individual objectives aligned to strategic priorities and objectives
- Coach all staff to reach their potential *and*
- Engage their teams by ensuring everyone has priorities that are aligned and connected to patient care and service excellence

CF2 is a system of regular, meaningful conversations between leaders and their staff, with training of some 6,500 leaders now underway. Trajectories have been put in place for each Care Organisations & Diagnostics & Pharmacy Group Business Unit to improve socialisation of the CF2 system.

Talent Management

2018/19 was a period of testing Talent Management methodologies and approaches across the NCA. The focus in the first instance has been on identifying and assessing Executives and Senior Leaders in Care Organisation and Group roles, with 126 'talent nominees' identified. Key learning from this initial cohort is being fed into a Talent Management delivery proposal for 2019/20.

Talent Management work this year has highlighted the need for:

- A digital solution to support the effective implementation of Talent Management at scale *and*
- continuing consultation with stakeholders, staff and associated groups to ensure the Talent Management ethos developed is fit for purpose

Workforce sourcing and utilisation

Like many other organisations in the NHS, Pennine has experienced difficulties trying to attract talent and has recognised the need to change its workforce sourcing model. The NCA developed a programme to transform our current recruitment arrangements and work towards our ambition to establish and promote Pennine and the NCA as an employer of choice, decrease the current deficit of nurses and medical staff (in particular), improve the volume and quality of candidates, improve the candidate and hiring manager experience and deliver best value now and in the future.

Our workforce sourcing plan now targets both active and passive candidates. There is a particular emphasis on the opportunities social media can bring, and we have significantly increased our followers and reach with great content on both Facebook and Twitter. International recruitment is also being used and we have seen success with our recent Indian nurse recruitment campaign.

The biggest impact of our targeted work can be seen in nursing, where our vacancy rate has reduced from 13.86% to 7.66% as at February 2019. We have also seen a steady reduction in the medical vacancy rate during 2018/19 and we now have dedicated support to recruit Allied Health Professionals and Healthcare Scientist staff groups.

THEME 5

Deliver operational excellence

Key priorities and objectives

1 We will ensure good operational planning and execution to deliver on our urgent care, cancer and elective plans and trajectories

Bury & Rochdale Care Organisation

Throughout 2018/19 Bury & Rochdale Care Organisation has focussed on working with Bury health and social care partners to improve urgent care pathways on the Fairfield General Hospital site. A significant piece of work was undertaken to reduce the average length of stay, particularly focussing on our more complex patients and their discharge from hospital. The primary focus of this work was to reduce the length of stay of the top 25 patients whose in-patient stay was the longest at any one time. This has resulted in a significant reduction in length of stay for this cohort of patients.

GP Streaming in the Emergency Department was introduced during 2018/19. After a number of tests of change, in which different streaming models were tested, the agreed streaming model was introduced in November 2018 with the introduction of the Urgent Care Treatment Centre. This is a jointly operated service between the Care Organisation, Bardoc and Bury GPs, and currently treats in the region of 60-70 patients per day, in conjunction with the pre-existing pathways for non-admitted patients.

The national standard target for emergency care is for 95% of patients to be seen within 4 hours. Throughout the year emergency care performance metrics for the Fairfield General Hospital, including performance against the 4 hour national standard target, have remained strong compared to Greater Manchester and national performance. Despite the aforementioned work, the national standard for emergency care was not achieved, with an overall performance for 2018/19 of 89.03%.

With respect to referral to treatment (RTT) for elective care, waiting times should not exceed 18 weeks for 92% of patients, with a further target applied where the size of the waiting list should not exceed the list size in March '18 by the end of March 2019. RTT performance at the end of March 2019 for Bury & Rochdale Care Organisation was 87.36% of patients seen within 18 weeks, this is 10.9% less than the March 18 baseline.

There have been no patients waiting over 52 weeks for elective treatment.

Oldham Care Organisation

Oldham Care Organisation continues to ensure good operational planning as it strives to deliver its key targets that focus on urgent care, cancer and elective plans.

During 2018/19, Oldham Care Organisation established a Patient Flow Improvement Board, aiming to improve performance against the 4 hour national standard target for emergency care, and to focus on the provision of efficient and effective patient care and getting patients back home as soon as possible. Performance for 2018/19 against the 4 hour national standard for emergency care was 76.79%.

A Cancer Improvement Board is now in place at Oldham Care Organisation, aiming to improve the services we provide to patients with cancer; this includes the 2 Week Wait Pathway for patients with the suspicion of cancer and the 62 day standard for cancer treatment. Improvements have been achieved in year for the 2 Week Wait Pathway, with 91.33% (February 2019) of patients receiving an initial appointment within 2 weeks of urgent referral for suspected cancer. This is slightly below the 93% compliance standard.

The Oldham Care Organisation is continuing to work with partners to improve the position regarding the 62 day standard for cancer treatment, with 58.95% of patients beginning their first definitive treatment within 62 days of referral, against the 85% compliance standard.

Significant capacity issues have conrtibuted to this under perfromance, particularly in upper and lower gastro-intestinal services. Improvement work continues across specific tumour groups and the number of long waiting patients is beginning to reduce.

With respect to referral to treatment (RTT) for elective care, RTT performance at the end of March 2019 for Oldham Care Organisation was 82.16% of patients seen within 18 weeks, this is 2% more than the March 18 baseline. This is a combined waiting list for Oldham and North Manchester Care Organisations.

North Manchester Care Organisation

2018/19 was a challenging year for the North Manchester Care Organisation, with demand for services increasing, along with difficulties in recruiting permanent staff. This adversely impacted on the Care Organisation's ability to achieve its access performance standards in relation to the 4 hour national standard target for emergency care, RTT and cancer. North Manchester Care Organisation worked hard throughout 2018/19 to enhance delivery of access standards.

With respect to emergency care, specific focus was placed on the delivery of the 'Making Safety Visible' Quality Improvement programme. The programme focussed specifically on activities to improve discharge planning, increase access for surgical patients by expanding the Surgical Triage Unit, and reduce the demand on the Emergency Department by streaming less clinically urgent patients through the 'Same Day Care facility'.

Whilst it was disappointing that the 4 hour national standard target was not achieved, with an overall performance of 73.84%, there were encouraging signs of improvement noted within all areas of the Making Safety Visible programme, and working relationships with mental health and social care partners have improved.

In addition to the capacity and demand and workforce challenges, the achievement of the RTT access standards was further complicated by the unforeseen closure of a number of theatres on the North Manchester Care Organisation site.

RTT performance at the end of March 2019 for North Manchester Care Organisation was 88.07% of patients seen within 18 weeks, which is 2% more than the March 18 baseline. This is a combined waiting list for the North Manchester and Oldham Care Organisations. Increased staffing capacity in challenged specialties has reduced the backlog of patients waiting to be seen on a waiting list. In 2019/20 further efforts and focus will be placed on expanding the workforce and exploring new and innovative ways of working. These include the roll out of "opt-in processes" to reduce the number of Do Not Attends, and Virtual Clinics to reduce the burden on Outpatient Clinic capacity.

In 2019/20 the North Manchester Care Organisation will continue to work with its partners to explore further opportunities to increase cancer access, with specific improvement programmes already in place for lung cancer and urology pathways.

A Cancer Improvement Board is in place at North Manchester, and this provides specific focus on technical areas such as the monitoring and validation of waiting lists and the improvement of booking and scheduling processes.

THEME 6

Develop and implement our Service Development Strategy and the NCA enabling strategies

Key priorities and objectives

1 With our partners we will determine future models of care and a sustainable service configuration to ensure clinical and financial sustainability

Over the last year, we have created our NCA Service Development Strategy (SDS) which solidifies our approach and priorities for Salford Royal and Pennine under the NCA's umbrella. The SDS describes how, in pursuing the NCA's vision, we will deliver more reliable, consistent, high-quality, safe and effective services, that meet the needs of our population.

The SDS has been developed in parallel with other closely-related programmes of work, including the North East Sector (NES) acute Clinical Service Strategy (CSS), the ongoing development of the North West Sector (NWS) Partnership and the Greater Manchester Plan (in particular Theme 3/ Improving Specialist Care). We are integrating health and care in each locality, as place-based care organisations improving population health.

Single Shared Services will be created for medical and surgical specialties, delivering significant benefits in improved experience, outcomes, workforce and finance. Our Specialist Centres will be supported to innovate, bringing benefits for the whole organisation and the populations we serve. Women's and Children's services will be enhanced, and Diagnostic and Clinical Support Services improved across the NCA.

Research and Innovation

Pennine is committed to research and innovation as a driver for improving the quality of care we provide to our patients. Only by carrying out research into "what works" can we continually improve treatment for patients, and understand how to focus NHS resources where they will be most effective.

Pennine currently supports 497 research studies, of which 159 are clinical trials involving medicinal products. Our engagement with clinical research demonstrates Pennine's commitment to testing and offering the latest medical treatments and techniques.

During 2018/19, we recruited over 32,000 patients to 165 National Institute for Health Research Clinical Research Network (NIHR CRN) research studies. This year, more patients from across Pennine participated in high quality NIHR research studies than in any other previous year. Furthermore, the NCA was the top recruiting NHS organisation to NIHR CRN studies in England, which is a fantastic achievement and demonstrates our commitment to high quality research.

Our reputation for attracting, initiating and delivering high quality industry trials has continued to grow this year. Our extensive collaborations with industry provide our patients with the very latest access to state of the art treatments and interventions. Our Bury & Rochdale and Oldham Care Organisations are both finalists in the Clinical Research Site of the Year category in this year's Pharmatimes Internal Clinical Researcher of the Year competition.

- **Service productivity is improved through digital transformation and the delivery of automation, clinical decision support and patient/user activation products**

GDE Fast Follower

As part of the national GDE Programme, in 2018/19 Pennine was appointed as a GDE Fast Follower organisation. Pennine aims to replicate a number of projects deployed at Salford Care Organisation to improve patient care systems across hospitals in Bury, Oldham, Rochdale and North Manchester.

Being a GDE Fast Follower provides Pennine with the opportunity to try, implement and, if necessary, modify and improve new technologies to support patient care following 'blueprint' principles and processes which have already been tested at Salford.

GDE Blueprinting

The wider aim of the GDE Programme is to develop national blueprints to share best practice across the rest of the NHS.

Salford's digital assessment tool to detect delirium and dementia has been rolled out as one of the first national NHS blueprints, and is helping patients and their families by accurately diagnosing more patients with delirium.

Future Digital Programme

Following on from the GDE Programme, the NCA has launched the Future Digital Programme to continue the development of digital maturity across the organisation. Based in the Digital Experience Centre at Salford Royal, the programme seeks to proactively test new digital initiatives and roll them out. More than 2,000 patients, partner organisations and potential suppliers have visited the Digital Experience Centre where new projects and initiatives are showcased and tested.

- **We will invest and reconfigure our estates and facilities to enable the delivery of an efficient and productive environment which improves patient and care experience**

Estates

2018/19 has been a period of transition for Estates and Facilities, cementing the NCA wide structure with operational delivery teams in each of the Care Organisations. A significant piece of work during 2018/19 was the alignment of contracts to provide better service efficiency and value for money.

Investment was committed to a new bespoke Computer-aided facility management (CAFM) system, linking our auditing and flow systems with our Estates Helpdesk and building management systems, and giving our Estates Teams full and accurate oversight of each site.

In 2018/19, work began to master plan the future use and make-up of the Pennine estate. A 4 Facet Survey was completed as part of the transaction process, highlighting areas of focus for backlog maintenance, physical condition and overall estates quality.

As a consequence of these surveys, which were conducted by external professional advisers in partnership with Greater Manchester Health & Social Care Partnership (GMHSCP), Pennine has been presented with a detailed understanding of the more pressing key estate risks, along with the actions needed to mitigate impact on safety and move beyond the temporary fixes which have been identified as "patch and repair".

These risks are considerable, and are the result of a lack of appropriate investment in the estate over a prolonged number of years. The North Manchester General Hospital and Royal Oldham Hospital suffer most from poor estate and infrastructure.

Key areas requiring immediate attention in the absence of significant long-term capital investment include:

- Fire Safety Systems
- Electrical Safety
- Water Safety
- Asbestos Management
- Medical Gases
- Lift Management
- Ventilation
- Nurse Call Systems
- Other Statutory Instruments

The NCA has concluded that it is imperative for appropriate investment to be made for all buildings to ensure compliance with statutory and other requirements and, at the end of 2018/19, requested emergency capital to address highest priority areas and maintain the safety of both staff and patients.

Emergency preparedness

As required by the Civil Contingencies Act 2004, Pennine has a responsibility to ensure that arrangements are in place for civil protection should an emergency occur. NHS England requires that Pennine is assured that it has tested major incidents and business continuity plans in place.service continuity risks are in place.

Emergency Preparedness Resilience and Response (EPRR) is led by the Chief Delivery Officer, who is the Group Accountable Emergency Officer (AEO) and Chair of the Group Resilience Forum. The Group AEO is supported by the EPRR Team.

During 2018/19, the EPRR Team supported operational managers in a number of incidents associated with IM&T outages across all North East Sector Care Organisations, and in September 2018 it assisted in planning more resilient IM&T services.

In addition there have been a number of other emergency incidents, including white powder, ward flooding, high infection-risk patient admissions, severe weather, and extreme operational pressures during January 2019, when medical emergency admissions were exceptionally high and required incident control response, particularly at the Royal Oldham hospital.

A new permanent decontamination unit has been funded this year and is to be located outside A&E at Fairfield General Hospital.

The training programme to help managers deal with major incidents and hazard decontamination has continued throughout the year across the North East Sector Care Organisations. The Major Incident Table Top Exercise in March 2019 at the North Manchester General Hospital had a business continuity focus to take into account potential hazards in the estate. This enabled the update and modification of business continuity plans, to cover the risk of an estates related service disruption in heating, hot water, or other utilities. Also considered was fire evacuation. At Rochdale Infirmary a method of responding to a fire in terms of rapid evacuation through the use of fire marshals has been adopted, and this additional fire safety regime is in the process of being rolled out across all sites, coordinated by the EPRR Team.

The EPRR Team are reviewing and modifying major incident plans and business continuity plans to a standard format across the NCA. The priority for the last quarter of 2018/19 and early next year is to ensure that the estates-related service continuity risks are in place.

Sustainability report

Introduction

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

Climate change is a significant threat to the planet. The NHS Carbon Reduction Strategy seeks to ensure that all NHS organisations establish a fully integrated strategy to address climate change. Its principle is firstly to identify and address all of the organisations sources of carbon emissions, and secondly to embed the principles of sustainability throughout the organisation and its stakeholders.

Energy and energy consumption

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

The organisation has successfully secured a multimillion pound grant from the NHS Improvement Energy Efficiency Funding (NEEF) scheme which will see a significant amount of LED lighting replacing older and less efficient fluorescent lighting throughout our estate.

The organisation continues to press ahead with an existing scheme at the North Manchester General Hospital site which will see the replacement of an older and inefficient boiler and steam raising plant as well as the introduction of a new Combined Heating and Power unit.

These works will not only improve our site resilience but will also have a significant impact in reducing our carbon footprint

Works are also underway at the Royal Oldham Hospital, again to improve our heating infrastructure, which in turn will reduce our energy and carbon footprint.

Over the last three years we have already significantly reduced our carbon impact by over 199 tonnes. Much of this has been achieved by the installation of the new Combined Heat and Power (CHP) unit at Fairfield General Hospital, which produces around 12% of our total energy demand.

During 2017/18 our gross expenditure on the Carbon Reduction Commitment Energy Efficiency Scheme was £303,563.50 for carbon emission allowances. This is a mandatory scheme aimed at improving energy efficiency and cutting emissions in large public and private sector organisations. At the time of writing, the 2018/19 report has not yet been published.

Procurement

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

Low carbon travel and transport

As a member of the Transport for Greater Manchester Travel Choices Business Network and Silver Accreditation Award winner in 2018, we are committed to encouraging active and sustainable travel across Greater Manchester. We continue to seek to deliver realistic active and sustainable travel actions and promotions throughout our organisation to facilitate changes to travel patterns and encourage reduced emissions.

During the 2018/2019 year as part of this work;

- We have updated the information our staff are provided with in relation to the cost savings and personal benefits of sustainable modes of commuting (e.g. personal travel planning advice, health benefits of active travel, and potential personal savings of different modes of transport)
- We are working with the Transport for Greater Manchester (TfGM) Sustainable Journeys Team and the Energy Saving Trust in an ongoing review of the impact of our business mileage and trust vehicle usage
- We have continued with the provision of electric vehicle charging points at each of our hospital sites, as part of the Greater Manchester wide charging network available to all users
- Our sustainable travel lead(s) are supported with training, access to Continuing Professional Development events and local/national forums for sharing of best practice/innovation

Waste recovery and recycling

In 2018/19 we recovered almost 2434 tonnes of waste (clinical & domestic) across the sites. Only very small amounts of waste e.g. residue form general skips, goes to landfill. In 2018/19 we recycled almost 375 tonnes of waste.

Water consumption

Our annual water consumption for 2018/19 was 518,650 cubic metres which is an increase from the 476,406 cubic metres consumed in 2017/18. The total cost for water and sewerage in 2018/19 was £1,579,176 which is a decrease from £1,613,904 in 2017/18.

Gas usage

Our annual gas consumption for 2018/19 was 70,615,200 kWh which is a decrease from the 79,886,713 kWh consumed in 2017/18. The total cost for gas 2018/19 was £2,078,215 which is a decrease from £2,174,875 in 2017/18.

Electricity usage

Our annual electricity consumption for 2018/19 was 36,379,240 kWh which is a decrease from the 37,612,902 kWh consumed in 2017/18. The total cost for electricity 2018/19 was £4,330,184 which is an increase from £4,162,795 in 2017/18.

Designing the built environment

Pennine's operational estate will continue to increase, with new site developments such as the planned new Healthier Together programme to provide improved patient care facilities. To maintain the drive to reduce our energy and carbon activity, Pennine needs to offset these additions by pursuing corresponding reductions. This is achieved by decommissioning under-utilised buildings wherever possible and striving for compliance with best practice, such as BREEAM, which is the world's leading sustainability assessment method for masterplanning projects, infrastructure and buildings.

Sustainability issues are included in our analysis of risks facing Pennine and the NCA. NHS organisations have a statutory duty to assess the risks posed by climate change. Risk assessment, including the quantification and prioritisation of risk, is an important part of managing complex organisations. Adaptation to climate change will pose a challenge to both service delivery and infrastructure in the future. It is therefore appropriate that we consider it when planning how we will best serve patients in the future.

Sustainable Development Management Plan

Pennine understands that those with responsibility for sustainable development have an ambition to make the NCA an exemplar organisation for sustainability and a better corporate neighbour within the North East Sector of Greater Manchester.

To address this situation, Pennine aims to first understand its overall current position in terms of being a sustainable organisation, which in turn will fulfil the objective of understanding the improvement margin available.

Deriving this understanding will place Pennine in a position whereby it can decide and then act upon specific improvement initiatives that will enable the environmental, social and economic benefits of sustainability to be realised. Whilst working to implement change, it is important to Pennine that a framework is in place to accurately quantify and evidence improvements, so that progression towards beacon status can be monitored.

Pennine's interpretation of these aims and aspirations enables five objectives to be established:

- To develop a clear understanding of what an 'Exemplar Organisation' for sustainability looks like
- To understand the present positioning of the organisation relative to the targeted status and to other organisations of a similar size and complexity
- To identify specific performance improvement opportunities that will enhance the NCA, including the full opportunity costs where applicable
- To compile a strategy and clear delivery/ action plan as a means of committing to, and structuring future improvements
- To establish a framework for measuring success as the NCA progresses (e.g. installation of an Environmental Management System (EMS)

This strategy sets out and proposes five packages of work which align to and reflect the five proposed project objectives. Activity can run concurrently across this development, as illustrated in the project timeline below. To be able to make a real impact next year, it is intended that this development strategy be board approved and implemented in Q1 2019/20.

		Apr	May	June	July	Aug	Sept
	Project Management						
WP1	**Preparing the Organisation for Exemplar Organisation status**						
WP2	**Understand the NCAs current performance**						
	Feedback to the Board & visioning paper			Workshop			
WP3	**Detailed Review of Improvement Areas**						
	Interim report and prioritised list of improvement actions				Report		
WP4	**Preparing your Sustainable Development Management Plan for publication**					Board Approval	Launch
WP5	**Establishing a framework for your EMS/SDMP**					Framework	
	Review of work and identification of further support needs					Review	

Delivery
Milestones

Staff awareness

By improving the awareness of staff on sustainable issues, we aim to encourage their support with energy and carbon reduction measures.

Modern Slavery and Human Trafficking Statement 2018/19

In accordance with the Modern Slavery Act 2015.

The Northern Care Alliance is an NHS Group formed by bringing together two NHS Trusts, Salford Royal NHS Foundation Trust (Salford Royal) and The Pennine Acute Hospitals NHS Trust (Pennine). This arrangement was formalised under a management agreement in April 2017, and paved the way for the establishment of the Northern Care Alliance NHS Group.

The Northern Care Alliance NHS Group (NCA) make the following statement regarding the steps it has taken in the financial year 2018/19 to ensure that Modern Slavery i.e. slavery and human trafficking, is not taking place in any part of its own business or any of its supply chains.

Organisation's structure and business

The NCA provides a range of healthcare services including five hospitals and associated community services - Salford Royal, The Royal Oldham Hospital, Fairfield General Hospital in Bury, Rochdale Infirmary and North Manchester General Hospital. From the 1 April 2017, the NCA was launched, bringing together over 17,000 staff, 2000 beds and serving a population of over 1 million. With an operating budget of £1.3bn, the NCA provides the benefits of scale but delivers this locally through multiple hospital sites and local healthcare services.

Our four Care Organisations are; Salford, Oldham, Bury & Rochdale and North Manchester. To enable the safe delivery of high quality care at scale, a Care Organisation Leadership Team of directors has clear accountability and authority to govern each Care Organisation.

The NCA position on modern slavery is to continue to:

- Comply with current legislation and regulatory requirements
- Make suppliers and service providers aware that we promote the requirements of the legislation
- Develop an awareness of human trafficking and modern slavery within our workforce and partner organisations
- Consider human trafficking and modern slavery issues when making procurement decisions

Northern Care Alliance NHS Group Policies, Training and capacity building about slavery and human trafficking available to its staff

We are committed to ensuring that there is no modern slavery or human trafficking in any part of our business and, in so far as is possible, to requiring our suppliers hold a corresponding ethos.

To identify and mitigate the risks of modern slavery and human trafficking in our own business, the NCA has in place robust recruitment procedures, details of which are found in its Management of Employment Checks Policy.

The policy supports compliance with national NHS Employment Checks and CQC standards. In addition, all other external agencies providing staff have been approved through Government Procurement Suppliers (GPS).

We will continue to audit and monitor agencies (via GPS) who provide staffing for the NCA once a year to ensure that they are able to provide evidence of identification, qualification and registration.

In addition, the NCA has a number of controls in place to ensure compliance with employment legislation.

Modern slavery is incorporated within both Salford Royal and Pennine Safeguarding Children and Safeguarding Adults policies and is highlighted within the Safeguarding Children and Adult mandatory training from Levels 1-3, which applies to all staff employed.

Safeguarding specialists and senior team members employed by the NCA continue to work with partner organisations including local safeguarding Adult and Children Safeguarding boards on issues related to social, community, modern slavery, anti-bribery and human rights issues.

Work is planned for 2019/20 to ensure that relevant organisational policies when under development, review or renewal consider the inclusion of any relevant information or training related to awareness and reporting any concerns related to modern slavery/trafficking and child or forced labour.

Northern Care Alliance NHS Group, Salford Royal and Pennine people must:

Undertake organisational safeguarding training appropriate to their roles and responsibilities.

Compile with relevant policies and procedures including those highlighted in this statement.

Work with the Procurement Department when looking to work with new suppliers so appropriate checks relating to modern slavery can be undertaken.

Working with suppliers

The NCA Procurement Department will ensure its supplier base and associated supply chain, which provides goods and/or services to the organisation have taken the necessary steps to ensure modern slavery is not taking place. The Procurement Department have committed to ensuring that this is monitored and reviewed with its supplier base via the Trust's 3 Year Procurement Strategy. The Procurement Department's senior team are all Chartered Institute of Purchasing and Supply (CIPS) qualified and uphold the CIPS's code of professional conduct and practice relating to procurement and supply. All members of the Procurement Department are required to undertake Safeguarding training at a level appropriate to their roles and responsibilities. The NCA follows good practice, ensuring all reasonable steps are taken to prevent slavery and human trafficking and will continue to support the requirements of the Modern Slavery Act 2015 and any future legislation.

Looking forward to 2019/20

The Annual Plan has been refreshed to more appropriately reflect the needs of the local Care Organisation populations, whilst working together to meet the objectives and strategic benefits that must be delivered through the scale of the NCA:

Strategic theme	Strategic priority / Principle objective
1. Pursue Quality Improvement to assure safe, reliable and compassionate care	1.1 We will demonstrate continuous improvement towards our goal of being the safest health and social care organisations in England
2. Improve care and services through integration, collaboration and growth	2.1 We will offer leadership, scales and technology to improve care to deliver the goals of our Care Organisations and their locality plans 2.2 We will develop Group Shared Services functions to deliver scale, resilience, operational excellence and transformation for our Care Organisations and partners 2.3 We will ensure a safe and sustainable future for the Care Organisations of Salford, Bury, Rochdale and Oldham and collaborate with the City of Manchester and NHS Improvement to secure the transition of North Manchester 2.4 We will grow and strengthen the Northern Care Alliance to ensure a sustainable future for our population served 2.5 Improve patient and care pathways to deliver improved prevention, earlier diagnoses, earlier treatment and earlier discharge across the system (including care at home or in a supportive environment)
3. Deliver the financial plan to assure sustainability	3.1 We will demonstrate continuous improvement in operational and workforce productivity and efficiency 3.2 We work with partners to ensure financial plans are sustainable and deliver on our annual income and expenditure budgets
4. Support our staff to deliver high performance and continuous improvement	4.1 We will demonstrate continuous improvement in operational and workforce productivity and efficiency 4.2 We work with partners to ensure financial plans are sustainable and deliver on our annual income and expenditure budgets
5. Deliver Operational Excellence	5.1 We will ensure good operational planning and execution to deliver on our urgent care, cancer, elective plans and trajectories and deploy relevant standard operating models 5.2 We will deliver on major transformation programmes to bring identified benefits (outpatients, diagnostics & pharmacy, theatres) 5.3 We will continue to deploy Standard Operating Models
6. Deliver our NCA Clinical Service Strategy and the NCA enabling strategies	6.1 With our partners we will determine future models of care and a sustainable service configuration to ensure clinical and financial sustainability 6.2 Service productivity is improved through digital transformation and the delivery of automation, clinical decision support and patient/user activation products 6.3 We will invest and reconfigure our estate and facilities to enable the delivery of an efficient and productive environment which improves patient and care experience 6.4 We will reduce variation in care and improve experience & outcomes through the development of our Standard Operating Model, our clinical reliability groups and the deployment of our quality and productivity improvement (QPID) methodology 6.5 Through excellence in change management and delivery of new ways of working we embed the changes resulting from our NCA strategies
7. Deliver excellence in research and education programmes	7.1 Demonstrate continuous investment and development of educational programmes and activities that enables our workforce to reach their potential 7.2 Produce quality research, appropriately funded, that is of national and international importance

In 2019/20 we have 4 key operational priorities:

1. Improving urgent and emergency care
2. Delivery on our financial plans
3. Strengthening cancer care
4. Improving planned care

Our plan and strategic objectives align to these priorities, ensuring that in making improvements we continue to drive forward the quality, safety and experience of care for patients and service users.

Signed: 

Date: *24 May 2019*

Raj Jain

Chief Executive & Accounting Officer

Salford Royal NHS Foundation Trust

The Pennine Acute Hospitals NHS Trust

The Pennine Acute Hospitals NHS Trust

Quality Report

2018 - 2019

Saving *lives*, Improving *lives*

Contents

If you require any further information about the 2018/19 Quality Report please contact:
The Quality Improvement Team on **0161 918 4940** or email Daniel Rowbotham at ***Daniel.Rowbotham@pat.nhs.uk***

Achievements in quality

42.34% **A 42.34% reduction in cardiac arrests has been achieved across innovation wards, since the start of the Deteriorating Patient Collaborative in November 2016**

50% **As of February 2019, 50% of NES wards were rated as Green/SCAPE against The Nursing Assessment and Accreditation System, a 12% improvement on the previous year**

23% **End PJ Paralysis achieved a 23% reduction in falls, and a 17% reduction in patient length of stay on the 'Top 5 Wards' engaged on the campaign**

2 **End PJ Paralysis won two awards at the National End PJ Paralysis Awards**

28% **A 28% reduction in category 2 hospital acquired pressure ulcers was achieved, alongside a 61% reduction in category 2 community acquired pressure ulcers across HMR community services**

Achievements in quality

Some 2018/19 achievements:

Stroke Services at Fairfield

are rated in the top 9 best performing units out of 209 hospitals nationwide according to Sentinel Stroke National Audit Programme (SSNAP) audit data.

Pennine Acute Hospitals

Achieved the top accreditation by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) for their endoscopy units.

Ward J6

at North Manchester and Ward 2 at Fairfield are the first Pennine wards to attain SCAPE status for delivering 'safe, clean and personal care every time'.

Staff Were Celebrated at the NCS Staff Awards

including Patients' Choice Awards voted and nominated by members of the public, which were awarded to John Mushing, Porter in the Pharmacy Department (Royal Oldham), Ward 8 at Fairfield General Hospital, and Louise McMahon, Sister in the Emergency Department (North Manchester).

End PJ Paralysis

initiative launched across all Pennine sites in 2018, and the Wolstenholme intermediate care unit at RI won 'Best Event' in the national End PJ Paralysis Awards.

The First Ever National AHP

(allied health professions) day was celebrated across the Trust with events for staff and the public to raise awareness of the roles of AHPs with patients and alongside other medical professionals.

North Manchester Community Tissue Viability Service

won the Person-Centred Care Champion Award at the NHS70 Parliamentary Awards for their wound clinics for the homeless.

Pennine's Security Team

Won a national award for 'Best Team,' at the British Security Industry Association (BSIA) awards proving they are a 'safe pair of hands' for staff, patients and visitors.

Victoria Breast Care Unit

at Oldham was awarded the Christie Quality Mark for the second time.

Events for the Public and Staff

were held at all Pennine sites to celebrate the 70th birthday of the NHS in July.

Rochdale Infirmary's Discharge to Assess

Home in a Day Team and Emergency Assessment and Treatment Team and North Manchester's Paediatric Emergency Department were shortlisted in the national HSJ Awards.

Fairfield

has become the first hospital in the UK to pledge to be part of the Homeless-Friendly programme – helping rough sleepers receive care before they fall dangerously ill.

A CQC Survey

Of new mums' experiences of maternity care at Royal Oldham and North Manchester hospitals showed significant improvement.

1

Statement on quality from the Chief Executive of the NHS Foundation Trust

Welcome to the Quality Report for Pennine Acute NHS Trust for 2018/19.

This year has been an extremely busy, somewhat challenging year, but we have so much to be proud of.

We are now one of the largest organisations in the NHS and we bring together our staff, expertise and resources under the umbrella of the Northern Care Alliance NHS Group (NCA) enabling us to work together as one Group to share and spread best practice. We deliver care in many forms from our domiciliary, community and hospital services and all are working together to deliver our mission of 'Saving Lives, Improving Lives'.

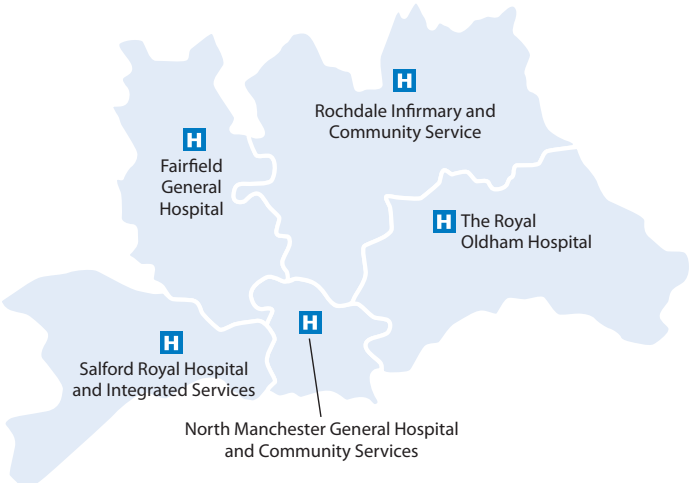
This report provides us with an opportunity to highlight some of the main developments to our services and the improvements we have made to care over the past year across the Trust, whilst also reporting on how we have performed against key national and locally determined clinical standards, waiting times and our key quality improvement priorities.

Throughout 2018/19, we have continued to deliver our Quality Improvement Strategy, which aims to make us the safest organisation in the NHS. You can read about a number of key improvement projects and programmes of work which are currently underway in Section 2 of this Quality Account.

Over the coming year Pennine will partner with Salford to become Manchester's first Global Digital Exemplar (GDE) Fast Follower organisation. This is a national initiative which aims to improve digital maturity across the NHS. This is a fantastic opportunity to try, implement and, if necessary, modify and improve new technologies to support patient care following 'blue-print' principles and processes which have already been tested at Salford. Importantly the GDE Fast Follower programme runs alongside our infrastructure improvement and future Electronic Patient Record programmes which, as a whole, will enable us to achieve a digital future for healthcare.

In wider Northern Care Alliance news, we have been ranked number 25 in the Inclusive Top 50 UK Employers List in recognition of its continued dedication to workplace diversity. The List ranks UK based organisations that promote inclusion at every level of employment within an organisation. This is a fantastic achievement and I am incredibly proud of the organisation and our staff for making the Northern Care Alliance, our hospitals and community services in Salford, Oldham, Bury, Rochdale and North Manchester, truly equal, diverse and inclusive places to work.

In addition to this, in June 2018 the NCA joined with Greater Manchester's other public sector employers and signed up to a historic commitment to address race inequality at work. Other signatories included other NHS organisations, local authorities, Greater Manchester Fire and Rescue Service and Greater Manchester Police. For years organisations have done their own work on this and made some good progress, but we haven't got it right. By coming together we can really make a difference to make sure everyone feels welcome in our public services and given the same opportunities to get on.



The Northern Care Alliance NHS Group has signed an Armed Forces Covenant promising that those who serve or who have served in the armed forces, and their families, are treated fairly by the organisation. By signing this document we are officially saying that we recognise the contributions that serving personnel in the regular and reservist Armed Forces, veterans and their families, all make to our businesses and country. We also promise to treat them fairly in our Organisation, including the injured and bereaved, so that they do not face any disadvantage.

In closing, I must pay tribute to all colleagues across the Northern Care Alliance who have risen to the challenge of coming together to create a Group that has the mission of improving and saving lives on a far greater scale than what the Trusts could achieve working on their own.

They have worked tirelessly to create better care for their patients with the results that a significant number of improvements have taken place at the North East Sector sites whilst Salford Royal has continued to retain its own high standards.

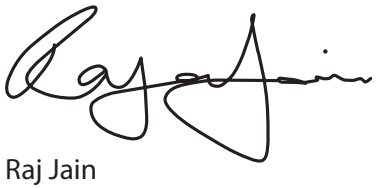
I am truly grateful for the support and contribution of staff at all grades and levels which have been crucial to our success.

What makes a real difference to our patients and service users is our people – our staff. It is the team spirit, shared values and 'can-do' attitude of staff across our Group that makes the real difference.

Finally, I am pleased to confirm that the Board of Directors has reviewed this 2018/19 Quality Account and confirm that it is an accurate and fair reflection of our performance.

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

Best wishes



Raj Jain
Chief Executive

Date: *24 May 2019*

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

1 Our aims

Our aims

Since 2016, we have had in place a clear Quality Improvement Strategy which addresses the distinct quality challenges addressing the three Care Organisations that make up the North East Sector (NES).

The current version of our strategy details how we plan to accomplish this. A strategy which covers the whole Northern Care Alliance is currently in development.

No preventable deaths

Estimating preventable deaths is complex. However, we are certain through the mortality reviews we carry out on all patients who die whilst under our care, that not all patients receive all ideal aspects of care for their conditions in a timely manner. We use these mortality reviews to find defects in care that can be fixed in service of pursuing our aim of having no preventable deaths.

In 2018/19 we have maintained our position for HSMR and SHMI. Both measures have now been 'as expected' for the past two consecutive years.

Continuously seek out and reduce patient harm

Harm is suboptimal care received by a patient, either because of something we shouldn't have done, or something we didn't do that we should have done. As of February 2019, 94.22% of our patients receive harm free care, as measured by the safety thermometer.

Achieve the highest level of reliability for clinical care

At Pennine Acute we use the principles of reliability science to maintain high performance, ensuring care is reliably a high quality for every patient, every time. In the pages that follow, we detail several projects worked on over the past year in the pursuit of high reliability.

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

The views of our patients and staff are very important to us and we receive feedback through a number of methods, including surveys and patient and staff stories, all of which provide us with vital information on how to improve.

Deliver innovative and integrated care close to home which supports and improves health, wellbeing and independent living

Caring for patients, their families and carers, is just as important out of hospital as it is when they're staying with us as an inpatient. Community based teams such as district nurses, community allied health professions, and intermediate care teams provide care closer to or in patients' homes.

A review of quality improvement projects 2018/19

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

	Target achieved / on plan	Close to target	Behind plan
Improving Urgent Care & Patient Flow			‹
Deteriorating Patients	=		
Sepsis	=		
Infection Prevention	=		
Pressure Ulcer Collaborative		»	
Nursing Assessment Accreditation Scheme	=		
Venous Thromboembolism	=		
Theatres Transformation Programme	=		
Elective Access Transformation Programme	=		
Clinical Reliability Groups	=		
Help Line	=		
Mortality Reduction	=		
End of Life / Bereavement Care	=		
End PJ Paralysis/Last 1000 Days	=		
National Maternal and Neonatal Health Safety Collaborative	=		

Improving urgent care & patient flow

All North East Sector Care Organisations saw an improvement in 4 hour A&E performance in 2018/19.

The North East Sector Care Organisation, continues to face the ever-challenging demand of providing safe, effective, and efficient service to all patients.

To fulfil this vision, each of the three North East Sector Care Organisations have established a series of work programmes designed to improve patient flow and to reduce the number of 'Stranded' patients (a "Stranded Patient" is defined as a patient who has a hospital stay of seven days or more.)

These work programmes consist of a number of linked work streams focussing on improvements in Urgent Care systems, Inpatient Flow processes and pathways, and Stranded Patients reduction.

The improvement programmes are directed, monitored, and assured at each Care Organisation's established (Patient Flow / Urgent Care) Improvement Board.

What:
To successfully improve patient flow throughout the whole organisation to reach the national A&E targets

How much:
90% of A&E patients seen within 4 hours/ bed occupancy below 90% (North Manchester and Royal Oldham)

92% A&E patients seen within 4 hours/ bed occupancy below 90% (Bury & Rochdale)

By when: March 2019

Outcome: A&E: 92.62 & (Bury and Rochdale ↑)
A&E: 77.60% (North Manchester↑)
A&E: 75.33% (Royal Oldham ↑)

Progress: Behind plan

What:
To successfully improve patient flow throughout the whole organisation resulting in improvements towards reducing the number of 'stranded' patients

How much:
Less than 40 patients per week (Bury & Rochdale)
15% reduction (North Manchester)
10% reduction (Royal Oldham)

By when: March 2019

Outcome: 19.4% ↑ (Bury and Rochdale)
13.8% ↓ (North Manchester)
1.12% ↓ (Royal Oldham)

Progress: Behind plan

Improving urgent care & patient flow *continued*

Urgent care

The aim of seeing patients presenting at A&E within the 4-hour allocated target remains challenging due to the increasing demand for the service. The Urgent Care improvement programme is working to meet that target through managing the high demand commanded of the service, as well as redesigning existing structures and processes to maximise efficiencies and productiveness.

Driver diagrams have been developed by each Care Organisation to describe specific improvement projects best suited for the Organisation's needs to improve Patient Flow.

Improvements achieved

- Improvement Boards have been embedded at each Care Organisation. The Board consists of leaders (both clinical and non-clinical) of all levels to review and drive changes across the programmes.
- The Same Day Care Centre was opened to the public in September 2018 at North Manchester General Hospital, further improving community accessibility to healthcare.

Further improvements identified

- Ensure all patients attending to A&E are having the best possible care and experience by 'streaming' to appropriate care pathways.
- Continued investment to better manage patient demand, such as increasing the size of A&E estates in Oldham Care Organisation.

Inpatient flow

Patients having the right care in the right place will reduce unnecessary and unwanted attendances in the wrong areas, resulting in improved patient care and experience, as well as ensuring maximum patient safety. Each Care Organisation dedicates improvement projects to develop effective and purposeful coordination across the system, making sure these aims are well met.

Improvements achieved

- Process mapping of assessment units and departments completed to understand improvement opportunities and identified system wastes such as delays and duplications.
- Relocation of the Ambulatory Care Unit (formerly known as the Treatment Centre) at North Manchester General Hospital now completed following feedback from CQC to maximise patient flow.

Further improvements identified

- Detailed diagnostic and process mapping exercises are currently being undertaken across each of the Care Organisations' assessment units to better understand capacity bottlenecks, and identify areas for improvements.
- The development and testing of Criteria Led Discharges to allow patients to be prepared for discharges at the earliest of opportunities as well as empowering other staff groups to discharge patients when medically ready.

Improving urgent care & patient flow *continued*

Stranded patients

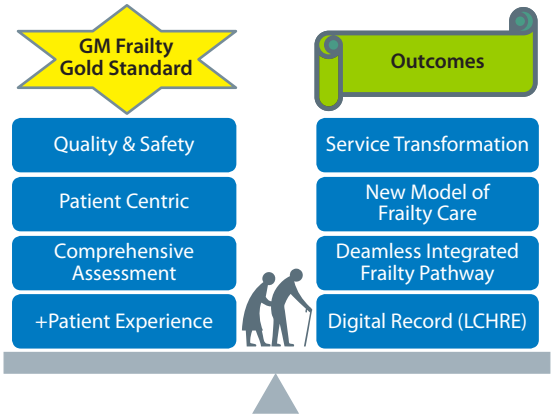
A "Stranded Patient" is defined as a patient who has a hospital stay of seven days or more. Improvement programmes and projects have been designed by each Care Organisations to make sure patients who do not need hospital interventions are safely and effectively returned back to their place of care in the community.

Improvements achieved

- A weekly Stranded Patient review is now in place for all Care Organisations, with the sole purpose of making sure all value added steps are taken to ensure patients are returned safely and timely to their chosen place of care.
- A dedicated Integrated Discharge Team has been **established in each Care Organisation** to aid safe discharge from the hospital. This specialist team works in collaboration with patients, staff, and external partners to make sure patients return to their place of care, at the earliest opportunity and when it is safe to do so.

Further improvements identified

- Oldham Frailty Network will be established imminently, bringing both internal and external (community) stakeholders together as a working group to tackle Oldham's frailty issues.



Improving urgent care & patient flow *continued*

Oldham Frailty Network aims and outcomes

- The 'Trusted Assessor' model is now being trialled with a Manchester care home, Wellington Lodge. This scheme allows staff to assess patients on the behalf of their care home, effectively accelerating recovery and maximising resource. A Learning Package is currently being developed with the view of adopting the scheme across the locality.

Principles for D2A model	What does this mean?
Essential criteria	● Supporting people to go home should be the default pathway[2], with alternative pathways for people who cannot go straight home. ● Free at the point of delivery, regardless of ongoing funding arrangements. ● To be safe if the person is going home, the assessment should be done promptly (within 2 hours) with rapid (on the day) access to care and support if it is required. ● Support services should be time limited - up to 6 weeks, in the best systems the average appears to be 2 weeks and can be longer than 6 weeks in exceptional cases. ● Non selective, a service that tries to always say 'yes' - to include support for end of life care.
User focus / patient centred care	● Put people and their families at the centre of decisions, respecting their knowledge and opinions and working alongside them to get the best possible outcome. ● Take steps to understand both the perspectives of the patient and their carers and the communities they live in, their needs, aspirations, values and their definition of quality of life. ● Ensure the person and their family receive clear information about their care within the acute setting including what will happen on discharge and who to contact if there are any problems after discharge. ● Ensure continuity of communication so all members of the team are working to the agreed care plan, until discharge from the pathway. ● Where the patient may not have capacity for a decision about discharge placement / assessment, apply the Mental Capacity Act 2005 (MCA), informed by the MCA Code of Practice and relevant case law.
Easy access to services	● Provide simple access to information, advice and services; including support and access to information to enable self-care and self-management. This will ideally be a one-stop shop, always available when needed, with the ability to provide a timely and responsive service for the people needing services and practitioners.

Some simple rules and principles for effective Discharge to Assess (D2A) ref: NHS Improvement

Deteriorating patient collaborative

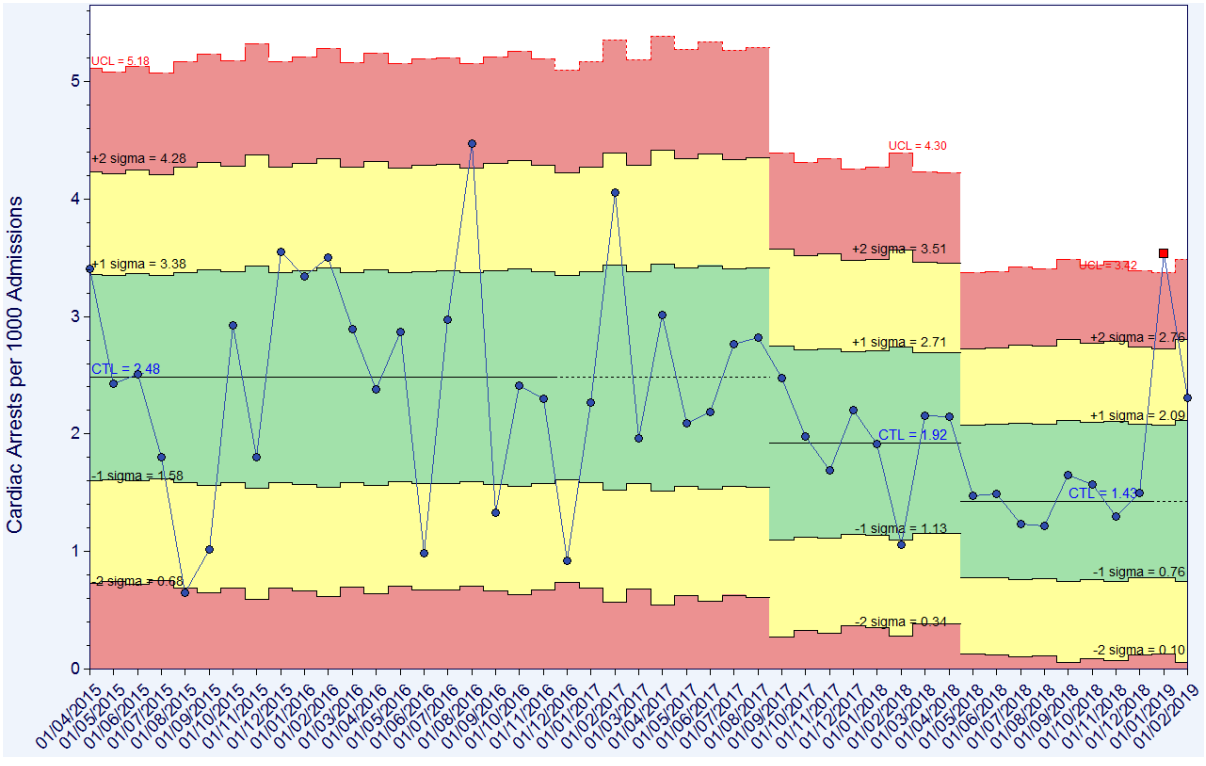
42.34% reduction against baseline period in the cardiac arrest rate per 1000 admissions for North East Sector Innovation Wards

Across the North East Sector Care Organisations, we are committed to achieving no preventable deaths.

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

What:	Reduce the cardiac arrest rate (per 1000 admissions) in North East Sector Innovation Wards
How much:	50% reduction
By when:	December 2019
Outcome:	During Phase 1 and 2 of the collaborative (since November 2016) we have achieved a 42.34% reduction in cardiac arrest rate in innovation wards
Progress:	On plan

Cardiac arrests rate for collaborative wards minus I5 & E3



Deteriorating patient collaborative *continued*

In December 2018 the collaborative wards have achieved a 42.34% decrease in the cardiac arrest rate.

Improvements achieved

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

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

As a collaborative, we have confidence in the changes which the wards have tested. Moving forward, the collaborative will spread to cover most inpatient wards across the North East Sector.

Further improvements achieved

- A video to support clinical staff with difficult conversations for treatment options has been recorded and is now being edited.
- In November 2018, the NEWS2 observation chart was launched Trust-wide.
- The Patientrack electronic observation system is now live across most North East Sector Care Organisations' wards.
- The Patientrack system requires clinical staff to input physiological observations at the patient's bedside using a handheld iPad in order to provide an automated calculation of the early warning score (EWS) score which removes the risk of calculation error. The system will also alter the monitoring frequency and provide escalation prompts as required in line with the Trust's escalation protocol.

Further improvements identified

- We plan to now bring on board more innovation wards to spread the change package and reduce cardiac arrests further across the North East Sector.

Sepsis

In December 2018, 80% of patients in A&E with 'red flag sepsis' received antibiotics within 1 hour of identification.

In December 2018, 92.1% of patients in in-patient ward areas with 'red flag sepsis' received antibiotics within 1 hour of identification.

What:	To treat patients who have sepsis with antibiotics within 1 hour
How much:	A minimum of 90% of patients with red flag sepsis to be given antibiotics within 1 hour of identification
By when:	September 2019
Outcome:	In December 2018 80% of A&E patients and 92.1% of in-patients with red flag sepsis were given antibiotics within 1 hour of identification
Progress:	On track 〓

Sepsis is a highly complex disease process which is difficult to diagnose and complex to treat. Red flag sepsis is a time critical condition, in which immediate action is required due to severe sepsis being present.

The mortality rates associated with septic shock remain unacceptably high (up to 50%) with an estimated 37,500 deaths per year in the UK. Evidence has shown that early identification and treatment of these patients with antibiotics can lead to improved survival.

The early identification and timely treatment of sepsis remains an organisational priority for Care Organisations and is therefore a key component within The Quality Improvement Strategy.

Improvements achieved

- Governance for sepsis improvement established.
- Fortnightly improvement meetings occurring in clinical areas.
- The North East sector sepsis policy has been updated to align to national guidelines and to support Trust-level improvement work.
- An improvement group was established which aims to improve the management of sepsis in community settings.

Further improvements identified

- In Spring 2019, a sepsis module will be added to the electronic observation system. This module will flag to clinical staff when a patient's observations trigger against any of the NICE red flag sepsis parameters and will enable staff to complete the screening and action tool electronically.

Infection prevention

At The Pennine Acute Hospitals NHS Trust we are committed to ensuring we deliver safe care for all our patients.

In 2018/19 two of our Hospitals celebrated over 100 days of being *C. difficile* free.

What:	To prevent, manage and minimise the risk of avoidable healthcare associated infections and achieve mandatory objectives set and monitored by our Clinical Commissioning Groups (CCG's) for reduction in *Clostridium difficile* (no more than 54 cases) and MRSA bacteraemia (zero tolerance approach)
By when:	April 2019
Outcome:	The Trust is on target to report an achievement of its objectives to the CCG's, to reduce *Clostridium difficile* infections with 34 cases to date against an annual objective of 54, with a 57% reduction of avoidable cases. The Trust has had 2 cases of MRSA bacteraemia

The Trust considers Infection Prevention to be one of its most important organisational priorities. Over the past year, the organisation has undertaken extensive work to prevent patient harm from occurring as a result of infection. The improvement work has been structured under a number of work-streams and utilises the approach of testing ideas for improvement in pilot areas, and then spreading successful change across our organisation (wherever possible across both Acute and Community sectors).

Improvements achieved

Clostridium difficile at Fairfield General Hospital

In August 2017, the senior management team at Fairfield General Hospital began a small scale improvement project to address the issue of *Clostridium difficile* infection (CDI). The main themes identified as potential areas of improvement were as follows:

- Insufficient anti-microbial stewardship.
- Outsourced cleaning.
- Culture and Leadership.

A selection of wards were chosen to participate in this improvement project and lead on the development and testing of change ideas.

Following a 90-day cycle of improvement, a selection of successful change ideas were identified as having a positive impact on reducing the number of hospital acquired CDI cases.

These changes include:

- The Trust introduced a revised programme of cleaning on ward areas.
- A new role of Antibiotic Pharmacist has been introduced across all 3 Care Organisations; Bury/Rochdale, Oldham and North Manchester.
- The impact of having the presence of the Antibiotic Pharmacist at ward level to provide the face-to-face training to the doctors and pharmacists to resolve antibiotic queries has had positive feedback from the wards.

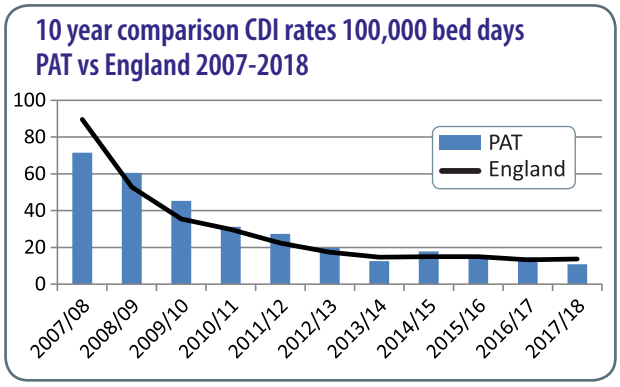
continued next page

Infection prevention *continued*

- The role of the Antibiotic Pharmacist has been standardised across the three COs and extra role such as the HITT service has been taken on. An audit by The Mersey Internal Audit Agency (MIAA) has produced a very positive report, with some recommendations which have been actioned.
- The impact of the Antibiotic Pharmacist role can be demonstrated in the table below which shows that the number of *Clostridium difficile* cases per site has decreased year on year.

Sustaining improvement

Over the last 10 years there has been sustained reduction in the number of health care acquired CDI infections within the Trust, the graph below demonstrates this.



The collaborative has been instrumental in identifying learning and allowing this to be shared across sites to reduce variance in practices. Some of the learning shared has included:

- Greater clinical engagement in the monitoring of cleaning standards and in the inclusion of the cleaning staff as "in house" Trust staff and not as an out-sourced service.
- A Consultant hand hygiene 'champion' on each hospital site.
- A "test of change" for the CDI risk assessment tool following staff feedback.
- Extra clinical hand wash basins installed at ward entrances on a rolling programme.
- The infection prevention team have been undertaking ward rounds with the Consultant Microbiologist and Antimicrobial Pharmacist to promote greater MDT working and engagement with clinical teams.

Further improvements achieved

- In addition to the C Diff improvement work at Fairfield General Hospital, The Royal Oldham Hospital also has a CDI collaborative.
- The Trust is taking part in an initiative to reduce Urinary Tract Infections (UTI).
- The patient hand hygiene project is being rolled out across all hospitals within the Trust and will form part of the annual plan for infection prevention to ensure sustained delivery.
- The Trust has been identified regionally as having a very low rate of MSSA infections.

Pressure ulcers collaborative

Background

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

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

The Care Organisations have committed to reducing harm to patient through Pressure Ulcers by developing the 'Pressure Ulcer Collaborative' using the Breakthrough Series Model to structure the improvement work. A number of acute pilot wards areas are actively testing change ideas using the Model for Improvement to guide their tests. The community teams are testing and implementing the change ideas from the recently launched Pressure Ulcer Community Change Package.

What: Reduce the number of pressure ulcers acquired by patients whilst under our care

How much:

- A 20% reduction in hospital acquired Category 2 pressure ulcers in pilot areas
- Zero tolerance of hospital acquired Category 3 & 4 pressure ulcers in pilot areas
- A 20% reduction in avoidable Category 2 pressure ulcers in community areas

By when: 1 April 2019

Outcome:

- 28% reduction in category 2 hospital acquired pressure ulcers across NES (all wards)
- Zero category 3 or 4 hospital acquired pressure ulcers on pilot wards
- Sustained 61% reduction in category 2 community acquired pressure ulcers across HMR community services

Improvements achieved

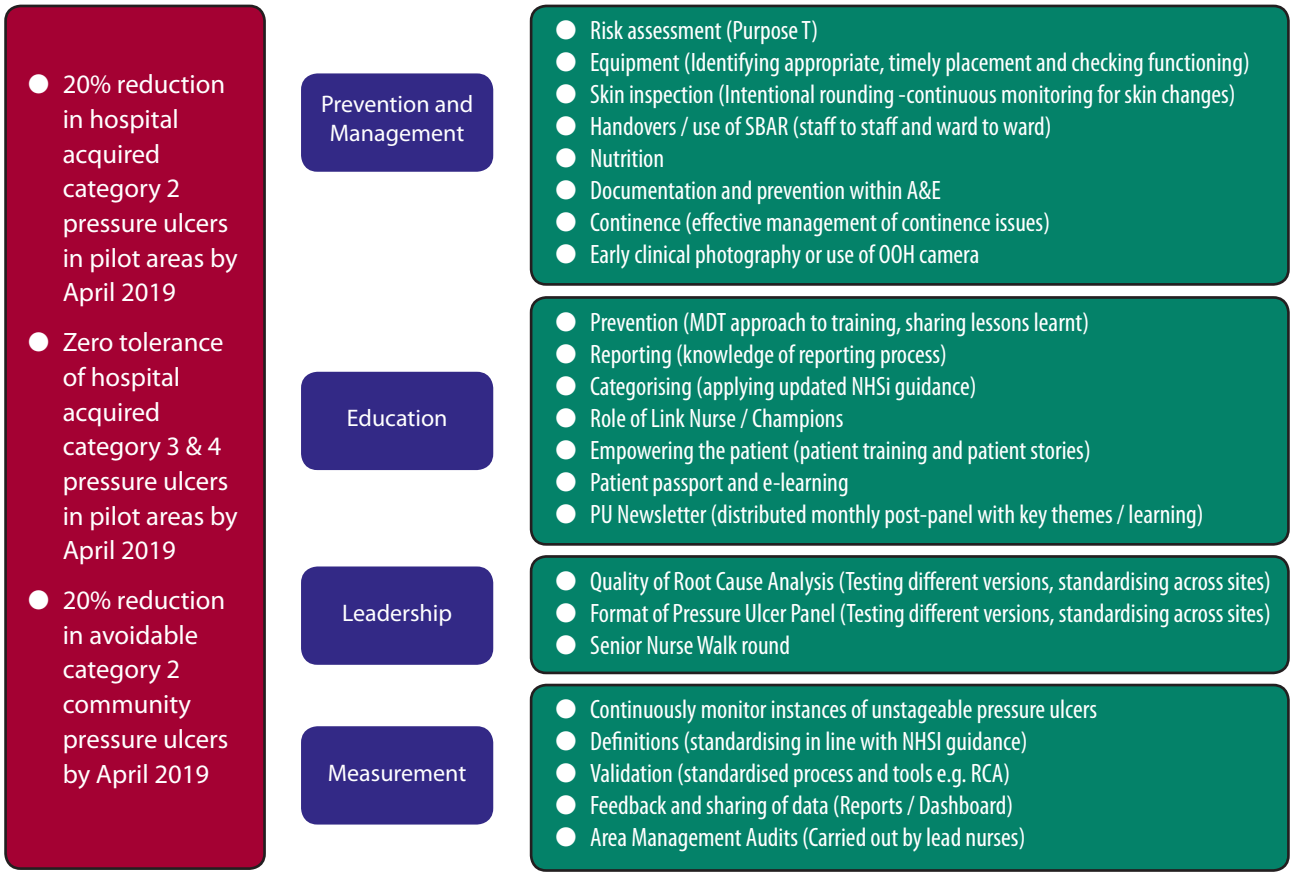
- The current tests of change from the collaborative pilot areas are:
  - Bed board visual prompt to highlight at risk patients
  - 'Time to turn' prompt to empower patients
  - Alert sticker in the patients notes for either 'At Risk' or 'Has Pressure Damage'
  - 'When pressure is found' process map to support ward staff
  - Reliable bedside handover to identify gaps in documentation before shifts end
  - Prevention and management pathway
- Critical Care Units have been working together to develop tests of change specific to their environment, including an innovative approach to securing feeding tubes.
- A Top Tips Guide to support healthcare assistants to deliver pressure care has been developed and is currently being piloted.
- Two collaborative learning sessions held in October 2018 and January 2019. The most recent event focussed on the Science of Reliability and how teams can apply reliable design concepts to embed their successful tests of change as 'business as usual'.
- Community Change Package Launch held February 2019.

Pressure ulcers collaborative *continued*

Further improvements identified

- Community teams will be supported to spread the Community Change Package and to make the tests of change 'business as usual'.
- The Acute Change Package is currently in development and will be launched in May 2019.

A Driver Diagram was designed within a Pressure Ulcer Steering Group to capture all activity identified to help us achieve our aim and provides direction for the improvement work.



Nursing Assessment and Accreditation System (NAAS)

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

NAAS was introduced at the Pennine hospital sites in September 2016 and is now well embedded in practice with all adult and children's inpatient wards assessed on a regular basis using a 'traffic light' scoring system of red, amber or green to identify how well a ward team is performing.

What: To ensure at least 50% of wards that are assessed are rated as green by the end of 2018

Outcome: All but 2 of the adult and children's inpatient wards/departments had been assessed at least twice at the end of December 2018

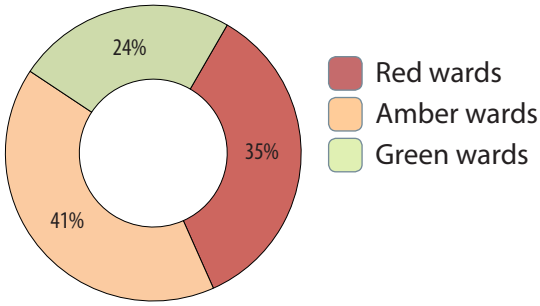
Progress: Aim achieved

As of February 2019 50% of wards were rated as green and two wards included in that figure were classed as 'SCAPE' blue wards.

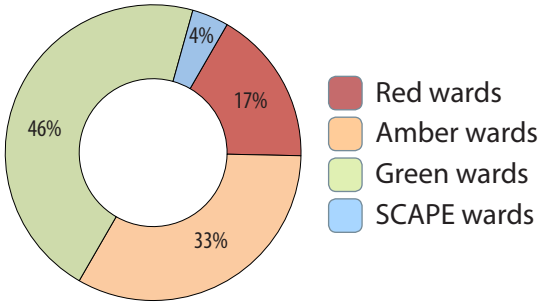
The SCAPE status is awarded when wards have demonstrated consistently high standards of care and as a result, they are invited to apply to the Trust Board to achieve this accolade.

These wards; Ward J6 at NMGH and Ward 2 at FGH were awarded this status in November 2018.

1st NAAS results prior to reassessments across all 4 sites - 51 areas in total assessed



Current NAAS results 14.2.19 across all 4 sites (55 areas) 103 reassessments undertaken



The aim for the next 12 months is to ensure all adult and children's inpatient ward areas have ongoing assessments and that wards are showing improvements.

Where progress is not seen additional focus is given to these areas to understand the problems and provide appropriate support.

The NAAS tool has been amended and agreed for Community Nursing Teams and is also being developed for maternity services.

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

Venous thromboembolism

Background

Venous thromboembolism (VTE) is a condition where a blood clot forms in a vein. This is most common in a leg vein, where it is known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE). 1 VTE includes both DVT and PE.

VTE is a major contributor to the global burden of non-infectious diseases. Almost anyone can be affected by VTE, and England sees around 64,000 cases of VTE a year, with a 10% mortality rate.

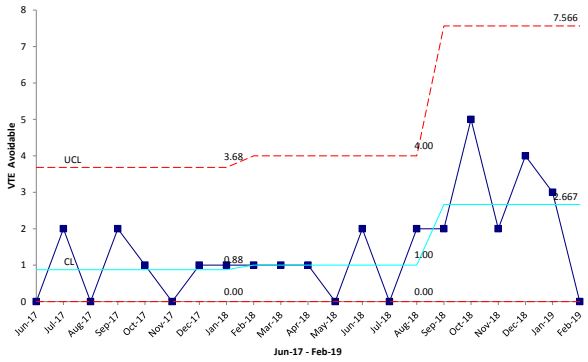
In 2017 Pennine Care and Salford Royal agreed to join under the umbrella of the Northern Care Alliance (NCA). In 2018 Salford Royal became a VTE Exemplar Centre, now the North East Sector sites (previously Pennine) aim to achieve the same status.

What:	For the NES COs to meet the exemplar criteria for VTE by September 2019
How much:	All criteria must be met
By when:	30 September 2019
Outcome:	Improved care across the NES in regards to VTE prevention and more robust process around incidents where they occur to better improve learning and care
Progress:	On track

Outcome so far

1. Number of avoidable hospital acquired VTE across the NES

A chart to show the number of avoidable hospital acquired VTE per month across the NES



Current performance reflects an accurate picture of the NES avoidable hospital acquired VTE incidents.

2. Progress against criteria

The table below shows a high level update of each theme within the criteria.

"Ongoing" refers to areas where the group is still working to meet the criteria, and "improvement" refers to areas where the requirements are met, yet improvements are underway.

Theme	Current stage
1. VTE Strategy	Improvement
2. Compliance and Processes	Ongoing
3. Training and Education	Improvement
4. Communications	Ongoing
5. Implementation	Ongoing
6. Patient and Community	Improvement

Further improvements identified

1. Agree a Trust wide incident process.
2. Care Organisation based VTE Leads.
3. Updated education packages.

Theatres transformation programme

To provide sustainable clinical services we must meet our financial targets in a very difficult economic context.

We do believe that high quality care often costs less because it is well organised, carried out with minimal waste and meets the needs of patients the first time around.

We know that to successfully do this, we must take the learning from our improvement programmes that have reduced harm across the organisation over the last ten years. The Quality and Productivity Improvement Directorate (QPID) formed approximately 12 months ago which brought together QI (Quality Improvement) and productivity delivery (Operational Experience). This has brought together a wealth of experience and expertise, which has proven to be effective in allowing us to develop new methodologies and innovative working.

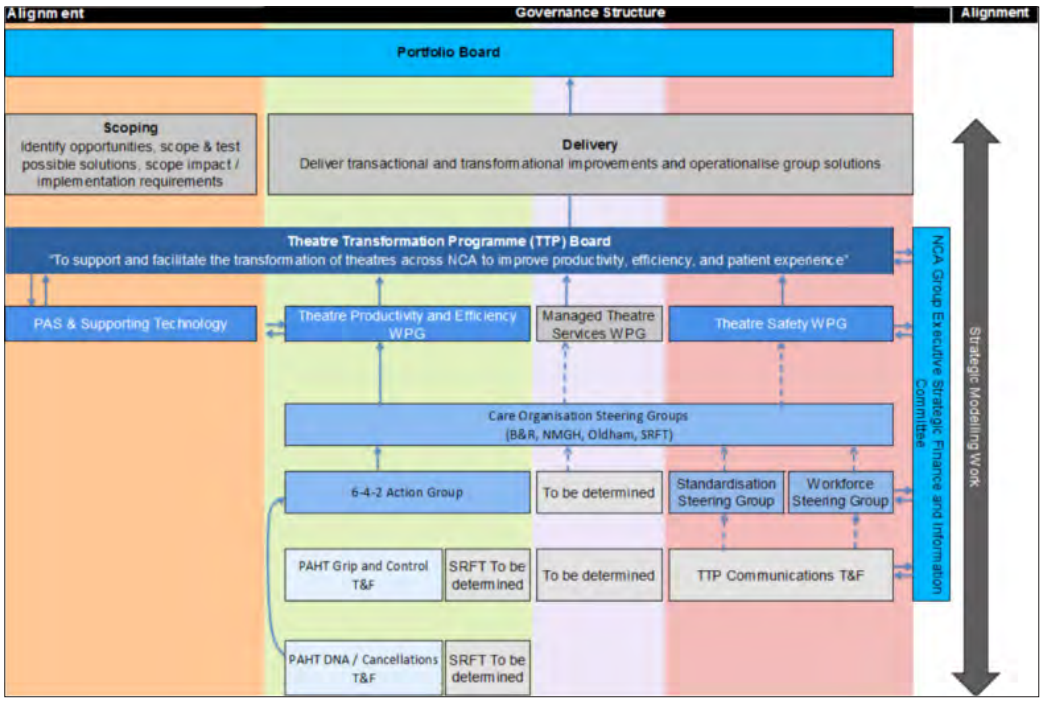
This approach to working has been applied to the NCA Transformation Programmes; Theatre Transformation, Elective Access Transformation (read more on page 69) and Diagnostics & Pharmacy Transformation.

What: To support and facilitate the transformation (standardisation) of theatres across the NCA to improve productivity, efficiency and patient experience

Progress: On track

Improvements achieved

A governance structure has been formed for the programme as shown in the diagram below, providing a clear escalation process and information flow between groups.



Theatres transformation programme *continued*

- Improvements in processes for booking and scheduling surgery including theatre resource meetings, 6-4-2, and Grip & Control.
- Implementation of a golden patient process to improve theatre start times.
- Task and Finish group established to reduce DNAs & OTD cancellations. This group has analysed data to identify key issues and focus specialties, and work is now progressing at a specialty level to address the issues identified, including review of communications with patients at pre-op, in letters and on the day.
- A Theatre Assessment and Accreditation System is in development to identify a set of standards and indicators providing assurance that patients receive the highest standards of care within all our NCA theatres.
- An NCA wide survey of staff working in theatres is being undertaken to identify and understand areas of good practice, as well as areas requiring improvements, which will direct some of the work programme.

Further improvements identified

- Standardisation of policies, standard operating procedures and working practices across NCA theatres.
- Piloting and roll out of Theatre Assessment and Accreditation System across NCA Theatres.
- Regular staff survey to ascertain progress on Safety Culture and continue to drive improvement.
- Increased utilisation of 23 hour unit at Rochdale Infirmary.

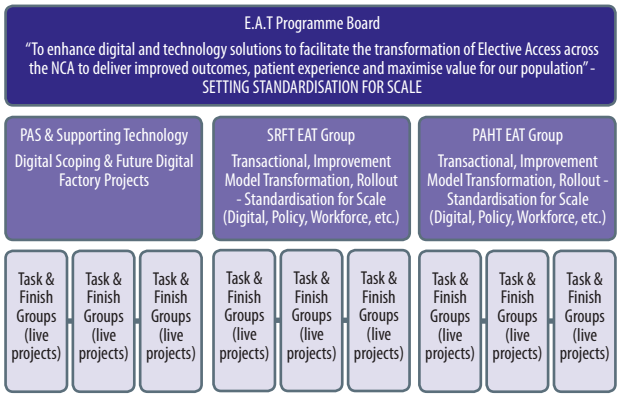
Elective access transformation programme

What:
To enhance digital and technology solutions to facilitate the transformation of elective access across the Northern Care Alliance to deliver improved outcomes, patient experience and maximise value for our population

Progress: On track

Improvements achieved

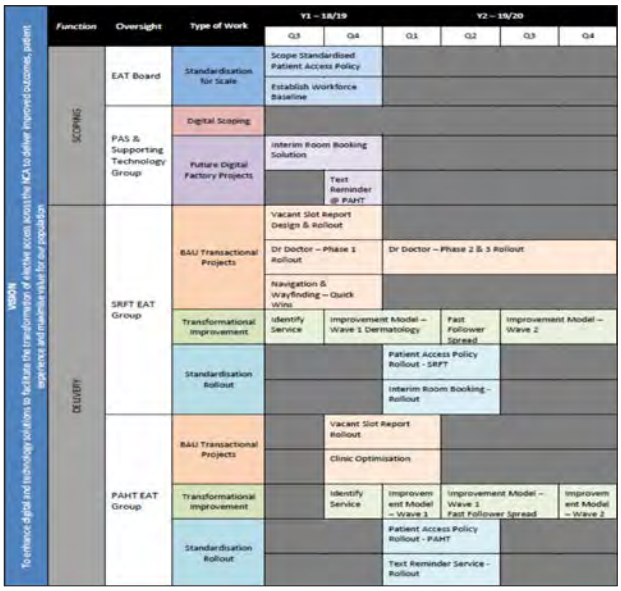
- Governance arrangements established for the programme.
- Stakeholder engagement with Clinical Commissioning Groups and patients.
- Focused task and finish groups established.
- Identified and analysed key issues across elective access and categorised these into key themes which are now directing the programmes work.
- Improvement model designed to support bottom up transformation within focused services.



Projects underway:

- Development and rollout of Vacant slot report to support full utilisation of available clinic slots.
- Clinic Optimisation. Working in collaboration with services across the Pennine sites to find ways of increasing clinic utilisation across Elective Access.

Image below shows the programme on a page document which includes live and pipeline projects across the Northern Care Alliance.



Further improvements identified

- Cardiology Improvement Model designed to support bottom up approach to support transformation.
- Room Booking utilisation- scoping of a process to support the full usage of clinic rooms.
- Patient Access Policy rollout.
- Text Message reminder service.
- Further development of the patient communication system - including patient led booking and digital correspondence.
- Further design, development and delivery of tailored digital solutions to support and enhance key processes across elective access.

Clinical reliability groups

Clinical Reliability Groups are an improvement approach which is used by hospitals which operate as a group (where individual hospitals come together to work under a common structure).

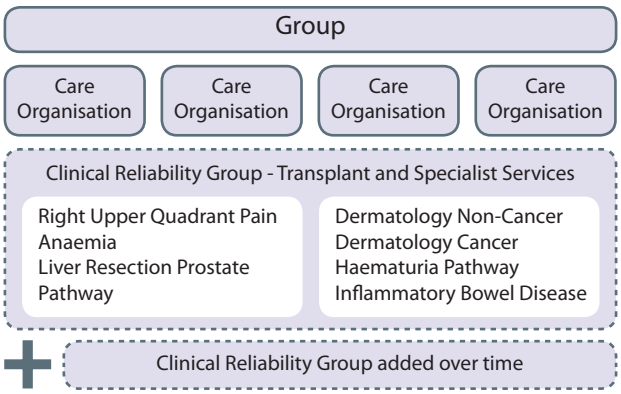
The approach brings together doctors, nurses and other health professionals to develop common standards across pathways of care. We, as a newly established group of hospitals are trialling this approach in a small number of areas of care, starting with end of life care

Trialling Clinical Reliability Groups is an important piece of work for us as we have a good opportunity to learn from the way care is delivered across the individual hospitals in our group (the Northern Care Alliance). We can then take the elements of care which we view to be the most effective and replicate them in each of the hospitals of the group.

What:	To trial the Clinical Reliability Group improvement approach
How much:	We will trial with two pathways of care
By when:	March 2020
Outcome:	We have started working with the end of life pathway
Progress:	On track

At the end of 2018 we started working with clinicians from all of our hospitals across the end of life pathway to start to develop a Clinical Reliability Group. So far, we have:

- Appointed a clinical chair to oversee delivery of the work.
- Had an initial meeting with clinicians to describe the purpose and ambition of the work.
- Started to draft a series of standards which describe what any patient coming into any of our hospitals should expect in relation to end of life care.



Structure of a Clinical Reliability Group approach

Next steps

- Establish monthly improvement team meetings.
- Continue to develop our end of life care standards.
- Develop pieces of work which will help us deliver those standards reliably.

Implementing the 'Helpline scheme'

What: For Helpline to be available 24/7 at each of our hospitals

Progress: On track

Work-stream

The Helpline scheme provides a mechanism for patients or their families to contact a senior member of staff if they have concerns about care or feel there is a risk of preventable harm. This scheme has been available since early 2017 at each of our Care Organisations.

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

Improvements achieved

- Promotion of the Helpline to ensure that posters are displayed and staff are aware of Helpline.
- Senior managers started checks to ensure the Helpline scheme was advertised appropriately and incorporated this as part of their senior nurse walk rounds, safety huddles, and ward and patient safety meetings.
- Each of our hospitals was provided with templates to produce small Helpline cards to display on wards and departments, that could be taken off site by patients or their families and used to contact the Helpline.
- On call managers were provided with updated mobile phone handsets.
- A method to log Helpline calls was introduced on 23 May 2018 using our existing risk management system (Datix). This allows calls to be logged easily by managers and for managers to be notified of calls entered onto the system to raise awareness and share learning.

Impact

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

Since the implementation of using Datix to record calls, there have been 29 calls made to the Helpline scheme that have all been successfully managed and resolved. Some calls were escalated for senior management information or input.

Implementing the 'Helpline scheme' *continued*

Calls taken by subject type since Datix Helpline launch 23/05/18

The type of calls taken has varied by subject type but include:

- Admission, transfer and discharge procedure.
- Equipment.
- Staff attitude, behaviour and communication.
- Treatment.

Calls taken by Divisional breakdown since Datix Helpline launch 23/05/18

	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	TOTAL
Bury Division of Integrated Care	1	2	0	1	2	3	1	2	1	**13**
North Manchester Division of Acute Medicine	3	0	1	1	0	1	0	0	0	**6**
North Manchester Division of Surgery	1	3	2	0	0	0	1	0	0	**7**
ROH Division of Surgery	1	1	1	0	0	0	0	0	0	**3**
TOTAL	**6**	**6**	**4**	**2**	**2**	**4**	**2**	**2**	**1**	**29**

The 29 calls represent contacts; however, there was one patient family that used the Helpline twice during their stay at North Manchester, so there were 28 unique calls.

Calls taken by subject type since Datix Helpline launch 23/05/18

	Admissions / transfers / discharge procedure	Aids / appliances / equipment	Attitude and behaviour	Clinical treatment	Comm-unication (oral)	Patient privacy / dignity	Patient status	Policy & commercial decisions of NHS board	Shortage / availability	TOTAL
Bury Division of Integrated Care	2	1	1	4	3	0	1	1	0	**13**
North Manchester Division of Acute Medicine	2	0	1	2	0	0	0	0	1	**6**
North Manchester Division of Surgery	0	0	2	2	2	1	0	0	0	**7**
ROH Division of Surgery	2	1	0	0	0	0	0	0	0	**3**
TOTAL	**6**	**2**	**4**	**8**	**5**	**1**	**1**	**1**	**1**	**29**

Mortality reduction

Learning from deaths. Ensuring we have a robust process to learn from deaths.

What:	Ensure all inpatient deaths at Pennine receive a Care Quality Mortality Review
How much:	100% of all inpatient deaths
By when:	March 2020
Outcome:	In Q2, 59% of inpatient deaths received a care quality review and 40% in Q3. Within this, 9% of inpatient reviews had a case record review using Structured Judgement Review (SJR) methodology
Progress:	On plan

The Care Quality Commission (CQC) report 'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England' found that learning from deaths was not being given sufficient priority and valuable opportunities to improve care for future patients were being missed.

In March 2017, the National Quality Board introduced new guidance for NHS providers on how they should learn from the deaths of people in their care. The implementation of this guidance is overseen by NHS Improvement.

Our aim is to ensure that learning from deaths is used to support the delivery of a wider clinical quality improvement agenda that encourages increased accountability and understanding of potential problems in care.

Pennine has achieved the following key milestones:

- A Learning from Deaths Policy was in place by September 2017.
- Data has been provided to a public Trust Board meeting from the third quarter of 2017/18 onwards, publication of the data is available on a quarterly basis from the Trust website, *and*
- A learning lessons framework has been implemented.

In July 2018, the National Quality Board introduced new guidance for NHS providers on how they should engage and support bereaved families. The Learning from Deaths process has been revised to reflect these recommendations and an updated Learning from Deaths Policy will be published and be available to the public by July 2019.

Objective

The Quality Account objective for 2019/20 is to ensure all in-patient deaths at Pennine receive a Care Quality Mortality Review; with at least 10% of all in-patient deaths, receiving an independent case records review using the recommended Structured Judgement Review methodology.

Pennine is on target with additional support being implemented to ensure the Quality Account objective is met. During Q3, 40% of all in-patient deaths received a Care Quality Mortality Review and 9% of all in-patient deaths received an independent case records review using the recommended Structured Judgement Review methodology.

The methodology for identifying deaths meeting the criteria for Structured Judgement Review will be revised to capture a larger cohort of patient deaths by July 2019. The selection will include a snapshot audit of deaths that align with improvement works.

Mortality reduction *continued*

Effective learning

North East Sector aims to develop a Learning from Deaths culture that reflects the NCA values:

Patient and People Focus | Accountability | Continuous Improvement | Respect

A Mortality Oversight Group convenes monthly to discuss the mortality review process, training needs, outcomes of case record reviews, investigations and reporting of deaths, themes, and the implementation of a learning and a clinical quality improvement agenda.

Following a case record review, any deaths where poor care has been identified and/or deaths that are determined as more likely than not to have resulted from problems in care are forwarded for review at speciality Mortality and Morbidity meetings. A learning action plan is then escalated to the Mortality Oversight Group for scrutiny and inclusion in the clinical quality improvement agenda.

NCA has achieved the following key milestones:

- Increase in consultants, nurses, bereavement leads allied health professionals and other support staff trained to undertake mortality reviews using the Structured Judgement Review methodology.
- Devolved in conjunction with the bereavement team a leaflet for those families who are bereaved.
- Development of methods for learning through a Learning from Death bulletin, Take 5 presentations and presentation of cases at speciality Mortality and Morbidity Meetings, *and*
- Development of a clinical quality improvement agenda bespoke to each Care Organisation at Pennine that draws on complaints, case record reviews, serious incident investigations, inquest findings, clinical audit and mortality indices (HSMR and Dr Foster).

NCA aims to achieve 'no preventable deaths' by identifying potentially avoidable factors that may have contributed to deaths and implementing remedial measures to support the fundamentals of care and to prevent these factors recurring in the future.

Next steps

NCA will continue to develop the mortality review process by achieving the following key milestones:

- Revising the Learning from Deaths Policy in July 2019 to reflect key changes in process;
- Support mortality reviews, Mortality and Morbidly Meetings and Mortality Oversight Groups to determine SMART learning (specific, measurable, achievable, realistic, timed); and
- Implement appropriate escalation methods for sharing organisational learning, high priority alerts and best practice across the NCA.

Palliative, End of Life, Chaplaincy and Bereavement Care

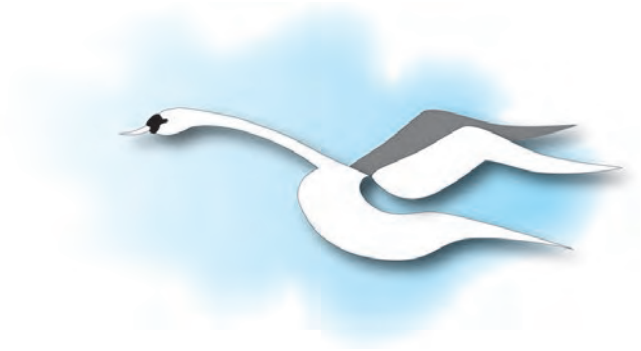
Swan model of End of Life Care and Bereavement

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

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

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

The Swan Bereavement Nurses support families at the time of death in any place by being there; listening, diffusing, calming, offering mementos, providing care, compassion and helping to turn each and every situation they're involved in, into a moment that becomes a memory. They also provide education, training and real time coaching to enable all staff to provide this care, wherever they are, whatever their role. They collect data, complete audits and are involved in supporting families before, during and after Inquest and Complaints. They support all families and visit the deceased of any age and Faith.



Specialist Palliative Care / EOLC Practice Development Team

The Specialist Palliative Care Service helps patients and families live as well as possible by providing high quality pain and symptom control, in addition to Specialist psychological, emotional, social, spiritual and input as appropriate.

The Service supports patients with life- limiting illnesses and is based on a multi-disciplinary model of care, with excellent relationships with many disciplines and specialties within the Trust and in the local community.

Patients receiving input from the Service are usually within the last 12 months of their lives. However, in some cases, patients and their carers may require input at the time of diagnosis and intermittently on an ongoing basis when in hospital or outpatient clinic. The Service will be involved, as appropriate, at any point in the patient's illness journey.

The EOLC Practice Development Team lead and facilitate quality improvements in the provision of End of Life Care by providing ongoing education and support for local, regional and National End of Life Care agendas.

Palliative, End of Life, Chaplaincy and Bereavement Care *continued*

Chaplaincy service

The Service offers emotional, spiritual, pastoral or religious support to patients, their family and loved ones, and also to Trust staff. Spiritual Care is person centred care which seeks to help people (re)discover hope, resilience and inner strength in times of illness, injury, transition and loss.

Spiritual Care is person centred care which, through affirmation, enables a person to make the best use of their personal and spiritual resources in facing and coping with the doubts, anxieties and questions which arise in a healthcare setting, and often accompany ill health and suffering.

Healthcare Chaplaincy is a service provided to patients, their carers and staff within the healthcare setting which involves haring and meeting their existential, spiritual, religious and pastoral needs.

Chaplains are trained to serve appropriately the needs of those of different faiths, denomination and backgrounds as well as those of no particular faith.

Improvements achieved

In 2018/19 the Trust has introduced the following:

- Development of Bereavement Support Groups.
- Quarterly service reports for end of life care, bereavement and specialist palliative care including patient stories, data, complaints, good news.
- Continued improvement of mortuary environment and facilities.
- Staff trained and empowered to offer mementos every time to every family - already offering locks of hair and personal message cards, now training to take handprints, footprints, lip 'kisses'.
- Development of Faith Death Procedure.
- SWAN bereavement Nurse role pilot for 12 months based at HMR coroners.
- Development of service level agreement for Shabbos room.
- Bereavement and loss module accredited for delivery at Bolton University.
- Long stay policy for the mortuary.
- Development of guidance following the death of a patient in an operating theatre setting.
- Development of an EOLC newsletter.
- Revised uDNACPR policy.
- Chaplaincy service now under new line management as part of Palliative, EOLC & Bereavement services.
- Assess to clinical supervision for teams.

Palliative, End of Life, Chaplaincy and Bereavement Care *continued*

- Revision of rapid Discharge checklist.
- Development of electronic coroner reporting form, tool kit and take 5 presentation.
- Development of Swan Implementation package.
- Development of verification of death policy & training.
- Production of quarterly service team reports.
- Development of bereavement operational policy.
- Audits:
  - Coroner referrals
  - National EOLC audit Opioid Transdermal Patch monitoring audit & Implementation of monitoring charts
- Training Needs Analysis for knowledge, skills & confidence around EOLC.
- Development of deteriorating patient video.
- Attendance / involvement at mortality & morbidity meetings.
- Implementation of Swan car park vouchers for families visiting loved ones at EOL.
- Development of funeral specification for those patients who die with no next of kin.
- Seven day week working for the Bereavement Service.
- Appointment of Mental Health bereavement liaison worker.

Further achievements identified

The Northern Care alliance remains committed to providing the highest standard of End of Life and Bereavement Care. Therefore, moving into 2019/20 we aim to prioritise the following improvements:

- Seven day week working for Specialist Palliative Care & Chaplaincy services.
- Hosting of EOLC community services for Oldham & Bury.
- Further integration/standardisation of services across the NCA.
- Evaluation of the Swan bereavement nurse role based at the coroner's office.
- Development of the Clinical Reporting Group for Palliative Care.
- Development of EOLC committees within each care organisation.

Palliative, End of Life, Chaplaincy and Bereavement Care *continued*

Patient story: Ralph Williamson

The story below was submitted by Mrs Williamson, wife of patient Ralph Williamson, who was treated at the Royal Oldham Hospital.

A year ago today you did an incredible act of kindness for me and my family but most of all for my husband, Ralph Williamson.

Ralph had been a patient on your ward, and others, many times due to his COPD and other illnesses which had rendered him virtually housebound and dependent on 24 hour oxygen in his last few years. He was always shown fantastic care and his adamant wish for a window open or at least a jar!! Was met with humour and a willingness to oblige where possible. We thank you for all the care he received.

On the 11 January 2018, Ralph was once again rushed by ambulance to A&E and put on the dreaded C-pap machine. We knew though although Ralph had beaten the odds on more than one occasion that this was to be his last day. Having called all his family we were told that although Ralph was dying there wasn't a bed to be had anywhere. Ralph had told us that under no circumstances did he wish to ever spend his last hours in ICU with all its manic bleeping, scary machines and frightening atmosphere that he so dreaded.

My daughters were able to speak to someone who incredibly found somewhere for us all to spend those last few precious hours. It was you.

I cannot convey to you how special that time was to us. In Oak Room, that you had prepared, even though your ward was overwhelmed you gave us sanctuary. Everything possible was done for Ralph to make his end so peaceful and dignified and with all his family around him. You gave him the best possible care and compassion and for us, his family, we will always be so very grateful.

When we talk of Ralph passing it is with one of peace. Our memories are good ones and you made that happen. We will never forget how peaceful he looked and we thank you from the bottom of our hearts for your compassion, thoughtfulness and care – not just for Ralph but for us all.

This letter has taken me a year to write though you have been thought and spoken of between ourselves many times. We would like especially to thank one nurse in particular although we are sorry that we cannot recall her name. She encouraged us to take some time hair each and this year we all had a glass locket and we put a bit of him on all our Christmas trees. You truly deserve every accolade.

Thank you for everything you did for Ralph.
We will never forget you.

#EndPJParalysis / Last 1000 days

Making people more active whilst staying in hospital can reduce the amount of time they spend as an inpatient.

What:	To rollout the End PJ Paralysis Change Package across our Care Organisations
By when:	December 2018
Outcome:	Change Package successfully rolled out
Progress:	Target achieved

Throughout 2018/19 the End PJ Paralysis / Last 1000 Days project has grown from a campaign to a full improvement project. By implementing the change package throughout the Northern Care Alliance, we can demonstrate that the most engaged wards have seen a reduction in harm to patients that can occur if patients are bed bound for longer than is necessary. We have measured this by looking at our falls, pressure ulcer and length of stay data.

In June we held the first national End PJ Paralysis conference attended by colleagues from across the country. The event hosted by Professor Brian Dolan took place at Salford Royal Hospital. The event was well attended and highlighted the importance of keeping up the hard work that has been undertaken and building upon further improvements in the future.

Improvements achieved

- 100% of wards engaged in the #EndPJParalysis campaign.
- 23% reduction in falls in the 'Top 5 wards' engaged in the campaign.
- 17% reduction in the length of stay for the 'Top 5 wards' engaged in the campaign.
- Winner of two awards at the National End PJ Paralysis Awards.

Further improvements identified

- The launch of phase 2 of the project targeting areas with potential to achieve further improvements, with a focus on preventing what is known as 'deconditioning' (a decline in patients' physical abilities due to being bed bound).
- Focusing on spreading the initiative into community services, ensuring that patients are out of bed and dressed if possible.
- The launch of the 'Dining Champions' scheme enabling volunteers to spend mealtimes with inpatients.

#EndPJParalysis / Last 1000 days *continued*

PJ Paralysis case study

On the Wolstenholme Intermediate Care Unit in Rochdale, the atmosphere is certainly not a stereotypical hospital environment.

When visiting the facility you will find patients in the day room socialising, listening and sing along to music or eating a meal in the dining room – there are smiles all round.

At the unit the wall are coated in displays and photographs showcasing activities that happen throughout the year as there are always lots of events going on.

As the Activities Co-ordinator, it is my responsibility to organise some amazing activities with the patients.

We bake, play sports activities, quizzes and even organise patients to sit outside on the terrace, so they can enjoy the sunshine and have fresh air whilst having ice lollies.

It's great to see patients up, dressed and moving around if they can. The Wolstenholme Unit has an open, caring and relaxed environment and we ensure that patients are as happy as can be when in our care.

Lynette Cook - Activities Co-Ordinator
Winner of the Best Event at the national #EndPJParalysis Awards 2018.

National maternal and neonatal health safety collaborative

Pennine Acute was successful in its application to join the first phase of this national safety collaborative.

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

The aim is to:

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

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

Improvements achieved

- Agreed Memorandum of Understanding with Greater Manchester and East Cheshire Strategic Clinical network for a midwife from North Manchester and a midwife from Oldham to work with the Specialist Midwife in Public Health Surveillance and support the implementation of the Saving Babies Lives Care Bundle. This funding was until the end of March 2019.
- Quarterly data reports are available to monitor progress of the four elements of the care bundle: smoking, detection of small for gestational age babies (SGA), fetal movements and fetal monitoring.
- Carbon Monoxide monitoring at booking is over 90%.
- Information from the perinatal institute places Pennine in the top 10 Trusts in the UK for detection of small gestational age babies.
- We have reached the target of 95% for the generation of birth centile charts and for the last three months have achieved over this target.
- We are achieving over 85% of 'fresh eyes' review every hour of cardiotocograph traces for women in labour.
- We are actively involved in the development of a regional fetal monitoring assessment tool.
- The identification of small babies alongside the implementation of the Saving Babies Lives Care Bundle has seen a 44% reduction in our still birth rates since 2013.

National maternal and neonatal health safety collaborative *continued*

Other current work streams

- **Improve the identification and management of sepsis in babies.**

  Across the NCA we are working with the neonatal teams to have set times for neonatal antibiotics on the postnatal ward and have implemented the red hats for babies who are assessed as high risk at birth. Along with the implementation of the neonatal observation charts which support early detection of concerns ensuring appropriate escalation.

- **Improve the optimisation and stabilisation of the very pre term infant.**

  Across the NCA we are working as part of the The PReCePT initiative. This is an evidence based project designed to help reduce cerebral palsy in babies with the administration of magnesium sulphate to mothers in preterm labour. The aim is to achieve 85% administration of magnesium sulphate in all maternity units in England with a stretch target of 95% by 2020 (at the outset the data demonstrated an uptake of 43.9% for eligible babies). We are currently collecting data across the NCA and have identified champions to lead the work.

Further improvements identified

- Increase carbon monoxide monitoring at 36 weeks of pregnancy.
- Reduce smoking in pregnancy - this would be improved with consistency in access to support services across the NCA.
- Improving the detection and management of diabetes.
- A sustained reduction in the separation of mums and babies following birth in line with the ATAIN programme (a national programme working at Avoiding Term Admissions Into Neonatal units). In conjunction with this working with our neonatal teams to implement transitional care to further reduce unnecessary separation of mother and baby.

2

Priorities for improvement and statement of assurances from the board

Priorities for improvement

Progress made since 2017/18 Quality Accounts.

On 1 March 2018, the Care Quality Commission (CQC) awarded Pennine Acute Hospitals NHS Trust a rating of Requires Improvement against the Safe domain. This rating is an improvement on 2016's inspection result of Inadequate and reflects the dedication of our staff to improve the safety of patients by adapting their working practices and embracing quality improvement initiatives.

For 2018/19 we continued this trend of working with our staff to continuously improve care for our patients. Below is a table of the aims we set a year ago and our progress towards achieving these aims.

2018/19 Priority	Measured by	Outcomes	2018/19	2017/18
Pursue quality improvement to assure safe, reliable and compassionate care	HSMR	As expected	96	98.3
	SHMI	As expected	97	1.01
	Cardiac arrest rate (per 1000 admissions)	The cardiac arrest rate for the all the North East Sector Care Organisations has been reduced by 24.58% as of December 2018*		
	Patient safety thermometer	94.22% of patients reporting harm-free care as of February 2019	94.22%	98.60%
	Acute pressure ulcers	Behind target	160	164
	Infection control	On target	78 cases of *C.difficile* infections against an annual local trajectory of 54	43 cases of *C.difficile* infections against an annual local trajectory of 55
	Inpatient flow and stranded patients workstream metrics	Measures of improvement dependent on specific areas of improvement chosen- please see Part 1for more detail		
Deliver Operational Excellence		Performance against national targets and locally selected indictors (please see sections 2 and 3)		
Support our staff to deliver high performance and continuous improvement	Staff survey scores	Please see section 2 for performance against core indicators		
	Associated improvements outlined in previous project pages as an indication of staff engagement in Quality Improvement principles and projects			

*Compared with baseline data for the North East Sector - please see the Deteriorating Patient Collaborative project page for more information.

The project pages found in Part 1 provide more detail regarding the improvement programmes undertaken over 2018/19 to achieve the above priorities and the appropriate measure of progress.

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

Priorities for improvement *continued*

Pursue quality improvement to assure safe, reliable and compassionate care

Objective:

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

Improve care and services through integration, collaboration and growth

Objective:

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

Deliver operational excellence

Objective:

We will ensure good operational planning and execution to:

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

Support our staff to deliver high performance and continuous improvement

Objective:

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

Ideas for improvement are also generated by staff across the COs through their participation in Quality Improvement initiatives. These ideas are taken forward as tests of change in specific project workstreams, to support the delivery of our improvement priorities in 2019/20.

Progress to achieving these priorities will be monitored and measured at project level with a suite of measures for each including outcome, process, and balancing measures. These projects will be monitored by individual steering groups and through the Care Organisation's Quality and People Experience Committees. Trust-wide measurement will also be monitored through the Quality Dashboard and Quality Improvement Strategy Update Report that goes to the Board of Directors Quarterly.

The priorities chosen above are priorities stated in the Trust's quality improvement strategy. This strategy was developed with wide collaboration and consultation with patients, members, governors, and staff.

Statements of assurance from the Board

Review of services

During 2018/19 the Pennine Acute Hospitals NHS Trust provided and or sub-contracted 58 relevant health services

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

The income generated by the NHS services reviewed in 2018/19 represents 100% of the total income generated from the provision of NHS services by The Pennine Acute Hospitals NHS Trust for 2018/19.

Participation in Clinical Audit

National clinical audit

During 2018/19, 52 national clinical audits and three national confidential enquiries covered NHS services that the Pennine Acute Hospitals NHS Trust provides.

During this period, out of the national clinical audits and national confidential enquiries of which it was eligible to participate in, the Trust participated in 50 (96%) of the national clinical audits, and two (67%) of the national confidential enquiries.

The national clinical audits and national confidential enquiries that the PAHT was eligible to and did participate in, and for which data collection was completed during 2018/19, are listed below. These are listed alongside the number of cases submitted to each audit or enquiry, as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The table below shows:

- The national clinical audits and national confidential enquiries that Pennine Acute Hospitals NHS Trust was eligible to participate in during 2018/19.
- The national clinical audits and the national confidential enquiries that Pennine Acute Hospitals NHS Trust participated in during 2018/19.
- The national clinical audits and the national confidential enquiries that Pennine Acute Hospitals NHS Trust participated in. and for which data collection was completed during 2018/19, are listed below alongside the number of cases to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Project Name	Provider Organisation	Eligible	Participated	% Submitted
National Neonatal Audit Programme (NNAP)	Royal College of Paediatrics and Child Health	Yes	Yes	100%
Maternal, New-born and Infant Clinical Outcome Review Programme	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	Yes	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Royal College of Obstetricians and Gynaecologists	Yes	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People	Royal College of Paediatrics and Child Health	Yes	Yes	100%
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	Yes	Yes	100%
ICNARC (Case Mix Programme)	Intensive Care National Audit and Research Centre	Yes	Yes	100%

National clinical audit *continued*

Project Name	Provider Organisation	Eligible	Participated	% Submitted
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	Yes	Yes	100%
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership	Yes	Yes	96%
National Diabetes Audit – Adults*	NHS Digital	Yes	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health	Yes	Yes	100%
Inflammatory Bowel Disease programme / IBD Registry	Inflammatory Bowel Disease Registry	Yes	No	N/A
National Asthma and COPD Audit Programme*	TBC	YES	YES	100%
Adult Community Acquired Pneumonia	British Thoracic Society	Yes	Yes	100%
Non-Invasive Ventilation - Adults	British Thoracic Society	Yes	Yes	100%
Elective Surgery (National PROMs Programme)	NHS Digital	Yes	Yes	100%
National Ophthalmology Audit	Royal College of Ophthalmologists	No	No	N/A
National Bowel Cancer Audit (NBOCA)	NHS Digital	Yes	Yes	110%
National Lung Cancer Audit (NLCA)	Royal College of Physicians	Yes	Yes	100%
National Oesophago-gastric Cancer (NAOGC)	NHS Digital	Yes	Yes	90%
National Prostate Cancer Audit	Royal College of Surgeons of England	Yes	Yes	100%
National Audit of Breast Cancer in Older People	Royal College of Surgeons	Yes	Yes	100%
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	British Society for Rheumatology	Yes	No	100%
National Audit of Dementia	Royal College of Psychiatrists	Yes	Yes	100%
Myocardial Ischaemia National Audit Project (MINAP)	National Institute for Cardiovascular Outcomes Research	Yes	Yes	100%
Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research	Yes	Yes	100%
National Audit of Percutaneous Coronary Interventions (PCI)	National Institute for Cardiovascular Outcomes Research	Yes	Yes	100%
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre	Yes	Yes	100%
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research	Yes	Yes	100%
National Vascular Registry	Royal College of Surgeons of England	Yes	Yes	100%
National Comparative Audit of Blood Transfusion programme*	NHS Blood and Transplant	Yes	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Serious Hazards of Transfusion	Yes	Yes	100%
Falls and Fragility Fractures Audit Programme (FFFAP)*	Royal College of Physicians of London	Yes	Yes	100%
Sentinel Stroke National Audit programme (SSNAP)	Royal College of Physicians	Yes	Yes	100%
National Audit of Intermediate Care	NHS Benchmarking Network	Yes	Yes	100%
Major Trauma Audit	The Trauma Audit and Research Network	Yes	Yes	100%
Feverish Children (care in emergency departments)	Royal College of Emergency Medicine	Yes	Yes	100%
Vital Signs in Adults (care in emergency departments)	Royal College of Emergency Medicine	Yes	Yes	100%
VTE risk in lower limb immobilisation (care in emergency departments)	Royal College of Emergency Medicine	Yes	Yes	100%
Seven Day Hospital Services	NHS England	Yes	Yes	100%
Surgical Site Infection Surveillance Service	Public Health England	Yes	Yes	50%

National clinical audit *continued*

Project Name	Provider Organisation	Eligible	Participated	% Submitted
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Public Health England	Yes	Yes	100%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)*	Public Health England	Yes	Yes	100%
National Mortality Case Record Review Programme	Royal College of Physicians	Yes	Yes	75%
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol's Norah Fry Centre for Disability Studies	Yes	Yes	100%
National Audit Care at End of Life (NACEL)	NHS Benchmarking Network	Yes	Yes	100%
BAUS Urology Audit - Cystectomy	British Association of Urological Surgeons			
BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	British Association of Urological Surgeons	Yes Yes	Yes Yes	100% 100%
BAUS Urology Audit - Nephrectomy	British Association of Urological Surgeons	Yes	Yes	100%
BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL)	British Association of Urological Surgeons	Yes	Yes	100%
BAUS Urology Audit – Radical Prostatectomy	British Association of Urological Surgeons	Yes	Yes	100%

Note: For Information on non-participation please see the Pennine Acute Hospital NHS Trust's Clinical Audit 2018/2019 Annual Report.

NCEPOD confidential enquiries

Title	Eligible	Participated	% of Cases Submitted	% Questionnaire Submitted
Pulmonary Embolism Study	Yes	Yes	100%	31%
Acute Bowel Obstruction	Yes	Yes	100%	75%
Long Term Ventilation	Yes	No	N/A	N/A

National clinical audit: actions to improve quality

The reports of 30 national clinical audits (including two NCEPOD reports) were reviewed by the provider in 2018/19 and Pennine Acute Hospitals NHS Trust has taken or intends to take the following actions to improve the quality of healthcare provided.

Title	Outcome
National Dementia Audit	The Trust participated in the 2018 National Dementia Audit achieving case ascertainment at each Organisation. The report will be published in 2019. Throughout the national data collection, evidence for local learning was simultaneously collated. The findings were delivered to the relevant divisional nursing leads thus eliminating the delay in addressing issues whilst awaiting publication of the national report. These will be discussed at relevant divisional meetings and will form a preliminary base for action planning.
National Audit of Inpatient Falls	The audit report was published in early 2018, each Organisation achieved case ascertainment. The report was discussed within the directorate and an action plan created. This included such items as: › Process mapping lying and standing blood pressures. › Education. › Test of change. All actions have been successfully completed. In 2019 the audit moved to continuous data collection with close links to the National Hip Fracture Audit. The Organisational questionnaire was completed in January 2019 and data collection commenced in February 2019.
National Heart Failure Audit	The Trust continued to participate in the national audit throughout 2018 working closely with clinical teams to ensure efficient data collection and submission. In 2018 the national reporting methodology switched to a combined National Cardiac Audit Programme (NCAP). This brought together six major cardiac audits for patients treated in the UK for heart disease. Heart Failure is within the six. The latest report was published in November 2018 and presents aggregate data from 2016/17; 16 key national recommendations were made. The report was shared widely within the directorate however due to the methodology change; local level data was not contained within the national report. Local data has been collated and shared with the directorate to assist action planning in 2019. The 2019 NCAP report is awaiting publication containing data for the 2017/18 period.
Sentinel Stroke National Audit Programme (SSNAP)	The Organisations continued to participate in SSNAP throughout 2018 with quarterly data submissions. The fourth annual report was published in 2018 and details results from 2016/17. Positive results were identified; the directorate are responsible, in collaboration with community staff, to complete an action plan around areas of concern during 2019.

National clinical audit: actions to improve quality *continued*

Title	Outcome
National Hip Fracture Database	The latest report, published November 2018 (2017 data) identifies good practice across both participating hospital sites. Areas of good practice evidenced around assessment criteria, especially physiotherapy assessment and post op bed mobilisation. This can be coupled with findings of the outcomes data, where very low numbers of patients developing a pressure ulcer are reported. The findings have been shared with the division and trauma and orthopaedic directorate. Action plans are requested for areas of failing / concerning performance, these actions will be monitored in monthly directorate meetings throughout 2019.
National Joint Registry	The Trust continues to submit data to the audit during 2018 and 2019 with combined current completeness rates at: › 2018 - 100% and 96% 2019 to date. › 571 hip procedures and 671 knee procedures were performed on 2018. › At the Royal Oldham hospital consent rates dipped in August and February 2018. A 2018 annual report is awaited however, the clinical audit department are in the process of compiling reports based on local available data.
National Bowel Cancer Audit	The 2018 report details patients accessing services between April 2016 and March 2017; it reviews the quality of bowel cancer services by monitoring against set measures. Case ascertainment exceeded 100%, improvements are observed in the proportion of patients having major surgery with no ASA recorded. Length of hospital stay has also reported improvements along with adjusted 18 month stoma rates. The report will be presented at the directorates Audit and Governance meeting on 26 February 2019 following which a comprehensive action plan will be created. Additional work has been undertaken by the lead clinician around the 90 day and 2 year mortality and length of stay data. This exercise involves a review of the last two years data, the findings will be presented in the same forum.
National Oesophageal Cancer Audit	The 2018 report was published in September 2018. Case ascertainment reached above 90% and some positive improvements were noted. The Trust does not treat non palliative patients therefore only holds responsibility for the referral and diagnostic proportion of this national audit with responsibility shared between Salford Royal and The Christie. The report and key findings were shared with the directorate; the lead clinician will be working directly with the clinical audit manager to produce an action plan.
National Prostate Cancer Audit	The latest annual report was published in February 2019; it contained very positive findings with the Trust reporting above national and regional benchmarks. Some slight reductions in the recording of TNM & Gleason score were noted. The report has been shared with the directorate and findings will be discussed at their audit and governance meeting in March 2019. An action plan may be pulled together however, the results are very positive and consistently above national levels.

National clinical audit: actions to improve quality *continued*

Title	Outcome
National Lung Cancer Audit	The Trust submitted a total of 625 lung cancer cases to the audit. 96.5% of cases had a complete pre-treatment staging and 91% had a performance status documented, both figures are higher than national findings however, both are a decrease in comparison to the previous years published results. One year survival rate is observed as 38.2%, compared to 38% nationally. The report was widely discussed within directorate and divisional meetings. An action plan was compiled by the audit lead and deadlines assigned to all items; these included the review of the medical oncology pathway and an audit of NOS cases.
National Breast Cancer in Old People	The 2018 national report details data on patients diagnosed between 2014 and 2016 and contains data for 739 Trust patients. The national reports contain aggregate data however local data is currently being reviewed and an action plan collated by the directorate with assistance from the clinical audit department.
National 4th Emergency Laparotomy Audit	The national report along with the key findings have been presented to the respective Care Organisations requesting review and provision of action plans on the areas identified for improvement. North Manchester achieved 91.3% case ascertainment, Oldham 100% both figures higher in comparison to to other hospitals. The report was presented at the directorate Audit and Governance meeting on 20 November 2018. Areas requiring improvement will be highlighted on a regular basis through newly implemented monthly dashboard reporting.
National Paediatric Diabetes Audit	Full participation in 2018 with data collection ongoing and the report expected in June 2019. The 2018 (2017 data) report has been presented at internal divisional meetings and an action plan was created in June 2018. The action plans look to deliver against the Trust being an outlier for HbA1c in comparison to national averages. The action plan is closely monitored within the division and is to be reviewed in March 2019.
National Neonatal Audit Programme (NNAP)	The Trust continues to participate annually in this audit programme. The 2018 report (2017 data) was published in October 2018 and shared widely throughout the division. Both North Manchester and Oldham hospitals have created comprehensive action plans to be monitored throughout 2019. The action plans are individual and look to address different areas reflecting the variance in practice across sites. A schedule of small audits combined with QI projects is planned.
National Diabetes Audit	The Trust continued to participate during 2018 with a methodology switch implemented to continuous data collection. The 2017 reports were presented at Clinical Effectiveness meetings during 2018. This informed on required actions for: › A reduction in the number of prescription errors. › Improvements to foot inspections and MDT meetings. › Overall patient satisfaction. An update on all actions is scheduled for June 2019.

National clinical audit: actions to improve quality *continued*

Title	Outcome
7 Day Services	The Trust met submission in April 2018 achieving above recommended case ascertainment. 79% compliance to clinical standard 2 (CS2) Time to first Consultant review, (target within 14 hours) with all data validated by Consultant leads. Week day compliance to CS2 reached 85% with weekend dipping to 71%. The model for reporting switched to a Board Assurance Framework (BAF) in 2019 and the Trust will participate in the Pilot of this reporting method in February 2019.
National Audit Care at End of Life (NACEL)	The Trust participated fully in this audit in 2018. Data was submitted by all Care Organisations with clinical leadership from Bereavement Nurses. The report for this audit was received in March 2019 from which the key findings were produced and shared across the directorate. An action plan has also been produced and will continue to be monitored in preparation for round 2 due to commence in June 2019.
National Mortality Case Record Review Programme	During 2018 the Trust has worked to standardise the mortality review process across each Care Organisation. Collaboration between management, QI and clinicians has seen an increase in reviews to 80%. Work is underway to build upon this and ensure the 100% target by 2020. Stage 1 reviews are currently being developed within directorates across each Organisation and the Trust continues to increase the number of staff qualified as Structured Judgement Reviewers (SJR).
National Vascular Registry	The Trust continues to submit and report on data from the National Vascular Registry. The latest report was published in 2018 and covers data from 2015-2017. **Carotid Endarterectomy:** Pennine Acute Hospitals Trust is one the highest performing Carotid Endarterectomy (CEA) Vascular Centre in the Northwest of England. › During 2017 the median delay, for a carotid endarterectomy from symptom to surgery, was 8 days, compared to 12 days across the UK. › Our in-hospital survival rate for CEA's, during 2017 was 99.2%. The national in-hospital survival rate was 98.0%. **Elective Infra-renal AAA repairs:** During 2015-2017 the vascular team performed a total of 176 abdominal aortic aneurysm (AAA) repairs. In-hospital survival rate for elective AAA repairs (Open and EVAR) is 99.0%. The national in-hospital survival rate was 98%. Our process of care for elective AAA patients shows: › 100.0% of patient had a formal anaesthetic review. › 98.0% of patient had their fitness measured. › 100% of patients were discussed at the weekly vascular MDT. **Lower Limb Amputations** NCA in-hospital survival rate for major lower limb amputations, over a three-year time period 2015-2017, was 95.6% compared to the national in-hospital survival rate of 94.5%. The results show that the Organisations are delivering safe surgical care with the results and practice being discussed at weekly MDT and directorate meetings.

National clinical audit: actions to improve quality *continued*

Title	Outcome
National COPD Audit Programme	Participation continued throughout 2018 with all sites barring Rochdale Infirmary eligible. Data is available for the first two quarters of the 2018/19 period and reports: › BPT at 26%. › Case ascertainment 97%. The last quarter will be populated in due course. Compliance reports are distributed throughout divisions and directorates ensuring early identification of performance / trends and allowing for adequate action planning. 2017 results were shared widely within the divisions resulting in the creation of a regularly meeting project group to monitor compliance and actions. The Trust results identified room for improvement in all areas ranging from provision of timely care, recording key clinical information, and smoking cessation.
ICNARC (Case Mix Programme)	The Trust continues to fully participate in the Case Mix Programme and has done so since its conception in 2011. The 2017/18 annual report identified: › 100% data completeness. › 319 high risk sepsis admissions. › 1 unit acquired blood infection. › Between 5-10% of admissions were out of hours. › Between 0-4% direct admissions to home. › Between 0-3% of non-clinical transfers to another unit and unplanned readmissions. The results are widely shared throughout the Critical Care directorate who hold overall responsibility for this audit. The results are positive but should any actions be required these would be addressed and monitored through Clinical Effectiveness Committees.
National Intermediate Care Audit	There was full participation to both the Organisational and Service User audit during 2017/18. The audit identified reductions in all three branches of categorising the effectiveness of intermediate care. Service user experience was generally positive with 99% of people feeling they were treated with dignity and respect. Waiting times post referral have increased in both home and re-ablement services. 71-81% of patients are successfully discharged to home. The Chief Executive received the latest report and has tasked the Trusts intermediate care leads to report on progress of the development and implementation of an action plan.
RCEM – Fractured Neck of Femur	The results of the audit were published in June 2018 and have been presented at the three Emergency Departmental Audit meetings. Localised action plans have been developed to include: › Education all triage staff importance of pain score. › New fracture neck of femur pathway has in cooperated assessment on arrival pain score assessment. › Posters developed highlighting the targets / standards. Snapshot reviews to be undertaken during 2019/20 to monitor compliance of the action plan.

National clinical audit: actions to improve quality *continued*

Title	Outcome
RCEM – Procedural Sedation in adults	The results of the audit were published in June 2018 and have been presented at the three Emergency Departmental Audit meetings. Localised action plans have been developed to include: › New assessment form is being used to assess and document pre procedure assessment. › Further education has been delivered to staff. › Poster encouraging use of pro forma to be put up in doctors' office. Snapshot reviews to be undertaken during 2019/20 to monitor compliance of the action plan.
RCEM – Pain in Children	The results of the audit were published in June 2018 and have been presented at the three Emergency Departmental Audit meetings. Localised action plans have been developed to include: › Educate all triage staff that pre-hospital analgesia should be documented as part of triage text. › Quality Improvement Project identified and is underway. › Poster displayed to assist with initial scoring and instructing triage staff to complete and hand out pain assessment sheets. Snapshot reviews to be undertaken during 2019/20 to monitor compliance of the action plan.
BTS - National Adult Bronchiectasis Audit	Both the organisation and audit finding reports have been distributed to the care organisation respiratory teams. Actions plan templates have been distributed to the respiratory leads and the paediatric leads across the care organisations. They have been generated to include the national improvement plan.
UK TARN	The Trust continues to participate in this annual national audit. The latest available data covers the first two quarters of 2018/19 and reports on evidence based measures and system indicators. These reports are provided for each Care Organisation. The reported quality of the data for the quarter one and quarter two are: › North Manchester 94.7%. › Bury 92.4%. › Rochdale 89.8%. › Oldham 96.9%. Actions are devised between the Lead Clinician and the Trusts UK TARN user Coordinator who monitor progress closely. Presently the team are concentrating on reducing times to CT and the grade of Doctor reviewing the applicable patients.
NCEPOD - Acute Heart Failure (Failure to Function)	The national report was received by the Trust in November 2018. The Cardiology teams across the Trust are in the process of reviewing the study results and are linking relevant areas identified for improvement from this study to the findings of the National Heart Failure audit.
NCEPOD - Peri-operatives Diabetes Patient Management (Highs & Lows)	The national report was received by the Trust in November 2018. The clinical teams across the Trust are in the process of reviewing the study results and will then develop action plans linked to their services to address any areas requiring improvement.

Local clinical audit

The reports of 79 local clinical audits were reviewed by the provider in 2018/19. The table below includes examples of local audits reported in 2018/19. Further actions planned and undertaken in response to the audit findings will be detailed in Trusts 2018/19 Clinical Audit Annual Report.

Bury & Rochdale Care Organisation	
Audit title	**Actions taken / planned**
GP Summary Letters after Attendance in the Emergency Department	The aim of the audit was to assess the quality of discharge letters completed by Doctors from the Emergency department at Fairfield General Hospital. Variance in results was identified with positive findings around the documentation of diagnosis, treatment, medication and additional comments to the GP. Improvements required in the documentation of status (ward admitted to) and imaging. As a result of this audit the following recommendation was created: Staff should be made aware of the importance of accurate coding and using added explanatory text to clarify diagnoses, management, and follow up that may be appropriate. This should be discussed at induction training. Compliance to this is monitored departmentally with a re-audit required to assess improvements.
Audit of Expectations of Patients in a Secondary Care Pain Clinic	An audit conducted with the aim of exploring the reasons why new patients attend pain clinic and to ascertain their expectations with regards to further management of their pain. A patient survey was completed and the findings suggested that patients are keen that their pain problem is recognised as a health problem affecting their life. A high proportion of patients are seeking medication changes or procedural interventions rather than psychological therapies and support and a significant number would like their pain to be further investigated. There is also an interest in exploring alternative therapies. This suggests either that patients are referred before they have reached the endpoint in their medical / surgical investigations or interventions. The findings were disseminated throughout all pain and anaesthesia colleagues and were presented at the audit and governance meeting in January 2019. Actions were compiled and will be monitored throughout 2019.
HMR Pressure Area Management Documentation re-audit	A re-audit undertaken in June 2018 with the aim to assess if standards of documentation and care in relation to Pressure Area Management delivered by the HMR Integrated Neighbour-hood teams had improved. 100% compliance was only achieved in two key areas, staging and incident reporting, however, the results show vast improvements in documentation of pressure area management. The majority of teams are now achieving 100% compliance in many of the areas audited. Where improvement isn't evidenced the results have remained static with no deterioration in the standard of documentation. The results were presented within the division and the following actions will be monitored. Ongoing provision of wound management training, pressure area management and documentation training alongside an annual audit.

Local clinical audit *continued*

North Manchester Care Organisation	
Audit title	**Actions taken / planned**
An assessment on appropriateness of listings and DNA for flexible cystoscopy	The main aim of the audit was to identify patterns in non-attendance rates (DNA) and cancellations in flexible cystoscopy clinics across the trust and to monitor appropriate indications for booking the procedure. The results of the audit highlighted that there is obvious variation in bookings across all three PAT sites where flexible cystoscopy is performed. There also appears to be a pattern of at least one DNA and one cancellation per list. The most common cause for last minute cancellation was found to be UTI identified on the day by urine dipstick. All procedures were requested for correct indications. The results of the audit have been discussed within a Urology audit and governance meeting in October 2018 from which a robust action plan has been developed. The division has been asked to monitor the implementation of the actions identified and a re-audit is planned for 2019.
Compliance with general surgery hot clinic standards and criteria	The aim of the audit was to perform a prospective baseline audit to assess on average how many patients are seen in the General Surgery Hot Clinic and what proportion of Hot Clinic patients meet the criteria for ambulatory care. The second objective was to implement a specific criteria-based guideline and monitoring programme to improve compliance with the ambulatory care criteria. The results of the baseline audit showed that the compliance with Hot Clinic criteria was very poor; however, the implementation of a specific criteria-based guideline for Hot Clinic significantly decreased the number of patients attending and improved the compliance with ambulatory care criteria. The findings from this audit were presented within a divisional governance meeting and a robust action plan was developed and successfully implemented including a specific criteria-based guideline for identifying eligible patients for ambulatory care.
Re-audit of needle stick injuries	A re-audit undertaken to determine if doctors are adhering to Trust protocols on dealing with needle stick injuries in order to ensure patients are provided with correct assessments and drugs and that follow ups are arranged for patients discharged from the department. Compliance was positive and the following actions have been taken. Creation of a single flowchart to include both staff and members of the public. Flow chart to be displayed in all ED's and all clinicians to ensure that all needle stick patients are appropriately discharged and follow ups arranged.
Intravenous Fluid Therapy	The aim of the audit was to assess the knowledge of junior doctors working in AMU and covering on call in IV fluid management, and their level of adherence to the NICE guidance. The results of the audit highlighted: A good level of knowledge of the type, rate and volume of fluid used, although reduced knowledge when to seek senior help and the role of human albumin solution in severe sepsis. Following the audit, teaching is being delivered to junior doctors in AMU during weekly teaching and planned to deliver teaching to foundation year doctors in December. To introduce information on IV fluid therapy into the junior doctor induction pack. › Weekly training for junior doctors in AMU. › Teaching for foundation year doctors. › Introduce IV fluid information into junior doctor induction pack.

Local clinical audit *continued*

North Manchester Care Organisation	
Audit title	**Actions taken / planned**
Patient discharges from Koala Admission Unit	The Paediatric Admission Unit or Koala Unit at North Manchester General Hospital has six beds and one back room for short stays unwell patients. Due to the high rates of referrals and admissions from either General Practice or Accident & Emergency department, delays to triage and assessment to patients occur during peak hours. An audit undertaken to identify the common medications that are dispensed to allow pharmacy to be aware of the high demand on certain medications, i.e. inhalers during winter seasons. Thus, this will ensure steps can be taken to ensure adequate medications are available and easily dispensed during peak hours. Secondly, potential causes can be identified, and measures implemented to assist delay reduction. The findings highlighted delays in completion of discharge summaries by the clinical team. Delays in medication request received by the pharmacist, inadequate staffing (pharmacist, technician, and dispenser) and multiple medication requests at one time for multiple patients. A comprehensive action plan was compiled by the directorate including the creation of a referral flow pathway and education of doctors on discharge summaries. These actions will be monitored throughout 2019.
Shoulder Dystocia Re-audit	Shoulder dystocia has significant association with maternal and neonatal morbidity. The aim of the audit was to review current compliance of shoulder dystocia management against standards of documentation, communications and both maternal and neonatal care. The results of the audit highlighted: › 0.9% incidence rate of shoulder dystocia. › 71% of women were not debriefed following delivery, this is an area for concern. › The fetal anterior shoulder was only documented in 66% of cases. › The Shoulder Dystocia Proforma was completed in only 69% of cases. The actions are currently under creation by the division.

Oldham Care Organisation	
Audit title	**Actions taken / planned**
Re-Audit Loss of Productivity due to IT delays	This audit / QI looked at the loss of productivity due to IM&T delays. It was conducted on a surgical ward at the Oldham Care Organisation over two separate time periods. The findings were very interesting resulting in evidence of potential delays of up to 7.5 hours in a week period. The re-audit was presented at the Trauma and Orthopaedic audit and governance meeting on 24 January 2019 where the findings and actions were widely appreciated. The clinician leading has devised solutions to overcome these time delays and has created an information tool for staff to follow. This will be shared at all Junior Doctor inductions / staff rotations across the Trust.

Local clinical audit *continued*

Oldham Care Organisation	
Audit title	**Actions taken / planned**
Skin closure technique in stoma reversal: Are we doing the best practice	An audit conducted with the aim to identify a multi-centre retrospective baseline to assess the most common skin closure technique used during stoma closure at the Trust. Stoma closure is associated with a high risk of Surgical Site Infection which can cause increased morbidity and poor quality of life. The audit identified that the Trust is not compliant to the recommended closure technique and practice varied between centres. This was raised within the surgical directorates and an action plan was successfully created. This included discussions between colorectal surgeons to consider PSC as the skin closure of choice. These discussions have been held in December and a re-audit planned for 2019.
Lymphoma Audit: concordance of departmental diagnosis and referral diagnosis	All suspected lymphoma cases at Oldham Care Organisation are sent to HMDS for an expert opinion with minimal tests completed locally, in accordance with local protocol. An audit conducted to evidence if some histopathology expertise has been lost with the advent of HDMS. The audit identified that 73% concordance locally with HMDS diagnosis and 100% compliance to the adequacy of core biopsy. There was clear evidence of an impressive reduction in inadequacy rates both locally and at HMDS. The findings were discussed at the Trust Lymphoma MDT meeting in July 2018. Positive findings resulted in a singular action of a combined senior decision as to the level of detail required locally prior to expedition to HMDS.
Follow up of hepatitis C positive serology	National recommendation is that all patients with a positive or indeterminate hepatitis C serology should have a confirmatory serology test and an RNA PCR test within 12 months of the first positive serological rest. As a consequence of this recommendation the audit aimed to establish how many patients across the Trust have a serological and molecular test for the hepatitis C virus within 12 months of a positive hepatitis C virus serology. The audit identified non-compliance with just 17% receiving both tests. There was variance seen in compliance to the tests individually. The results of the audit were presented on 11 July 2018 departmentally, it was recommended that the trusts Microbiology Laboratory fall In line with the new UK SM and move towards reflex NAAT testing of first positive HCV serology samples. Currently the audit findings are under review with the management team. The audit findings and minutes of the meeting have been shared with clinicians, GPs and other clinics dealing with high risk patients for HCV in order to highlight the need for improvement of patient follow ups.

Local clinical audit *continued*

Oldham Care Organisation	
Audit title	**Actions taken / planned**
Re-audit Paediatric Escalation and Care Quality (MANCHEWS)	The MANCHEWS (Manchester Children's Early Warning System) is a track and trigger traffic light system used to record and score the patient observations using age specific parameters for six physiological recordings. A second round re-audit to ensure the action plan put in place previously has been successfully implemented and improvements have been made. The results of the audit highlighted that the actions from the previous re-audit have not shown a high level of improved compliance, with the exception of patient's observations being documented in 25.82% more cases. Actions have been created and are monitored within directorate meetings. These include the medical team reminded at each morning handover to ensure Consultants see every new patient on their ward round. Medical staff reminded of the importance to use labels for patients scoring amber and red and the importance of documenting observation in the patient's notes.
Re audit of the use of Vancomycin on the Neonatal Unit	The original audit showed babies less than 29 weeks gestation were not achieving therapeutic levels with the existing Vancomycin schedule, as per the recommendation the schedule was changed. The aim of this re-audit was to assess whether the amended schedule was appropriate in achieving therapeutic concentrations. Findings were positive with significantly more patients achieving therapeutic range sooner and 100% of patients were treated as per the guideline. The findings were discussed within the division and further amendments were made to the schedule to assist continued improvements.

Participation in clinical research

The Trust is committed to research and transformation as a driver for improving the quality of care we provide to our patients. It enables our staff and the wider NHS, regionally and nationally, to improve the current and future health outcomes of the people we serve. Only by carrying out research into "what works" can we continually improve treatment for patients, and understand how to focus NHS resources where they will be most effective.

We currently support 497 research studies, of which 159 are clinical trials involving medicinal products. Our engagement with clinical research demonstrates the Trust's commitment to testing and offering the latest medical treatments and techniques. During 2018/19, we recruited patients to 111 National Institute for Health Research Clinical Research Network (NIHR CRN) clinical research studies. The number of patients receiving NHS services provided or sub-contracted by the Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 31,500. This year, more patients from across our Trust have participated in high quality NIHR research studies than in any other previous year.

Furthermore, the Trust was the top recruiting NHS organisation to NIHR CRN studies in England, which is a fantastic achievement and demonstrates our commitment to high quality research.

The Trust's reputation for attracting, initiating and delivering high quality industry trials has continued to grow this year, with the Trust currently supporting 118 industry sponsored trials. Our extensive collaborations with industry provide our patients with the very latest access to state of the art treatments and interventions.

Goals agreed with commissioners: use of the CQUIN payment framework

A proportion of Pennine Acute NHS Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Pennine Acute NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

For 2018/19 the baseline value of the CQUIN for Acute clinical contracts was 2.5% of the contract value, the national CQUIN schemes attracted 1.25% of the available 2.5%. The remaining 1.25% is linked to local Sustainability & Transformation plans. For NHS England specialised services the CQUIN value equates to 2.8% of the contract value – this is because NHS England are using the CQUIN framework to incentivise those Trusts that lead one or more operational delivery networks. Pass through costs such as high cost drugs and devices do not attract CQUIN payments. The value of the schemes for the acute clinical contracts is £5m with a further £5m associated with STF. The value of NHS England CQUIN schemes is £1.27m. There is a further £80k related to community services contracts.

For year to date performance 2018/19 (Q1 to Q3 inclusive) Commissioners for the NHS England contract have indicated that the majority of milestones have been met satisfactorily. Final performance for Q4 has yet to be appraised; for the indicators not currently performing, there is an opportunity to rectify by year end. For the community contract CQUIN schemes Q1–3 performance has been judged as achieving the required milestones.

For the acute activity contracts commissioners have indicated that some milestones have not been satisfactorily met for some discrete areas of specific schemes. It has been agreed that where milestones have not been met but there is an opportunity to address in the final quarter that these milestones will be judged in Q4. Q4 data will be shared with commissioners at the end of April 2019; and a final response is usually to be expected for the end of the following month.

Appendix A

Provides a breakdown of CQUIN goals for 2018/19.

Statements from the Care Quality Commission

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

The CQC has not taken enforcement action against The Pennine Acute Hospitals NHS Trust during 2018/19.

The Pennine Acute Hospitals NHS Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2018/19:

1. Reviewing of Safeguarding in the Emergency Department at Fairfield Hospital as part of the CQC health economy wide 'Children looked after and safeguarding reviews'

The CQC visited the Emergency Department at Fairfield General Hospital on the 7 September 2018 and undertook a review of safeguarding systems and processes as part of their health economy wide 'Children looked after and safeguarding reviews'.

The identified issues have required a health-economy approach to address; the ones with a specific impact at the Bury & Rochdale Care Organisation are as follows:

I. **Capacity of the Safeguarding team** across the Pennine Acute Trust footprint; a business case was developed for an additional two nurse posts, one for children's and one for adults. These posts have been advertised.

II. **Effective communication** to ensure community health practitioners are promptly informed about children and young people presenting at ED; the Health visitor is now informed when a child between the ages of 0-5 years attends ED and the school nurse notified of all attendees of age 6-16 years. There are now procedures in place to follow up any concerns.

III. **System wide quality of information and communications technology (ICT)** to enable well-co-ordinated, streamlined and efficient transfer of information about children and young people who move between health and care services; Children safeguarding referrals are now submitted online as opposed to faxing; the pathway for routine information sharing between the ED and community services, such as health visiting and school nursing is being reviewed. A proforma has been developed for all clinicians to receive feedback on actions identified at safeguarding reviews and a secure email system is being set up to facilitate the transfer of information electronically.

IV. **Think Family' approach** has been strengthened to ensure regular and effective communication between midwives, health visitors, adult health practitioners and GPs by joint awareness raising of the need to escalate concerns. 'Think Family' has been discussed with all ED staff at FGH as part of the training to recognise safeguarding issues, including those patient attendances where there may be high risk mental health or domestic violence situations and the patient attends without their children who may be at home and may have witnessed inappropriate situations. The effectiveness of both the training and the 'Think Family' approach is monitored by the CCG led Safeguarding Governance and Assurance Group.

V. **Raised awareness of professional curiosity** of frontline clinicians was a key aspect for FGH. Specifically, this related to clinicians checking, following up and recording actions to safeguard children and young people. This has been strengthened by implementation of the Child Protection Information System (CP-IS), an electronic database that enables staff to review whether a child or young person is already known to social services. Additionally, a daily retrospective audit is in place which reviews all admissions against a standardised safeguarding checklist to ensure all appropriate referrals have been made.

VI. **Appropriate levels of paediatric doctor and nurse expertise** within the ED at FGH has been reviewed and additional recruitment has been successful and further is planned.

CQC inspection October / November 2017

Between 17 October and 16 November 2017 the Care Quality Commission inspected services at North Manchester General Hospital, The Royal Oldham Hospital and Fairfield General Hospital.

Oldham Care Organisation

At Oldham Hospital the CQC inspected: urgent and emergency services, medical care, surgery, critical care and service for children and young people. End of life care and outpatient and diagnostic imaging were not assessed and outcomes relate to the most recent inspection in 2016.

2016

Ratings for Royal Oldham Hospital

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

2017-18

Ratings for Royal Oldham Hospital

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

Following the inspection a full action plan was developed and continues to be monitored via the Oldham Care Organisation Assurance Committees. Action plans have been developed at divisional and directorate level and these are reviewed regularly to ensure appropriate progress is being made.

Key successes of the improvement plan

- Strengthening of response to workforce challenges with on-going recruitment events and improved recruitment proecsses, development of additional roles such as the trainee nurse associate, and improved nursing retention rates at Oldham Hospital.
- Improvement in paediatric pathways within the Emergency Department.
- A working group focusing upon the WHO (World Health Organisation) checklist within theatres, led by theatre staff to improve compliance and processes related to the checklist.
- Development of risk processes around incident management, risk registers and complaints.
- Engagement of staff in quality improvement projects across the organisation including deteriorating patients, pressure ulcer reduction and ending PJ paralysis.

Key challenges within the improvement plan

- Risks associated with IM&T including old unsupported IM&T systems.
- Continued focus required on recruitment particularly of nursing and medical staff and the impact this has upon reductions in usage of bank and agency.
- Management of capacity and demand and the operational pressures within services across the organisation; including urgent and emergency care and services for patients with cancer.

Bury and Rochdale Care Organisation

At Fairfield General Hospital the CQC inspected urgent and emergency care, medical services and surgery. The CQC did not inspect Rochdale Infirmary or Community Services which were rated as good overall at the last inspection.

2016

Ratings for Fairfield General Hospital

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

2017-18

Ratings for Fairfield General Hospital

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

2016

Ratings for Rochdale Infirmary

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

2017-18

Ratings for Rochdale Infirmary

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

Ratings for community health services

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

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

A full action plan was developed and is monitored at Assurance Committee and divisional level via a dashboard and visual checking by all senior staff.

Key successes of the improvement plan

- Quality Improvement project on deteriorating patients.
- Safeguarding Improvement Board – evidence based improvements focussed A&E.
- Implementation of revised paediatric assessment documentation in ED.
- Bespoke system of local nurse assurance audits.
- Statistically significant reduction in avoidable falls.
- Robust risk management system underpinned by Datix (risk management and incident reporting) database.
- Storage and documentation of medicines.
- Improvements to Registered Nurse staffing levels overall.
- Viewing room for recently deceased patients at FGH.
- Enhanced privacy in ED triage at FGH.

Key challenges within the improvement plan

- Safeguarding; continuing to evidence sustained reliability in response to September 2018 visit.
- Medical staffing; continuing to respond to challenges and ensuring reliable, consistent cover.
- Reducing reliance on temporary medical workforce.
- Ensuring reliable application and understanding of the Mental Capacity Act and Deprivation of Liberty legislation.

North Manchester Care Organisation

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

2016

Ratings for North Manchester General Hospital

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

2017-18

Ratings for North Manchester General Hospital

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

Following the inspection a full action plan was developed and continues to be monitored via the North Manchester Organisation Assurance Committees. Action plans have been developed at divisional and directorate level and these are reviewed regularly to ensure appropriate progress is being made.

Key successes of the improvement plan

- A strengthened response to workforce challenges with innovative approaches to recruitment including; overseas recruitment events and joint appointments in hard to recruit specialties.
- A reduction in agency spend.
- Achievement of trajectories for key areas of harm.
  - Infection control trajectories
  - Pressure ulcers
  - Falls
- Successful implementation of E-Obs.
- Embedded Governance Structures.
- Improvements in Governance Processes.
- Successful implementation of NAAS with 60% of wards either Green or SCaPe status.
- A working group focusing upon the WHO (World Health Organisation) checklist within theatres, led by theatre staff to improve compliance and processes related to the checklist.
- Engagement of staff in quality improvement projects across the organisation including deteriorating patients, pressure ulcer reduction and ending PJ paralysis.
- Mortality Reduction continuing to reduce.

Key challenges within the improvement plan

- Risks associated with IM&T including old unsupported IM&T systems.
- Continued focus on embedding support functions and training to consolidate application of the Mental Capacity Act.
- Continued focus required on recruitment particularly of nursing and medical staff and the impact this has upon reductions in usage of bank and agency.
- Management of capacity and demand and the operational pressures within services across the organisation; including urgent and emergency care and services for patients with cancer.

NHS number of General Medical Practice code validity

The Pennine Acute Hospitals NHS Trust submitted records during 2018/19 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episodes Statistics which are included in the latest published data.

The figures below are based on the full financial year for 2018/19:

The percentage of records in the published data which included the patient's valid NHS number was:

99.73% for admitted patient care;
99.87% for outpatient care; *and*
98.94% for Accident and Emergency care

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

99.95% for admitted patient care;
99.98% for outpatient care; *and*
99.83% for Accident and Emergency care

Information Governance and Information Security Assurance

The Information Governance Toolkit is no longer used nationally and has been replaced by the Data Security Protection Toolkit (DSPT). DSPT is an online self-assessment, which allows the Trust and partners to assess themselves against the National Data Guardian review's 10 data security standards and key requirements of the General Data Protection Regulation (GDPR). Pennine Acute NHS Hospitals Trust has additionally achieved the Cyber Essentials PLUS. Attainment of the new standards remain fundamental to accessing the NHS N3 secure network and to promote safe data sharing both key in supporting delivery of effective clinical care.

Clinical coding error rate

The Pennine Acute Hospitals NHS Trust was not subjected to the 'Payment by Results Clinical Coding Audit' during 2018/19.

During the course of 2018/19 a number of internal audits took place as part of our overall Clinical Coding Assurance programme, the below accuracy rates were submitted as evidence for the DSP Toolkit Standard 1 requirement. The Trust achieved the mandatory standard based on the below audit results.

The audit programme includes random samples of activity from the three care organisations, mortality indicators and data quality metrics.

The results should not be extrapolated further than the actual sample audited.

Primary Diagnosis	**94.22%**
Secondary Diagnoses	**96.66%**
Primary Procedure	**95.51%**
Secondary Procedure	**96.42%**

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

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

High quality information is:

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

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

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

Learning from deaths

In March 2017, the National Quality Board introduced new guidance for NHS providers on how they should learn from the deaths of people in their care. The Learning from Deaths framework is designed to help NHS providers identify where improvements in the quality of the care they provide to patients and their families can be made.

The Northern Care Alliance values prompt learning from experience from all aspects of patient care. As a Trust we are committed to learn from both positive and negative aspects of patient's care, with a clear process for completing mortality reviews to help identify where changes should be made to improve patient experience and safety for the future. The Learning from Deaths framework has been implemented to learn and continually improve the quality of care provided to all patients.

A care quality mortality review is carried out by named clinicians on patients who have died to determine whether there were any problems in the care provided. This is undertaken routinely to reflect, learn and improve in the absence of any particular concerns about care. By 03/2020 the Trust aims to have completed care quality mortality reviews on 100% of all in patient deaths.

Following a care mortality review a more in depth review may be undertaken called a structured judgement review (SJR). An independent clinician will conduct the SJR using a review methodology that has been validated by the Royal College of Physicians. It is based upon a clinician using explicit statements and care scoring to comment on the quality of healthcare in five specific phases of a patient's journey.

This is undertaken routinely for patients with learning disabilities, severe mental illness and unexpected deaths to ensure opportunities for learning and improving the care provided to these particular patients is not missed. It is also done where concerns exist, such as when bereaved families or staff raising concerns about care.

Following the publication of the guidance for learning from deaths The National Health Service (Quality Accounts) (Amendment) Regulations 2017 was introduced to require NHS providers to share the following data below:

During 2018/19 (between 1 April 2018 and 31 March 2019) 2,385 of The Pennine Acute Hospitals NHS Trust patients sadly died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

669 in the first quarter;

612 in the second quarter;

763 in the third quarter;

341 in the fourth quarter

By 28 February 2019, 722 deaths have received a mortality care quality review and 49 investigations have been carried out in relation to 2,385 of the deaths included above.

The following reporting is based on number of deaths from April-December 2018 as deaths in the fourth quarter are still subject to the mortality review process. These will be reported on separately in the Quality Accounts for 2019/20.

By 28 February 2019, 97 SJR methodology have been undertaken, and 41 investigations have been carried out in relation to 2,044 of the deaths included above. In 13 cases a death was subjected to both a case record review using SJR methodology and an investigation.

The number of deaths in each quarter for which a mortality care quality review, case record review using SJR methodology or an investigation was carried out was:

Mortality care quality review	Structured judgement review	Investigation	Total
252 in the first quarter	42	3	259
246 in the second quarter	21	18	249
159 in the third quarter	33	20	162

An estimate of the number of deaths during the reporting period included above, for which a case record review or investigation has been carried out which the Trust judges as a result of the review or investigation, were more likely to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the method used to assess this:

1 case record review using SJR methodology, representing 0.04% of the patient deaths during the reporting period, was judged to be having been more likely due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

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

1 representing **0.1%** for the second quarter.

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

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

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

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

The predominant themes from learning have been: improvement around delays in escalation of deteriorating patient and quality improvement work around poor documentation and improved clerking and handover information.

A description of the actions which the Trust has taken in the reporting period, and proposes to take following the reporting period, in consequence of what has been learnt in relation the death identified above:

The Trust has introduced a deteriorating patient collaborative and a North East Sector Sepsis collaborative to drive improvement.

In the following reporting period SMART learning (specific, measurable, achievable, realistic, timed) will be introduced to support follow up quality improvement action where learning has been identified.

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

3 case record reviews and 2 investigations completed after 1 April 2018 related to deaths which took place before the start of the reporting period.

An estimate of the number of deaths included above which the Trust judges as a result of the review or investigation were more likely to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this:

0 representing 0% of the patient deaths before the reporting period are judged to be having been more likely due to problems in the care provided to the patient.

Seven day hospital services

Pennine Acute NHS Trust has committed to implementing the NHS Improvement standards for seven day hospital services. The sections below describe the progress that has been made against the four priority standards:

Standard 2
Time to first consultant review

- The April 2018 audit showed that the Trust overall compliance with standard 2 was 91% at North Manchester, 78% at Oldham and 66% at Bury.
- All sites have increased the presence of acute / general medical consultants on site to a minimum of 12 hours per day at weekends and 14 hours per day presence of Emergency Medicine consultants.
- The Trust has expanded the paediatric consultant base to improve evening cover. Areas where the standard is difficult to achieve are the smaller surgical specialties such as Ear, Nose and Throat, Head and Neck, and Urology).
- A consultant for general surgery is on-site at the weekend to review admissions and operate 8am-8pm.
- There is 7 day consultant presence for obstetrics and gynaecology, including overnight shifts (but not on all nights). The Trust is working to recruiting more consultants.

Standard 5
Access to diagnostic tests

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

Standard 6
Access to consultant-directed interventions

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

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

- We have completely revised the working practices in medicine at the weekend. There are three consultant physicians (including acute physicians and general physicians) working each weekend. This facilitates consultant review of medical patients referred to medicine in accident and emergency, continuous post take ward rounds 8am-8pm and consultant review of the most unwell ward patients.
- On-call physicians visit all post-acute medical wards at weekends
- Increased establishment of acute physicians has enabled seven-day working on the acute medical unit (AMU) with acute physicians and/or general physician present and working in AMU from 8am to 8pm, seven days per week. This has also led to a daily consultant ward reviews of new AMU medical admissions seven days a week, until 8pm.

Business cases are being developed for further expansion of acute and general medical consultant numbers to further develop improved consultant presence.

Raising concerns at Pennine Acute Trust 2019

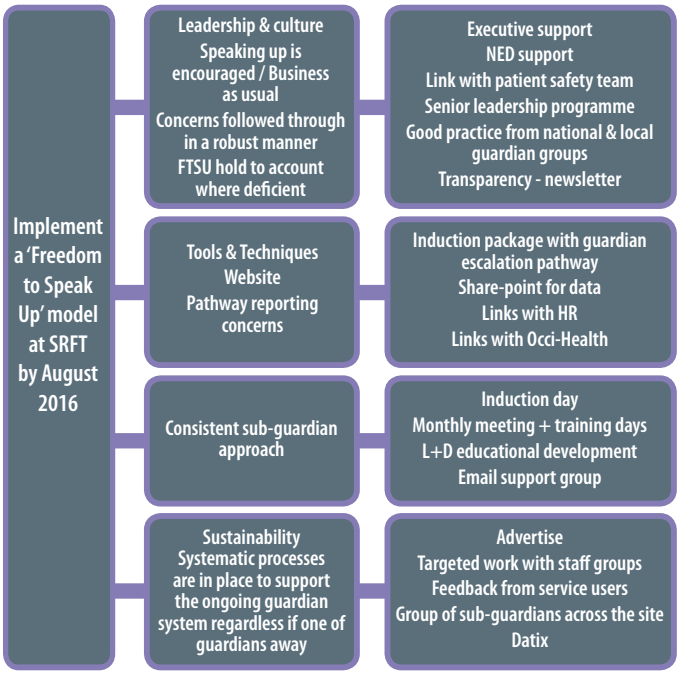
The Whistleblowing / Concerns Reporting Policy is a comprehensive document which outlines and provides guidance to staff about how to speak up. This policy provides support, reassurance and signposting for staff who may wish to report a concern.

In the first instance staff are encouraged to raise concerns via their line manager / HR or using the DATIX system. However, it is recognised that staff may feel it is challenging to report a concern and the Freedom to Speak Up Team (FTSU) have been established to provide confidential support to staff, particularly with regards to concerns which are related to patient safety. Staff are also informed about Safecall which is another independent means for staff to raise concerns.

The FTSU Team consists of a Lead Guardian and a team of sub-guardians independent of existing divisions and representing various staff groups and disciplines. The FTSU model was launched at Salford Care Organisation in August 2016, and the programme has been gradually rolled out to Pennine Acute Trust, with Royal Oldham Hospital first having a FTSU in place in September 2018, and Bury and Rochdale in November 2018. Interviews for the NMGH CO FTSU lead will take place on 29 March 2019.

The FTSU Team is responsible for supporting a culture where staff can feel confident to raise concerns. The service does this through increasing awareness of how to raise concerns, supporting individuals who wish to speak up and making sure that individuals who raise concerns receive feedback and outcomes related to their issues. The service works proactively to tackle barriers to speaking up.

Driver diagram representing implementation of FTSU



The FTSU team do not get directly involved in investigations, but remain independent and impartial to this process. The FTSU Guardian ensures regular contact is maintained with the individual who has raised the concern. This enables the FTSU team to hold the investigating team to account. Feedback is specifically requested on whether individuals suffer any detriment as a consequence of speaking up and the FTSU team provide support to the individual concerned and escalate to the executive governance and safety lead if any detriment occurs.

Updates and outcomes from any investigations are sought from the investigating team and are shared with the individual wherever possible in terms of how the issue was investigated and the conclusion of any investigation. If all outcomes cannot be disclosed (e.g. if it infringes the right to confidentiality of others) the guardian will explain this to the individual.

FTSU also ask for feedback from individuals who have approached the service. Anonymised example below:

Given your experience would you speak up again?
Yes.

Please explain your response to given your experience would you speak up again.
I raised my concerns and they were dealt with and escalated in a promptly and adequate manner.

Were you satisfied with the service from the Freedom to Speak up team.
Yes.

Please explain your response to were you satisfied with the service from the Freedom to Speak up team.
It was taken seriously and escalated appropriately.

Would you use the Freedom to Speak up Team again? (Please tick the box for Yes).
Yes.

Other comment:
I cannot praise higher your help with this matter. Thank you for raising this for me. Now it seems that common sense has prevailed. Now we will start conversations to streamline the service and measure its effectiveness, which was the right thing to do from the beginning.

Thank you again for your help.

The FTSU guardian is responsible for ensuring all concerns are appropriately and correctly logged, including confidentiality preferences and details of themes are reported.

The FTSU send out quarterly newsletters providing updates on the service and a synopsis of cases seen (when permission has been secured, with anonymised data) to ensure transparency of the FTSU service. The first Northern Care Alliance newsletter was sent out in October 2018 to coincide with FTSU month.

The Northern Care Alliance FTSU lead has support from a non- executive director.

FTSU at Salford Care Organisation also report to the National Guardian's office on a quarterly basis.

Since the team has been established at Pennine Acute Trust, 2 concerns have been raised to ROH, and 2 at Bury and Rochdale.

Reporting against core indicators

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

The core indicators are listed in the table below:

Domain	Indicator	2018/19	National average	Where applicable - Best performer	Where applicable - Worst performer	Trust statement	2017/18	2016/17	2015/16
Preventing people from dying prematurely	SHMI value and banding (most recent: January 2018 to December 2018)	**97.0** (October 2017-September 2018) (latest period available)	**100**	N/A	N/A	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reason: mortality reduction has been a focus for the Trust since publication of the Quality Improvement Strategy in 2017. The actions which the Trust has taken to achieve this score is detailed on the Mortality project page and throughout this Quality Account.	**101**	**107**	**111**
Enhancing quality of life for people with long-term conditions	% patients deaths with palliative care coded at either diagnosis or speciality level (most recent: October 2017 to September 2018)	**1.2%** (data taken from SHMI data – provided by NHS Digital)	**1.8%**	N/A	N/A	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust now has an established palliative care team who provide in reach across the hospital. The Pennine Acute Hospitals NHS Trust continues to take the actions highlighted in this Quality Account. to improve this percentage and so the quality of its services, by continuing to place the upmost. importance on high quality palliative care for our patients.	**21.3%**	**20.0%**	**21.7%**
Helping people recover from episodes of ill health or following injury	Patient reported outcome scores for groin hernia surgery (1 April to 30 September 2017 - most recent data release published in June 2018)	Data collection for this procedure ceased on 1 October 2017				The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. Nationally data collection ceased for this cohort of patients on 30th September 2017. Patients are encouraged to participate in the Friends and Family Test.	**0.04**	**0.077**	**0.102**
	Patient reported outcome scores for varicose vein surgery 1 April to 30 September 2017 - most recent data release published in June 2018)	Nationally data collection ceased for this cohort of patients on 30 September 2017				The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. Nationally data collection ceased for this cohort of patients on 30th September 2017. Patients are encouraged to participate in the Friends and Family Test.	**0.09**	**0.07**	*Trust data not published nationally due to low numbers
	Patient reported outcome scores for hip replacement surgery (1 April to 30 September 2018 - most recent data release)	Less than 30 modelled responses	**0.48%**	N/A	N/A	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. The Trust pre-operative assessment clinics for hip replacement are based on the site where the surgery is to take place and this has seen an improvement in patient compliance and expectation following surgery. The Trust continues to take the following actions to improve this outcome and so the quality of its services, by implementation of our Quality Improvement strategy.	**0.449**	**0.439**	**0.43**
	Patient reported outcome scores for knee replacement surgery (1 April to 30 September 2018 - most recent data release)	Less than 30 modelled responses	**0.343**	N/A	N/A	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. The Trust pre-operative assessment clinics for hip replacement are based on the site where the surgery is to take place and this has seen an improvement in patient compliance and expectation following surgery. The Trust continues to take the following actions to improve this outcome and so the quality of its services, by implementation of our Quality Improvement strategy.	**0.33**	**0.447**	**0.339**

Reporting against core indicators *continued*

Domain	Indicator	2018/19	National average	Where applicable - Best performer	Where applicable - Worst performer	Trust statement	2017/18	2016/17	2015/16
Helping people to recover from episodes of ill health or following injury	28 day readmission rate for patients aged 0-15	NHS Digital has not updated this metric since 2013.							
	28 day readmission rate for patients aged 16 or over	NHS Digital has not updated this metric since 2013.							
Ensuring that people have a positive experience of care	Responsiveness to inpatients' personal needs: CQC national inpatient survey score (care & treatment section score)	Data currently embargoed	N/A	9.0	7.5	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons: Improving the experience of the people that access our services, carers and families is one of the key priorities for the northern care alliance which Pennine Hospitals are part of. Significant work is in progress to support the development of corporate led programmes of improvement work and locally focused responsive systems. A variety of feedback systems are used and in development to improve real-time and near real time feedback including NHS Choices, patient stories and Observe & Act. The NCA approach is focused on developing user led driven improvements working with key stakeholders and community.	**7.8%**	**7.5%**	**7.7%**
	Percentage of staff who would recommend the provider to friends or family needing care 2018 Staff Survey	**60.1%**	**69.9%**	**90.3%**	**49.2%**	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust has implemented a number of actions from April 2016 onwards, such as the Pioneers' programme, 1000 voices and open surgeries with directors. These were aimed at further improving staff engagement and we can see from the 2018 survey that these have had a positive impact on staff which in turn benefits patients and patient care. The Pennine Acute Hospitals NHS Trust continues to take further actions to improve these outcomes and so the quality of its services, by continuing to deliver against any actions.	**56.4%**	**51.8%**	**55.4%**
Treating and caring for people in a safe environment and protecting them from avoidable harm	% of admitted patients risk-assessed for Venous Thromboembolism (Q3 2018/19)	**95.64%** (data published by NHS Improvement)	**95.65%**	**100%**	**54.86%**	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons: the Trust has an ongoing VTE project covering the entire North East Sector Care Organisations. Part of this project concerns increasing the completion of VTE risk assessments through improving compliance processes. The actions the Trust is taking to improve this percentage is detailed on the VTE project page in this Quality Account.	**95.61%**	**96.30%**	**96.72%**
	Rate of *C.Difficile* per 100,000 bed days	19.59	N/A	N/A	N/A	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons: Infection control is seen as one of the Trust's highest priorities with all cases of Hospital acquired C.Difficile reviewed and opportunities for learning are shared. Each case of C.Difficile is subject to a rigorous root cause analysis investigation involving a multi-disciplinary team, including colleagues from the CCGS, and any lessons learned are identified. These are shared with the team, and reported to the trust to promote best practice and to facilitate a whole health economy engagement process. The Pennine Acute Hospitals NHS Trust has taken the following actions to improve its percentage and so the quality of its services, by improving both the assessment and management of diarrhoea of unknown origin, improve timely isolation of patients with diarrhoea with the use of a risk assessment tool. Education and audit around assessment and management, an increase in cleaning where infection is suspected, high level disinfection of wards where patients are particularly vulnerable, the use of hydrogen peroxide vapour in areas with confirmed cases or where periods of increase incidence of infection are identified through surveillance,	**14.7**	**58**	**56**

Reporting against core indicators *continued*

Domain	Indicator	2018/19	National average	Where applicable - Best performer	Where applicable - Worst performer	Trust statement	2017/18	2016/17	2015/16
Treating and caring for people in a safe environment and protecting them from avoidable harm	Rate of patient safety incidents per 1000 bed days Prior to 2014/15 rate was based on 100 admissions 2018/19 data shows Q1 and Q2 only due to publication dates	Number reported = 8,701 Number per bed days = 46.2	**35.2**	**107.4** Croyden Health Services NHS Trust	**13.1** Weston Area Health NHS Trust	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. The Trust continues to promote a culture of open and honest reporting, whilst endorsing a fair blame culture. Pennine Acute Hospitals continues to take the following actions to improve this outcome and so the quality of its services, by encouraging a culture of voluntary reporting and endorsing a fair blame culture.	Number reported = 13,657 Number per bed days = 35.3	Number reported = 15,484 Number per bed days = 34.6	Number reported = 13,901 Number per bed days = 35
	Rate of patient safety incidents that resulted in severe harm or death per 1000 bed Prior to 2014/15 rate was based on 100 admissions 2018/19 data shows Q1 and Q2 only due to publication dates	Number reported = 42 Number per bed days = 0.2	**0.03**	**0.00** (Multiple Trusts)	**0.62** York Teaching Hospital NHS Foundation Trust	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. The Trust continues to promote a culture of open and honest reporting, whilst endorsing a fair blame culture. Pennine Acute Hospitals continues to take the following actions to improve this outcome and so the quality of its services, by encouraging a culture of voluntary reporting and endorsing a fair blame culture.	Number reported = 88 Number per bed days = 0.2	Number reported = 190 Number per bed days = 0.5	Number reported = 149 Number per bed days = 0.4
Ensuring that people have a positive experience of care	Inpatient Friends and Family Test	**90.9%** (January 2019)	**95%**	**100%**	**81%**	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. The Trust continues to promote the FFT survey to patients on their discharge. The Trust utilises this data to ensure a culture of open and honest reporting and encourages as many patients to participate as possible. The Pennine Acute Hospitals NHS Trust continues to take actions to improve these outcomes and so the quality of its services, by prioritising patient experience and engagement.	**90%**	**91%**	**93%**
Ensuring that people have a positive experience of care	Accident and Emergency Friends and Family Test	**83.7%** (January 2019)	**86%**	**100%**	**43%**	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. The Trust continues to promote the FFT survey to all patients who have attended accident & emergency. Feedback demonstrates transparency of our organisation. The Pennine Acute Hospitals NHS Trust continues to take actions to improve these outcomes and so the quality of its services, by prioritising patient experience and engagement.	**82%**	**81%**	**92%**

3

Other information

Performance against locally selected indicators

		Target	2018/19	2017/18	Comment
Patient Safety Outcomes	Hospital standardised mortality rate (calculated using annual benchmark)	Expected ratio = 100. Under 100 is better than expected	96.0%	98.3%%	
	Standard Hospital Mortality Indicator (SHMI)	National average = 1.00	97.0%	1.01%	Data collection is from October 2017 – September 2018 due to NHS Digital publishing date
	Hip Replacement SSI	National benchmark: 0.5%	1.0%		Most recent Trust wide data collection was 2017/18. SSI Surveillance Specialist Nurse is now in post with surveillance to commence first quarter of 2019/20
	Knee Replacement SSI	National benchmark: 0.4%	0.4%		
	Reduction of Long Bone SSI	National benchmark: 1%	3.0%		
	Repair of Neck of Femur SSI	National benchmark: 1.1%	3.1%		
	Safety thermometer acute - % of patients safe from new	95.0%	94.22%	98.6%	
	Safety thermometer community - number of patients safe from new harm	Local Target: 97.93%	94.42%	98.74%	
	Pressure Ulcers acute	Local measure not nationally benchmarked	160	164	
	MRSA	Local Target: 0	2	2	
	C.diff - All cases (including unavoidable)	Local Trajectory: 55 Cases	78	43	
	28 Day Readmission rate for patients aged 0-15	NHS Digital hasn't updated this metric since 2013			
	28 Day Readmission rate for patients aged 16+	NHS Digital hasn't updated this metric since 2013			
Clinical Effectiveness	Advancing quality - Composite Qualtiy score for Alcohol Related Liver Disease	70.7%	58.2%	51.5%	Please note the data provided is from 1 January 2018 to 30 November 2018
	Advancing quality - Appropriate Qualtiy score for Alcohol Related Liver Disease	50.0%	15.4%	1.9%	
	Advancing quality - Composite Quality Care score for AKI	55.3%	62.2%	35.3%	
	Advancing quality - Appropriate Quality care score for AKI	50.0%	21.6%	5.4%	
	Advancing quality - Composite Quality Care score for Diabetes	66.0%	69.6%	53.4%	
	Advancing quality - Appropriate Quality care score for Diabetes	50.0%	29.2%	9.9%	
	Advancing quality - Composite Care score for Pneumonia	89.2%	86.9%	82.1%	
	Advancing quality - Appropriate Care Score for Pneumonia	66.0%	65.3%	50.8%	
	Advancing quality - Composite Care score for SepsisNEWS	75.0%	74.7%	82.9%	
	Advancing quality - Appropriate Care Score for SepsisNEWS	50.0%	49.5%	50.1%	
	Advancing quality - Composite Care score for Sepsis	82.7%	86.9%	82.9%	
	Advancing quality - Appropriate Care Score for Sepsis	54.8%	61.6%	50.1%	
	VTE Risk assessment	95.0%	95.9%	95.3%	Please note the data provided is from 1 April 2018 to 31 December 2018

Performance against national indicators 2018/19

		Target	2018/19	2017/18	Comment
Patient Experience	% of adult in-patients who felt they were treated with respect and dignity	-	Data embargoed until August 2019	77.0%	
	% of adult in-patients who had confidence in the trust doctors treating them	National Picker score average	Data embargoed until August 2019	78.0%	
	Count of patients who waited more than 52 weeks for treatment	Local target: 0	Data embargoed until August 2019	-	
	GP Out of Hours - Time from case active to definitive telephone clinical assessment. Urgent calls within 20 minutes	-	Data embargoed until August 2019	-	
	GP Out of Hours - Time from case active to definitive telephone clinical assessment. Non-gent calls within 60 minutes	-	Data embargoed until August 2019	-	
Infection Control	Number of *C.diff* cases	**Local trajectory: 55 avoidable cases**	**78**	**43**	
	Number of MRSA Acquisition	**Local target: 0**	**2**	**2**	
	Number of MRSA Bacteremia	**Local target: 0**	**2**	**2**	
Access to Cancer Services	% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment	**96.0%**	**97.47%**	**98.22%**	
	% of cancer patients waiting a maximum of 31 days for subsequent treatment(anti cancer drugs)	**98.0%**	**100.0%**	**98.50%**	
	% of Cancer patients waiting a maximum of 31 days for subsequent treatment (surgery)	**94.0%**	**88.16%**	**93.91%**	
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (radiotherapy)	**No longer reported on**	**No longer reported on**	**No longer reported on**	
	% of cancer patients waiting a maximum of 62 days from urgent GP referral to treatment	**85.0%**	**74.07%**	**82.02%**	
	% of cancer patients waiting a maximum of 62 days from the consultant screening service referral to treatment	**90.0%**	**81.48%**	**71.43%**	
	% of cancer patients waiting a maximum of two weeks from urgent GP referral to date first seen	**93.0%**	**73.13%**	**89.07%**	
	% of symptomatic breast patients (cancer not initially suspected) waiting a maximum of two weeks from urgent GP referral to date first seen	**93.0%**	**64.13%**	**96.17%**	
Access to Treatment	18 weeks RTT - patients on incomplete pathway (Non Breached)	**N/A**	**33601**	**32447**	
	18 weeks RTT - patients on incomplete pathway (Breached 18 weeks)	**N/A**	**6072**	**5009**	
	Maximum 6-week wait for diagnostic procedures	**Maximum 6 week wait**	**23 weeks**	-	Note: measurement displays the longest waiting time experienced by a patient during 2018/19.
	Total patients on incomplete Pathway	**N/A**	**39673**	**37456**	
	% Incomplete pathways <92%	**92.0%**	**85.0%**	**86.60%**	
Access to A&E	% of patients waiting a maximum of 4 hours in A&E from arrival to admission, transfer or discharge	**95.0%**	**84.91%**	**83.56%**	Prior to July 2015 A&E was reported weekly
Cancelled operations	% of patients whose operations were cancelled by the hospital for non clinical reasons on the day of or after admission to hospital	**0%**	**1.56%**	**1.66%**	
Cancelled operations not treated within 28 days	% of those patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital, and were not treated within 28 days	**0%**	**15.58%**	**9.32%**	

NHS England patient safety alerts information 2018/19

Patient safety alerts are issued by NHS England (NHSE) to warn the healthcare system of risks and provide guidance on preventing incidents that may lead to harm or death.

The table below details the alerts issued by NHSE during 2018/19 and the Trust's response to each alert.

Reference	Alert title	Issue date	Response	Deadline date
NHS/PSA/W/2018/001	Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders.	9.1.18	The alert has been discussed at Pharmacy meetings and the Pennine Medication Safety Committee, liaised with colleagues at SRFT and a bulletin produced for issue to staff. A poster on safe use of cylinder produced by Head of Pharmacy and Medical devise Governance Manager. Estates also produced additional information regarding the use of the cylinders.	20.2.18
NHS/PSA/W/2018/002	Risk Of Death Or Severe Harm From Inadvertent Intravenous Administration Of Solid Organ Perfusion Fluids.	20.4.18	These products are not on our pharmacy system and the product is not ordered by pharmacy. The fluid is provided by the transplant teams and theatres have confirmed they do have any of this fluid in stock.	31.5.18
NHS/PSA/RE/2018/003	Resources to support the safe adoption of the revised National Early Warning Score (NEWS2).	25.4.18	NEWS2 Champions identified. Documentation reviewed, new NEWS 2 Chart produced Adult Observation Policy now updated to include documentation required as described in Alert.	21.6.18
NHS/PSA/RE/2018/004	Resources to support safer modification of food and drink.	27.4.18	Associate Directors AHPS for Speech and Language Therapy (SALT) are leading on a actions identified in alert. Implementation plan adopted in SRFT being shared to introduce at Care Organisations.	1.4.19
NHS/PSA/RE/2018/005	Resources to support safer bowel care for patients at risk of autonomic dysreflexia	25.7.18	Leads identified and specialist nurses involved in ensuring information disseminated and actions in the alert completed.	25.1.19
NHS/PSA/RE/2018/006	Resources to support safe and timely management of hyperkalaemia (high level of potassium in the blood)	8.8.18	Medical Directors provided leads to implement actions required in Alert. Progress to be monitored by care Organisations Clinical Effectiveness Committees.	8.5.19
NHS/PSA/RE/2018/007	Management Of Life Threatening Bleeds From Arteriovenous Fistulae And Grafts	12.11.18	Liaised with Medical Directors, leads identified for this alert to implement actions required. Quality & Patient Experience / Clinical Effectiveness Committees to monitor progress and agree to sign off when actions are complete.	13.5.19
NHS/PSA/RE/2018/008	Safer temporary identification criteria for unknown or unidentified patients	5.12.18	Alert Distributed to all Care Org Medical Directors, Dir Nursing, EP Lead to identify lead for combined approach across all care organisations.	5.6.19
NHS/PSA/RE/2018/009	Risk of harm from inappropriate placement of pulse oximeter probes	5.12.18	Medical Devices Governance Manager completed initial scoping exercise to identify where we have ordered which type of probe across all Care Orgs. Further work with practice educators to carryout actions. To be monitored by Clinical effectiveness committee prior to sign off.	5.6.19

Never Events reported during 2018/19

Never events are serious incidents that have occurred despite the presence of national guidelines or safety recommendations that should have prevented them from happening. Never events provide important insights into safety processes and highlight potential areas for improvement across the Trust.

During 2018/19, two never events were reported by the Trust. The details of what happened and the actions we have taken to prevent them from happening again are provided in the table below.

Never Event	Location Incident Occurred	Description	Key findings from root casue analysis	Actions to prevent recurrence
Unintentional connection of a patient requiring oxygen to an air flowmeter	North Manchester A&E	A patient who required oxygen was connected to an air flowmeter when the intention was to connect them to an oxygen flowmeter, this was a near miss incident that did not cause any harm to the patient.	Despite using black meters with black worded covering caps, the air tubing was attached.	All air flowmeters were removed from the Accident and Emergency Department (and all other clinical areas). This was following a discussion with the Consultant Clinical Lead who agreed that the need for piped air was not required in the department. Staff in ED will now be unable to connect any tubing to an air flowmeter as they are no longer available anywhere in the ED. Sufficient replacement nebuliser machines have been purchased. Incident now impossible to replicate.
Wrong site surgery - biopsies taken from wrong site	Rochdale Theatres	Patient consented for a colonoscopy procedure. Scope unintentionally introduced into the vagina and biopsies taken.	Investigation currently underway.	Report was immediately reported and an investigation is underway. This is currently within the 45 day timeframe for investigation. Learning will be shared following sign off of this investigation.
Wrong site surgery	Rochdale Theatres	Wrong sided interscalene brachial plexus block administered.	Investigation ongoing.	Action plan in development.

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

CCG statement for the Pennine Acute Hospitals NHS Trust Quality Accounts 2018/19.

A Quality Account is a report about the quality of services offered by an NHS healthcare provider and is published annually by all non-foundation NHS Trusts. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of the care and treatment patients receive; and feedback provided about their experience.

The Quality Account from the Pennine Acute Hospitals NHS Trust looks at achievements made during 2018/19, gaps in provision and sets out the Quality Plan for 2019/20.

Pennine Acute Hospitals NHS Trust (PAHT) has consulted widely with the Commissioners who make up the Pennine Acute Hospitals NHS Trust Footprint and this response is on their behalf and we are pleased to have the opportunity to comment on the Quality Account for 2018-2019.

The Commissioners are:

- NHS Bury CCG
- NHS Oldham CCG
- NHS Heywood, Middleton and Rochdale CCG

The Northern Care Alliance NHS Group (NCA) of which Pennine Acute Hospital NHS Trust is part of has grown in strength over the last year bringing together leadership, staff and expertise from Salford Royal Foundation Trust with the Care Organisations (CO) of North Manchester General Hospital, Oldham Royal Hospital, Fairfield General Hospital and Rochdale Infirmary; along with Domiciliary and Community Services.

In 2016 a Quality Improvement Strategy was put in place for the four hospitals of PAHT and we are looking forward to a refreshed strategy for the NCA as a whole.

Commissioners are supportive of the 5 overarching aims outlined in the 2016 strategy:

- No preventable deaths
- To seek out and reduce patient harm
- Achieve the highest level of reliable clinical care
- Put patients' needs at the heart of the business
- Deliver innovative and integrated care close to home

Quality improvement is a high priority for the NCA and is detailed in the day to day work of the organisation. Commissioners have seen a culture of making things better for patients from the leaders within the organisation and there has been a consistency in the approach of being open and engaging with us. We have had the opportunity to frequently meet with and work with the leadership team including the Medical Directors, Directors of Nursing and Managing Directors in resolving issues, partnership working and developing strategies for improved care for our local populations.

The quality improvement projects are well recognised by commissioners. CCG quality leads have had the opportunity to review, contribute and make recommendations to the projects that are underway across the Care Organisations.

The organisation has demonstrated progress in quality improvements in a wide range of initiatives throughout the year. The quality improvement projects reach across the organisation to include all professional groups and staff. A significant proportion of these projects are driven by front line staff of all disciplines and grades. The use of statistical monitoring provides robust evidence of the impact of projects on both the delivery, experience and outcomes for people in receipt of healthcare from the organisation. Commissioners would support the view that the evidence of improvement outlined in the Quality Report is an accurate reflection of the progress that has been made in 2018/19.

The priorities for 2019/20 are welcomed, they align to the expectations set out by NHS England both locally and nationally and are priorities that we would want to see for people in our boroughs.

The Care Quality Commission (CQC) provide a rigorous assessment of organisations. There has been a consistent steady improvement in all the domains measured by the CQC and we are particularly pleased to see an improvement in the domain of safety. Each Care Organisation has a robust plan of action to ensure there is focus and methods to reach the standards required to achieve a 'good' or better judgement from the CQC.

The organisation can evidence investment in their staff to be able to deliver the improvements set out by the CQC. The staff survey, recruitment/retention and sickness/absence are under constant review and the organisation demonstrates understanding of the importance of the workforce in delivering their objectives.

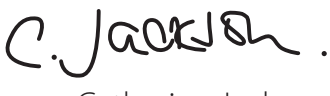
The 4 priority aims are:

- Pursuing quality improvement to assure safe, reliable and compassionate care
- Improve care and services through integration, collaboration and growth
- Deliver operational excellent
- Support our staff to deliver high performance and continuous improvement

The NCA describes high ambitions for the organisation for quality and sets itself targets and trajectories for improvement at pace for all aspects of the business.

The Quality Account acknowledges the challenges PAHT faces in the delivery of the improvements it strives for by recognising the need for IM&T solutions that can better support the business and service needs, recruiting and retaining a high-quality healthcare workforce and meeting their training and educational requirements. Furthermore, the increasing demand of services for both acutely unwell people and for elective admissions creates difficulties in meeting access and waiting time standards and impacts on the ability of the organisation to implement the quality improvement strategy at a pace it would wish.

The Commissioners acknowledge the work the organisation has done over the last year in relation to quality improvement and recognises that the NCA have taken great strides in providing assurance around their commitment to quality. The Commissioners look forward to continued collaboration and transparency to meet the quality agenda and improve outcomes for patients in the coming year.



Catherine Jackson
Executive Nurse Bury CCG on behalf of:
NHS Bury CCG
NHS HMR CCG
NHS Oldham CCG

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

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

We note the progress made on the 2017/18 Quality Account Aims and support the ambitious 2018/19 aims.

Quality

MHCC works very closely with partner Clinical Commissioning Groups that make up the North East Sector which works together to oversee quality and performance of PAHT as a whole.

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

Quality achievements of note in 2018/19 include:

- Achieved the top accreditation by the Joint Advisory Group on Gastrointestinal Endoscopy for their endoscopy units.
- The end PJ paralysis work which aims to get older people back home to their loved ones living much happier and fuller lives.
- Sepsis work- focused work on improving early detection and treatment.

MHCC commends PAHT on remaining below expected for the national risk adjusted mortality measures the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital Mortality Indicator (SHMI). MHCC is pleased to see that PAHT continues to prioritise reducing preventable deaths in 2019/20.

Performance

Although meeting the 4 Hour Accident and Emergency constitutional targets continues to be challenging, we have seen areas of improvement in urgent care. These include:

- NMGH have adopted the principals of the Greater Manchester ambulance handover standards. This has resulted in improved ambulance handover performance across all acute sites, thus reducing patient risk and improving patient experience.
- Delivery of same day emergency care service, incorporating primary care streaming and minor injury, operational 7 days a week.
- Expansion of patient flow and integrated discharge teams, extended discharge lounge opening hours, and embedding national patient flow principles, in order to improve bed capacity and hospital flow.
- A continued focus on reducing long length of stays, by working in collaboration with our system partner organisations on discharge planning, in order to ensure patients are discharged as soon as they are medically fit.

NGMH has taken positive steps to address cancer performance by creating a local cancer improvement group. This has facilitated positive work towards implementing best timed cancer pathways in lung and urology. These steps will improve patient outcomes and timely treatments.

Conclusion

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

We will continue to build on our relationship with the Trust as we move forward into 2019/20.

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

Ian Williamson
Chief Accountable Officer
Manchester Health and Care Commissioning

Date: *May 2019*

Response of North East Sector Healthwatch organisations (Healthwatch Bury, Healthwatch Rochdale and Healthwatch Oldham) to the Pennine Acute Hospitals NHS Trust Quality Account 2018/19

Healthwatch welcomes the opportunity to provide a combined response to the Pennine Acute Hospital NHS Trust Quality Report 2018/19.

General Comments

Healthwatch commends the many successes and the positive work being undertaken by Pennine Acute as highlighted in the Quality Report and welcomes the ambitious scope of its future priorities designed to drive up service quality across the combined hospital group.

We recognise the improvements in performance, particularly relating to the treatment of Sepsis and reduction in cardiac arrests and falls and welcome the high-ranking performance of stroke services at Fairfield Hospital. We commend the fact that Fairfield is the first in the UK to be part of the Homeless-Friendly programme and, along with North Manchester, is the first to achieve SCAPE status delivering 'safe, clean and personal care every time'. We also welcome other successes including Rochdale Infirmary's Discharge to Assess service and the positive CQC inspection showing an improvement in the experiences of new mothers using the maternity services at the Royal Oldham Hospital.

The Quality Improvement reviews and future priorities highlighted in the document show how the Trust is working to address many of the issues that have been raised by patients, services users, CQC, and health professionals. The examples show a positive approach to learning with actions from lessons learnt implemented and the adoption of best practice which is rolled out across the hospital group such as the Swan End of Life Care and Bereavement work.

We welcome the Trusts openness about its CQC ratings and are confident that areas that require improvements will be robustly addressed.

Specific Comments

Aims

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

  Healthwatch recognise the significant improvements pursued by the Trust but have concerns about inconsistent approaches to listening and engaging with public, patients and their families/carers to routinely offer qualitative feedback and help shape the transformation of Pennine Acute services. Healthwatch welcomes the opportunity to work with the Trust to ensure patients and members of the public are actively involved in the codesign of services through regular two way discussion and through the active response by the Trust to Healthwatch recommendations on behalf of the public set out in its acute service reviews.

continued next page

- **Deliver innovative and integrated care close to home which supports and improves health, wellbeing and independent living**

  We support this as a positive approach that can improve patient and carer experience through easier access to ongoing services, especially for patients managing one or more long term health conditions. We also recognise the challenge this poses as each area has slightly different locality arrangements for providing care close to home. We would encourage greater joint working at the local level to build more effective relationships with each Integrated Care Organisation and the active collaboration between partners to acknowledge local pressures facing primary care and social care teams. We also encourage the Trust to connect with the local community and voluntary sector to support reablement and recovery within a community setting and help reduce hospital readmissions.

Quality Improvements

- **Improving Urgent Care and Patient Flow**

  This is a positive approach designed to standardise practice and speed up appropriate discharge. We recognise the challenges posed by the increasing demands being placed on A&E Departments and welcome initiatives such as the Oldham Frailty Network being developed and encourage the active engagement of local stakeholders, patients and families to help shape this approach. We also encourage the Trust to consider the role of unpaid carers and family in the hospital discharge process through the statutory carers assessments process and access to carers support services within the community.

- **Clinical Reliability Groups: Achieve the highest level of reliability for clinical care**

  We welcome the work of the Clinical Reliability Group designed to improve standards of clinical care across the hospital group. Healthwatch recognise that this area faces challenges due to staff turnover and vacant posts and understand that this is an issue for other Trusts and not limited to Pennine Acute.

Priorities for future Improvements

- **National Clinical Audit**

  Regarding the 7 Day Service Healthwatch recommends improvements to the 71% average success rate of cases where the first consultant review has met the target of seeing a patient within 14 hours.

- **Access to Cancer Services**

  The target for symptomatic breast patients to be seen within two weeks of referral by the GP is significantly below target. This reflects patient feedback coming through Healthwatch and the NHS Advocacy service which has highlighted problems with referrals being subject to further triage and delay within the hospital system. We recognise the issues of capacity but would draw attention to the low achievement levels for this target that could significantly impact on success rates and patient experience.

We commend the number of audits which the Trust has undertaken and continue to expect that the NICE quality standards are explicitly complied with.

Annex 2:
Statement of responsibilities for the Quality Report

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

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

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2018/19 and supporting guidance Detailed requirements for quality reports 2018/19.
- 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 2018 to 24 May 2019
  - Papers relating to quality reported to the board over the period April 2018 to 24 May 2019
  - Feedback from commissioners dated 10/05/2019 (Bury, HMR and Oldham CCG) and MHCC 17/05/2019
  - Feedback from governors dated 13/05/2019
  - Feedback from Overview and Scrutiny Committee dated 17/05/2019
  - Feedback from local Healthwatch organisations dated 13/05/2019
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 13/03/2019
  - The 2018 national patient survey released June 2019
  - The 2018 national staff survey 26/02/2019
  - The Head of Internal Audit's annual opinion of the Trust's control environment dated May 2019
  - CQC inspection report dated 01/03/2019
- 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.

James J Potter
Chairman

Date: *24 May 2019*

Raj Jain
Chief Executive & Accounting Officer

Date: *24 May 2019*

Independent Practitioner's Limited Assurance Report to the Group Committees in Common of The Northern Care Alliance NHS Group on the Quality Report

We have been engaged by the Board of Directors of Pennine Acute Hospitals NHS Trust to perform an independent limited assurance engagement in respect of Pennine Acute Hospitals NHS Trust's Quality Report for the year ended 31 March 2019 (the "Quality Report") and certain performance indicators contained therein as part of our work.

NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

NHS Trusts have the option to include these quality account requirements in a quality report, together with additional requirements for quality reports set out in 'Detailed requirements for quality reports 2018/19' issued by NHS Improvement.).

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these national priority indicators collectively as "the indicators".

Respective responsibilities of the directors and Practitioner

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

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

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

As the Trust has opted to produce a Quality Report for 2018/19 the directors are also responsible for the content and the preparation of the Quality Report in accordance with the additional requirements set out in the 'Detailed requirements for quality reports 2018/19' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report is not prepared in all material respects in line with the criteria set out in the Regulations and 'Detailed requirements for quality reports 2018/19';
- The Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; *and*
- The indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the ''Detailed requirements for quality reports 2018/19' and the six dimensions of data quality set out in the "Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the Regulations and the "Detailed requirements for quality reports 2018/19', and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period 1 April 2018 to 24 May 2019;
- Papers relating to quality reported to the Board over the period 1 April 2018 to 24 May 2019;
- Feedback from commissioners dated 10 May 2019 (Bury, Heywood Middleton and Rochdale, and Oldham CCGs) and MHC 17 May 2019);
- Feedback from governors dated 13 May 2019;
- Feedback from local Healthwatch organisations dated 13 May 2019;
- Feedback from the Overview and Scrutiny Committee dated 17 May 2019;
- The Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated 13 March 2019;
- The national patient survey dated June 2019;
- The national staff survey dated 26 February 2019;
- The annual governance statement dated May 2019;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated April 2019;
- The Care Quality Commission's inspection report dated 1 March 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Board of Directors of Pennine Acute Hospitals NHS Trust as a body, to assist the Board of Directors in reporting Pennine Acute Hospitals NHS Trust's quality agenda, performance and activities.

We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Board of Directors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body, and Pennine Acute Hospitals NHS Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- Comparing the content requirements of the "'Detailed requirements for quality reports 2018/19' and supporting guidance to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary.

Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the Regulations and 'Detailed requirements for quality reports 2018-19'.

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

Our audit work on the financial statements of Pennine Acute Hospitals NHS Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Pennine Acute Hospitals NHS Trust's external auditors. Our audit reports on the financial statements are made solely to Pennine Acute Hospitals NHS Trust 's directors, as a body, in accordance with the Local Audit and Accountability Act 2014.

Our audit work is undertaken so that we might state to Pennine Acute Hospitals NHS Trust's directors those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Pennine Acute Hospitals NHS Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose.

In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Pennine Acute Hospitals NHS Trust and Pennine Acute Hospitals NHS Trust's directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- The Quality Report is not prepared in all material respects in line with the criteria set out in the Regulations and the "Detailed requirements for quality reports 2018/19';
- The Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; *and*
- The indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the "Detailed requirements for quality reports 2018/19' and the six dimensions of data quality set out in the "Detailed requirements for external assurance for quality reports 2018/19'.

Grant Thornton UK LLP
Chartered Accountants
4 Hardman Square
Spinningfields
Manchester
M3 3EB

Date: *24 May 2019*

4 Appendices

Appendix A: Breakdown of CQUIN goals for 2018/19

Applicable to	Name	Indicative value year two Community	Indicative value year two Acute
Acute and Community	NHS staff and wellbeing.	-	-
	Part 1 – Staff Survey	£2,172	£337,870
	Part 2 – Healthy foods	£2,172	£337,870
	Part 3 – Flu vaccinations for staff	£2,172	£337,870
Acute	Reducing the impact of serious infections	-	-
	Scheme 1 Part a – timely identification of sepsis – ED and Inpatient settings	-	£253,403
	Scheme 1 Part b – timely treatment of sepsis ED and Inpatient settings	-	£253,403
	Part c – Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours	-	£253,403
	Part d - Reduction in antibiotic consumption per 1,000 admissions	-	£253,403
Acute	Improving services for people with mental health needs who present in A&E	-	£627,919
Acute	Improving services for people with mental health needs who present in A&E - implementation of ECDS and quality of coding	-	£338,110
Acute	Offering advice and guidance	-	£1,013,611
Acute - 2018/19	Preventing ill health by risky behaviours	-	-
	Part 1	-	£50,681
	Part 2	-	£202,722
	Part 3	-	£253,403
	Part 4	-	£253,403
	Part 5	-	£253,403
Community - 2018/19	Preventing ill health by risky behaviours	-	-
	Part 1	£326	-
	Part 2	£1,303	-
	Part 3	£1,629	-
	Part 4	£1,629	-
	Part 5	£1,629	-
Community	Wound Care	£6,517	-
Community	Personalised care and support planning	£6,517	-

Appendix A: Breakdown of CQUIN goals for 2018/19 *continued*

Applicable to	Name	Indicative value year two Community	Indicative value year two Acute
NHS England	Improving HCV treatment pathways through ODNs (Y2)	-	£672,499
NHS England	Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy (SACT) (Y2)	-	£59,071
NHS England	Activation System for Patients with Long Term Conditions (Y2)	-	£68,159
NHS England	Medicines Optimisation (Y1)	-	£245,371
NHS England	Neonatal Community Outreach (Y1)	-	£227,196
Oldham CCG Community - Diabetes	Practice support clinic	£6,536	-
Oldham CCG Community - Respiratory	Structured review and Education re: improving asthma care / scope and present options for setting up a transition clinic	£9,886	-
Oldham CCG Community - Ophthalmology	Demand management / review of pathways	£24,564	-
HMR Community - anticoagulant therapy	No CQUIN proposed by commissioners / agreed in 2018/19	£11,131	-
HMR IECP Local (Acute)	Local indicator re developing Outcome Measures ((all other CQUINs assessed as part of Acute Schemes	-	£47,583
		£78,186	**£6,340,352**

Appendix B

Glossary of definitions

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

Appendix B

Glossary of definitions *(continued)*

Term	Explanantion
Deep vein thrombosis (DVT)	A blood clot occurring in the deep veins of the leg.
Dementia	Condition includes symptoms such as memory loss and confusion.
Department of Health	Ministerial department responsible for government policy for health care in England.
Driver diagram	A Quality Improvement tool which helps to visualise the aims, drivers and change ideas for a particular improvement project.
E-observations	Patient observations which have been recorded electronically within our e-observation system, Patientrack.
EOLC	End of life care.
EWS	Early Warning Score.
Executive Team	The most senior managers in the Trust consisting of the Group Chief Executive Officer, the Group Chief Nursing Officer, the Group Chief Medical Officer, the Group Chief Finance Officer, the Group Chief Strategy and Organisational Development Officer and the Group Chief Delivery Officer.
GDE	Global Digital Exemplar.
General Medical Practice Code	Organisation code of the GP Practice that a patient is registered with.
GP	General Practitioner.
Harm	An unwanted outcome of care intended to treat a patient.
Hospital Episode Statistics	A data warehouse containing details of all admitted patient care, outpatient attendances and A&E attendances in England.
Hospital Standard Mortality Ratio (HSMR)	A system which compares expected mortality of patients to actual mortality based on a patients' risk of dying.
HSJ	Health Service Journal.
Huddle/Safety huddle	A brief meeting which often occurs at the start or finish of shifts in care areas.
Human Factors	Study of human behaviour and the influence that this has on an environment.
IG toolkit	Information Governance Toolkit is a performance tool produced by the Department of Health.
Intervention	A treatment which is intended to improve a patient's condition.
Intermediate care units	Units which patients go to when they no longer require the acute care of the hospital but are not yet ready to go home.
JAG	Joint Advisory Group.
Mersey Internal Audit Agency (MIAA)	Provide external audits and diagnostics for the Trust.
Maternity Early Warning Score (MEWS)	Early warning tool which aims to improve maternal morbidity through the recording of physiological observations to identify deterioration.
Morbidity	Morbidity comes from the word morbid, which means "of or relating to disease".
Mortality	Mortality relates to death. In health care mortality rates means death rate.
MRSA	Methicillin-resistant staphylococcus aureus (MRSA) is a type of infection.
MSSA	Methicillin-susceptible Staphylococcus aureus (MSSA) is a type of infection.
Multi-disciplinary Team (MDT)	A team consisting of members of staff from different professional groups, for example doctors, nurses, physiotherapists and pharmacists.
NAAS	Nursing Accreditation and Assessment System.

Appendix B

Glossary of definitions *(continued)*

Term	Explanantion
NCA	Northern Care Alliance.
NCEPOD	The National Confidential Enquiry into Patient Outcome and Death reviews clinical practice following a patient death.
North East Sector Care Organisations	The Bury and Rochdale, North Manchester and Oldham Care Organisations (otherwise referred to as Pennine Acute) are together referred to as the North East Sector Care Organisation.
Never event	Never events are patient safety incidents that are preventable and should not occur because: - There is guidance that explains what the care or treatment should be. - There is guidance to explain how risks and harm can be prevented. - There has been adequate notice and support to put systems in place to prevent harm from happening.
NEWS/EWS	National Early Warning Score- the NEWS is a scoring system in which a score is allocated to six physiological measurements in order to detect and respond to clinical deterioration. The NEWS was developed by the Royal College of Physicians to provide system-wide standardisation in the measurement and documentation of physiological observations.
NHS England	Executive non-departmental public body, sponsored by the Department of Health.
NHS Improvement	Responsible for overseeing Foundation Trusts and NHS Trusts, as well as independent providers that provide NHS-funded care.
NHS Quest	NHS Quest is a network for Foundation Trusts who wish to focus relentlessly on improving quality and safety.
NICE	National Institute of Clinical Excellence- an independent organisation that provides national guidance and standards on the promotion of good health and the prevention and treatment of ill health.
Nursing Assessment and Accreditation System (NAAS)	The NAAS is designed to support nurses and the wider ward teams to understand how they deliver care and where further improvements are needed. The NAAS measures specific aspects of safety, cleanliness, nursing care and multi-disciplinary working. Wards are then allocated a rating of red, amber or green.
Oesophago-gastric cancer	Refers to cancer of the oesophagus (gullet).
PDSA	The 'Plan, Do, Study, Act' cycle is a Quality Improvement methodology which provides a framework for developing, testing and implementing changes leading to improvement. Using PDSA cycles enables teams to test out changes on a small scale, building on the learning from these test cycles before wide scale implementation.
PReCePT	Preventing celebral palsy in preterm labour.
Process mapping	Process mapping is a tool through which a system/process is visually mapped out in order to identify opportunities for improvement to improve patient experience of make efficiencies.
Prophylaxis	Preventative medicine or care.
Quality Improvement	Quality Improvement is a systematic approach which uses specific techniques and methodologies to improve quality.
Quality Improvement strategy	A document which outlines the aims and objectives of the Trust relating to patient safety and improving quality.
Rapid assessment and treatment model (RAT)	Is a model used within emergency departments to provide early senior assessment of patients in order to improve patient safety and flow within the department.
Red flag sepsis	Is a definition from the national Sepsis Trust which identifies a set clinical parameters. The presence of one of these parameters in the context of infection define sepsis as high risk of death with a requirement for urgent treatment.
Reliability science	The science relating to ensuring that all processes and procedures perform their intended function.
Root cause analysis (RCA)	A method of problem solving that tries to identify the root causes of issues and why they are happening.
Run charts	Run charts are graphs used to display data for quality improvement purposes. Run charts are easier for teams to work with than control charts, although they may be less statistically sensitive. Run charts are helpful for monitoring performance and improvement work. If there is an active improvement effort going on, these tools can be used to determine if an improvement has been made.

Appendix B

Glossary of definitions *(continued)*

Term	Explanantion
SAFER	The SAFER patient flow bundle is made up of five elements of best practice which, when implemented, helps to reduce delays for patients in adult inpatient wards.
Safety thermometer	A point of care survey which is used to record the occurrence of four types of harm (pressure ulcers, falls, catheter associated urinary tract infection and venous thromboembolism).
SCAPE	Safe clean and personal care everytime.
Secondary uses service	Is a single comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.
Sepsis	A life-threatening condition caused when the body is overcome by infection.
SGA	Small for gestational age.
SHMI	The Summary Hospital-level Mortality Indicator reports on mortality at trust level across the NHS in England.
SSNAP	Sentinel Stroke National Audit Programme.
SSI (surgical site infection)	A healthcare-associated infection in which a wound infection occurs after an invasive (surgical) procedure.
Steering group	A group of people who are involved in the management of a piece of work or a project.
Thrombosis	Formation of blood clots within a vessel.
uDNACPR	Unified do not attempt cardiopulmonary resuscitation.
Urinary catheter	A device which is placed into a patient's bladder for the purpose of draining urine.
Venous Thromboembolism (VTE)	A blood clot forming within a vein.
WHO	World Health Organisation.

2

Accountability report

Corporate governance report

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

Directors report

The Board of Directors operates according to the highest corporate governance standards. It is a unitary board with collective responsibility for all aspects of the performance of Pennine, including financial performance, clinical and service quality, management and governance. The Pennine Board of Directors comprises the Chairman, 3 Non-Executive Directors and 5 Executive Directors, which includes the newly appointed Executive Director of Pennine Transaction from 1 December 2018.

Composition of the Pennine Board of Directors 2018/19

Sir David Dalton

Chief Executive Officer

Sir David has been a Chief Executive for over 20 years; he has a strong profile, both locally within Greater Manchester, and also nationally in the areas of quality improvement and patient safety. Sir David retired as the Chief Executive of Pennine on 31 March 2019. In addition to retiring from this role, Sir David was also the Chief Executive of Salford Royal and therefore, the Group Committees in Common, and also retired from both positions on 31 March 2019.

Mrs Elaine Inglesby-Burke CBE

Executive Nurse Director

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

Mr Damien Finn

Executive Director of Finance

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

Composition of the Pennine Board of Directors 2018/19 *continued*

Professor Matthew Makin

Executive Medical Director

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

Mr Patrick (Pat) Crowley

Executive Director Pennine Transaction *(from 1 December 2018)*

Pat recently retired as Chief Executive of York Hospitals NHS Foundation Trust, having served for 11 years. Whilst there he successfully led the acquisition of Scarborough and North East Yorkshire NHS Trust; becoming the largest (geographically) acute and community provider in the country. Prior to his appointment as Chief Executive, Pat was the Director of Finance and played a significant part in achieving Foundation Trust status in 2007. Pat has been appointed to provide support to the Pennine Transaction programme.

Non-Executive Directors

Mr James (Jim) Potter

Chairman

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

Mr John Willis CBE

Non-Executive Director/Vice-Chairman/Chairman of Audit Committee

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

Mrs Diane Brown

Non-Executive Director

Diane has over 30 years' experience as a HR Director, Talent Director and Global Business Partner. Diane has worked with Senior Global Leaders in FTSE 100 companies including AstraZeneca Pharmaceuticals, M&S Money and Marks and Spencer PLC. Diane is a Fellow of the Chartered Institute of Personnel and Development. In addition to her role at Pennine, Diane was the Senior Independent Director at Salford Royal. Diane stood down from her Non-Executive Director roles on 31 March 2019.

Mrs Christine Mayer CBE

Non-Executive Director

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

Dr Hamish Stedman

Non-Executive Director (*from 1 April 2019)*

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

Group Committees in Common

As described in the introductory section, with effect from 1 April 2017 the Trust Board at Pennine and Salford Royal Board of Directors approved the establishment of a Group Committees in Common (CiC) and delegated the exercise of all functions (other than those required by law, and/or as set out within the Scheme of Reservation of Powers & Delegation of Powers) to the Group CiC, whose key responsibilities include:

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

Composition of the Group Committees in Common 2018/19

During 2018/19 the Group CiC comprised the Chairman and six Non-Executive Directors along with six Executive Directors (of Salford Royal): the Chief Executive, Chief Medical Officer, Chief Nursing Officer, Chief Financial Officer, Chief Strategy & Organisational Development Officer and Chief Delivery Officer. Care Organisation Chief Officers are non-voting members of the Group CiC.

Executive Directors and Non-Voting Members

Sir David Dalton
Group Chief Executive Officer

Mrs Elaine Inglesby-Burke CBE
Chief Nursing Officer

Mr Chris Brookes
Chief Medical Officer

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

Mr Ian Moston
Chief Financial Officer

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

Mrs Judith (Jude) Adams
Chief Delivery Officer

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

Mr Raj Jain
Chief Strategy & Organisational Development Officer

Raj spent the early part of his career in the oil and gas industry. He is an economist by training and a Human Resources and Organisational Development professional. Raj has held senior roles in a number of NHS Trusts, including Chief Executive, and Managing Director of the Greater Manchester Academic Health Science Network. In addition to his role as Executive Director of Corporate Strategy and Business Development at Salford Royal, Raj was appointed as Chief Strategy and Organisational Development Officer for the Group CiC in March 2017. From the 1 April 2019, Raj was appointed as the Chief Executive Officer for Salford Royal, and the Group Committees in Common, and, via the management agreement, will be the Chief Executive of Pennine.

Executive Directors and Non-Voting Members *continued*

Mr Steve Taylor

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

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

Mrs Nicola Firth

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

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

Mr James Sumner

Chief Officer Salford Care Organisation
(Non-voting member of the Board of Directors)

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

Mr Damien Finn

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

Non-Executive Directors

Mr James (Jim) Potter
Chairman

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

Mrs Diane Brown
Non-Executive Director *(until 31 March 2019)*

Mrs Christine Mayer CBE
Non-Executive Director

Dr Hamish Stedman
Non-Executive Director

Professor Chris Reilly
Non-Executive Director

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

Mr Kieran Charleson
Non-Executive Director

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

Mrs Carmen Drinkwater
Non-Executive Director *(from 1 April 2019)*

Carmen is the Director for HR Projects and HR Transformation for Sodexo in the UK. She joined Sodexo in July 2013 as HR Director for the HR Shared Services function at Sodexo, accountable for smooth operation of employee relations, HR transactional and payroll services for a multi-site, multi-services business with 37,000 employees across the UK. Prior to joining Sodexo, Carmen held a number of senior HR roles creating and running shared services operations and has built breadth and depth in this specialism and in business transformation by holding the leader position for HR Shared Services at Royal Bank of Scotland, SPX Corporation and AstraZeneca. Carmen is also a Non-Executive Director at Salford Royal.

Executive Directors

Name	Responsibilities	Board of Directors attendance	Group Committees in Common attendance
Sir David Dalton	Chief Executive Officer/Group Chief Executive Officer	4/4	10/10
Mr Chris Brookes	Chief Medical Officer	N/A	10/10
Mrs Elaine Inglesby-Burke CBE	Executive Nurse Director/Chief Nursing Officer	4/4	10/10
Mr Ian Moston	Chief Finance Officer	N/A	10/10
Mr Raj Jain	Chief Strategy & Organisational Development Officer	N/A	9/10
Mrs Judith Adams	Chief Delivery Officer	N/A	10/10
Mr Steve Taylor	Chief Officer Bury & Rochdale Care Organisation	N/A	9/10
Mrs Nicola Firth	Interim Chief Officer Oldham Care Organisation	N/A	10/10
Mr Damien Finn	Executive Director of Finance/Chief Officer North Manchester Care Organisation	4/4	10/10
Mr James Sumner	Chief Officer Salford Care Organisation	N/A	10/10
Professor Matthew Makin	Executive Medical Director/Medical Director North Manchester Care Organisation	2/4	N/A
Mr Pat Crowley	Executive Director Pennine Transaction	0/1	N/A

Non-Executive Directors

Name	Responsibilities	Board of Directors attendance	Group Committees in Common attendance
Mr James Potter	Chariman	4/4	10/10
Mr John Willis CBE	Vice-Chairman/Chairman of Audit Committee	4/4	10/10
Mrs Diane Brown	Non-Executive Director/Senior Independent Director	4/4	10/10
Professor Chris Reilly	Non-Executive Director	N/A	8/10
Dr Hamish Stedman	Non-Executive Director	N/A	8/10
Mrs Christine Mayer CBE	Non-Executive Director	4/4	9/10
Mr Kieran Charleson	Non-Executive Director	N/A	10/10

Declaration of interests of the Board of Directors

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

The Register of Declared Interests is made available to the public via the Group CiC papers and within the Declarations of Interests Register available on Pennine's website *(www.pat.nhs.uk/aboutus/declaration-of-interests.htm)*. Members of the public can also gain access by contacting the Group Secretary:

Mrs Jane Burns
Director of Corporate Services
Group Secretary
3rd Floor, Mayo Building
Salford Royal NHS Foundation Trust
Stott Lane
Salford
M6 8HD.

Tel: **0161 206 5185**

Email: **jane.burns@srft.nhs.uk**

Committees of the Pennine Board of Directors

The Pennine Board of Directors has established the following committee:

- Group Committees in Common

The Group Committees in Common has established the following committees:

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

Audit Committee

The Group CiC has established an Audit Committees in Common for Pennine and Salford Royal, known as the Audit Committee. Audit Committee plays a key role in supporting the Group CiC by critically reviewing and reporting on the adequacy and effectiveness of effective systems of integrated governance, risk management, and internal control that supports the achievement of Group objectives and its constituent Care Organisations.

In carrying out this work, the Audit Committee primarily utilises the work of internal and external audit, and established committees within the NCA Assurance Framework, specifically the Group Executive Risk and Assurance Committee (GRAC). Audit Committee also receives assurance from the views of other external agencies such as the Care Quality Commission.

Non-Executive Directors (with the exception of the Chairman) are members of Audit Committee. Attendance during 2018/19 was as follows:

Mr John Willis CBE	6/6
Mrs Diane Brown	5/6
Mr Kieran Charleson	2/6
Mrs Christine Mayer CBE	2/6
Professor Chris Reilly	6/6
Dr Hamish Stedman	6/6

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

Pennine's External Auditors regularly attend Audit Committee, providing an opportunity for the committee to assess their effectiveness. The Audit Plan for Pennine was presented to Audit Committee in February 2019, confirming the audit would be conducted with an understanding of the key challenges and opportunities Pennine was facing.

The Audit Committee received assurance that the audit would consider the impact of key developments in the sector, take account of national audit requirements and ensure compliance with International Standards on Auditing (ISAs). In addition, the Audit Plan highlighted steps taken to safeguard and ensure compliance with ethical standards on independence. There were no other significant facts or matters that may impact on the External Auditors independence drawn to Audit Committee's attention during 2018/19.

At its meeting in April 2018, the Audit Committee reviewed the first draft of the PAHT Annual Report, including the Annual Governance Statement, Quality Report and unaudited Accounts 2017/18.

This was followed by further review and approval, prior to submission to NHS Improvement, at the meeting in May 2018. Audit Committee also received the External Auditors Findings Report (ISA 260) in May 2018

As the year began, Audit Committee reviewed the opening NCA Board Assurance Framework and confirmed that the strategic and operational risks identified were fully aligned to the Annual Plans submitted to NHSI. As Audit Committee's relationship with the GRAC developed during the year, a number of matters were referred to and from committee meetings, most notably a request for further assurance with respect to the outstanding internal audit actions, specifically high priority IM&T internal audit actions that were overdue for implementation. Following escalation via GRAC, subsequent reviews of 'Follow Ups' took place at the Audit Committee meetings held in September 2018 and November 2018. Audit Committee was informed that progress had been made across both Group and Care Organisations, with the majority of actions implemented or evidence provided to support progression, although further focus was required by management to ensure timely completion of those not yet implemented.

Alert to the significant number of outstanding audit actions that remained relating to IM&T, Audit Committee requested a deep dive on this matter and escalation to the GRAC. In February 2019, Audit Committee conducted a detailed review with respect to overdue high priority IM&T internal audit actions, including reflection of causal factors and current level of risk associated with the overdue actions. Audit Committee sought assurance regarding the clarity of vision for IM&T across the NCA and the progressive nature of investment required to stabilise the Pennine IM&T infrastructure.

The Audit Committee is authorised by the Group CiC to investigate any activity within its terms of reference and to seek any information it requires from staff. Senior managers from the Trust (including the Chief Officer of Salford Care Organisation, Chief Strategy & Organisational Development Officer, Director of Workforce, Head of Clinically Coded Data and Standards Assurance, Group Procurement Director and Director of Governance and Corporate Nursing) attended meetings during 2018/19 to provide a deeper level of insight into key issues within their respective areas of expertise.

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

The Non-Executive Directors 'site visit' programme continued during 2018/19, encompassing services, wards and departments across the NCA. The programme enables Non-Executive Directors to triangulate information gathered during the visits with that presented to the Group CiC and Audit Committee, for the purpose of gaining assurance and obtaining feedback from staff and patients. The visits enable Non-Executive Directors to further understand how the organisation works and the impact of Board-level decisions on clinical services. The following North East Sector Care Organisation services were visited during 2018/19: Estates & Facilities (Oldham, North Manchester), Diagnostics & Pharmacy (Oldham, Bury & Rochdale), Patient journey through the Elective Pathway (North Manchester), Patient journey through the Non-Elective Pathway (including Emergency Department) (Bury & Rochdale, North Manchester), Womens & Childrens Services (North Manchester, Oldham) and Surgery (Oldham).

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

Nominations, Remuneration and Terms of Office (NRTO) Committee

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

Charitable Funds Committee

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

Strategy and Investment Committee

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

Group Executive Risk and Assurance Committee

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

Group Executive Development Committee

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

Standing Committee Reporting Arrangements

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

NHS Improvement's Well Led Framework

Stepping into 2017/18, and aware of the new guidance for NHS Trusts and NHS Foundation Trusts regarding 'Developmental reviews of leadership and governance using the well led framework', in November 2017 each Care Organisation conducted a self-assessment of their developing leadership and governance arrangements.

Following this, MIAA, in partnership with AQuA, led a series of 'Confirm and Challenge' workshops, providing early opportunity to explore integrated quality, operational and financial governance arrangements within each Care Organisation, interface with the Group CiC, and undergo consideration of further evidence to support the developmental self-assessments.

In the latter part of 2018/19, the NCA completed a Self-Assessment against the Well-Led Framework for Governance. Mersey Internal Audit (MIAA) conducted an independent review of the self-assessment, considering comprehensiveness and sources of evidence, in order to provide further assurance with respect to compliance with the Key Lines of Enquiry (KLOEs).

The outcome of the independent review, in summary, concluded that the position statements were comprehensive and presented a compelling and positive picture of the NCA. It added that the thoroughness and quality of the self-assessment placed the NCA in a strong and informed position in terms of selecting an external review approach that adds most value (if and when appropriate).

Membership and Group Council of Governors

Local people and those accessing Pennine's services as a patient or carer are invited to become a member of Pennine. Membership strengthens the links between healthcare services and the local community; it is voluntary, and free of charge and obligation. Members are able to give their views on relevant issues to help improve the experience for patients, visitors and staff.

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

Public members

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

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

The table below highlights Pennine's public membership figures at 31 March 2019.

Public members	Actual 31 March 2019
Bury & Rochdale	6,155
North Manchester	2,473
Oldham	3,624
Rest of England and Wales	457
TOTAL	**12,709**

Staff members

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

Staff members	Actual 31 March 2019
Bury & Rochdale	3,100
North Manchester	3,859
Oldham	3,175
TOTAL	**10,134**

Membership recruitment

Recruitment of new members is an ongoing activity to ensure overall membership numbers are maintained, whilst focussing on those areas where membership is under-represented i.e. young people. Over the last 12 months we have visited schools and colleges across the boroughs of Pennine, and over 400 young people have joined our membership.

Membership engagement

During 2018/19, Pennine regularly communicated with members, patients and the public using a range of communication channels and feedback mechanisms. These include:

- Members Newsletter – The Loop
- Pennine Website
- Medicine for Members – Talks and Tours
- Open Days and Annual Members Meeting 2018
- Social Media

In September and October 2018, Pennine hosted 'Open Days' at each of the hospital sites, followed by the first NCA Joint Annual Members & Public Meeting. The Open Days were an excellent opportunity for staff and services to showcase their work, including; Theatres, Cardiology, Sepsis, Learning Disabilities, Maggie's Oldham, Quality Improvement, Macmillan Cancer, Catering, Volunteers and Carers. Students from local schools and colleges attended the events and the feedback received from visitors was very positive.

At the NCA Joint Annual Members & Public Meeting, members received an update on key strategic developments and had a chance to ask questions to members of the Group Committees in Common.

Medicine for Member events

Over the past twelve months we have held twenty-five 'Medicine for Members' events on various health related topics, including End PJ Paralysis, Crumpsall Vale Talk & Tour, Sepsis, Hepatitis, Urgent Care, Oasis Unit Talk & Tour, Maternity Services, Head & Neck Cancer, Critical Care, Liver Disease, Arthritis and Delirium, to name a few.

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

The membership office continues to be a central point of contact for all members to contact the Trust. It can be contacted during office hours:

Monday to Friday, on **01706 517302**

or by email: **membership@pat.nhs.uk**

Shadow Group Council of Governors

In March 2017, Salford Royal's Council of Governors approved changes to its own composition, and agreed to establish a subcommittee of the Salford Royal Council of Governors; the Shadow Group Council of Governors. Bearing resemblance to the establishment of the Group CiC to which the Boards of Salford Royal and Pennine delegated their functions, the Shadow Group Council of Governors, (known as the Group Council of Governors) includes both Salford Royal Governors and Shadow Pennine Governors, and assists the Council of Governors by carrying out those functions set out in the Salford Royal Scheme of Reservation and Delegation of Powers.

The Group and SRFT Council of Governors held five general meetings during 2018/19, assisting in, and discharging, a number of our statutory duties, including the appointment of two new Non-Executive Directors, approval of the appointment (by the Chairman and Chief Executive) of the new Chief Executive and review of the performance of our Chairman and Non-Executive Directors.

One of the key pieces of work the Group and SRFT Council of Governors has been engaged with this year is the acquisition of the Oldham, Bury and Rochdale components of Pennine Acute by Salford Royal. Governors have been involved in a number of briefings and workshops to consider the additional benefit to the patients and populations of Salford, Oldham, Bury & Rochdale and to ensure that the views of members, and the community as a whole, are considered.

There have been a number of changes to the Group and SRFT Council of Governors during 2018/19. In addition, bi-elections were held in February 2019 to fill vacancies in the Oldham and North Manchester constituencies.

The composition of the Group Council of Governors as at 31 March 19 is as follows:

Name	Consituency / organisation	Term of office (end of the annual members meeting)
Public elected governors		
James Collins	Salford	3 years (2020)
David Pike (Lead Governor)	Salford	3 years (2020)
Chris Mullen	Salford	3 years (2020)
Gill Collins	Salford	2 years (2019)
Gary Kerr	Salford	2 years (2019)
Sandra Breen	Rest of England & Wales	3 years (2019)
Jeredine Benjamin	Rest of England & Wales	3 years (2019)
Shadow public elected governors		
David Davis[1]	Bury & Rochdale	3 years (2020)
John Rodgers[2]	Bury & Rochdale	3 years (2020)
Terri Evans	Bury & Rochdale	3 years (2020)
Shaun Furlong	Bury & Rochdale	2 years (2019)
Brian Davies[3]	Bury & Rochdale	2 years (2019)
David Edwards[4]	Oldham	3 years (2020)
Mohammed Jahan[5]	Oldham	3 years (2020)
James Allen[6]	Oldham	2 years (2019)
Kevin Thomas	North Manchester	3 years (2020)
Mohammad Shafiq	North Manchester	2 years (2020)
Staff elected governors		
Deborah Seddon	Clinical Support & Tertiary Services	3 years (2020)
Nicola Kent	Corporate & General Services	3 years (2019)
Agnes Leopold-James	Salford Healthcare	3 years (2019)
Sheila Tose	Surgery & Neurosciences	3 years (2020)
Shadow staff elected governors		
Gemma Lievesley	Bury & Rochdale	3 years (2019)
Amanda Chesney	Bury & Rochdale	2 years (2019)
Eduard Siegg-Hogg[7]	Oldham	3 years (2020)
Vacant[8]	Oldham	2 years (2019)
Mark Taylor[9]	North Manchester	3 years (2020)
Philippa Jones	North Manchester	2 years (2019)

Name	Consituency / organisation	Term of office (end of the annual members meeting)
Appointed governors		
Prof. Ruth Boaden[10]	University of Salford	3 years (2020)
Cllr Richard Critchley	Salford City Council	3 years (2020)
Shadow appointed governors		
Brian Boag	University of Salford	3 years (2020)
Cllr Julie Reid (Manchester)[11]	Local Authority Governor	3 years (2020)
Cllr Wendy Cocks (Rochdale)[12]	Local Authority Governor	3 years (2020)
Cllr Karen Leach (Bury)[13]	Local Authority Governor	3 years (2020)
Vacant (Oldham)	Local Authority Governor	3 years (2020)

1 Luise Fitzwalter resigned in September 2018
The next highest polling candidate was David Davis

2 Sylvia Edney resigned in December 2018
The next highest polling candidate was John Rodgers

3 Marie Douglas resigned in June 2018
The next highest polling candidate was Brian Davies

4 Robert Scott resigned in January 2019
David Edwards was elected

5 Fabhia Chowdhury resigned in January 2019
Mohammed Jahan was elected

6 Maurice Gorton resigned in December 2018
James Allen was elected

7 Julia Riley resigned in January 2019
Eduard Sieg-Hogg was elected

8 Georges Na Man Kwong resigned in November 2018
Current vacant post

9 Mireia Cassou resigned in February 2019
Mark Taylor was elected

10 Appointed Governor Nick Grey resigned in May 2018
Professor Ruth Boaden was selected

11 Cllr Julie Reid (Manchester) was appointed in September 2018

12 Cllr Wendy Cocks (Rochdale) was appointed in September 2018

13 Cllr Karen Leach (Bury) was appointed in February 2019

The following table summarises governor attendance at Group and SRFT Council of Governor Meetings from 1 April 2018 to 31 March 2019.

Name	Consituency	Group Council of Governors meetings attended
Salford public governors		
James Collins	Salford	4/5
David Pike (Lead Governor)	Salford	4/5
Chris Mullen	Salford	4/5
Gill Collins	Salford	4/5
Gary Kerr	Salford	2/5
Sandra Breen	Out of Area	5/5
Jeredine Benjamin	Out of Area	3/5
Shadow public elected governors		
Terri Evans	Bury and Rochdale	4/5
Shaun Furlong	Bury and Rochdale	2/5
John Rodgers	Bury and Rochdale	2/2
David Davis	Bury and Rochdale	2/3
Brian Davies	Bury and Rochdale	3/5
Sylvia Edney	Bury and Rochdale	1/3
Marie Douglas	Bury and Rochdale	0/0
Louise Fitzwalter	Bury and Rochdale	1/1
Kevin Thomas	North Manchester	4/5
Mohammad Shafiq	North Manchester	4/5
James Allen	Oldham	1/1
Mohammed Jahan	Oldham	1/1
David Edwards	Oldham	1/1
Robert Scott	Oldham	1/3
Fabhia Chowdrury	Oldham	0/3
Maurice Gorton	Oldham	0/3
Deborah Seddon	Clinical Support & Tertiary Services	3/5
Nicola Kent	Corporate & General Services	0/5 (Maternity leave)
Agnes Leopold-James	Salford Healthcare	4/5
Sheila Tose	Surgery & Neurosciences	4/5
Shadow staff elected governors		
Philippa Jones	North Manchester	4/5
Mark Taylor	North Manchester	N/A
Mireia Cassou	North Manchester	2/3
Amanda Chesney	Bury & Rochdale	2/5
Gemma Lievesley	Bury & Rochdale	5/5
Julia Riley	Oldham	0/4
Georges Ng Man Kwong	Oldham	0/4
Eduard Siegg-Hogg	Oldham	0/1

Name	Consituency	Group Council of Governors meetings attended
Appointed governors		
Cllr Richard Critchley	Salford City Council	0/5
Professor Ruth Boaden	University of Manchester	1/1
Shadow appointed governors		
Brian Boag	Salford University	1/5
Cllr Julie Reid	Local Authority - Manchester	1/3
Cllr Wendy Cocks	Local Authority - Rochdale	3/5
Cllr Karen Leach	Local Authority - Bury	0/1
Vacant	Local Authority - Oldham	N/A

Communicating with Governors

There are a number of easy ways for you to communicate with the Group Council of Governors.

Email: **membership@pat.nhs.uk** *or* **foundation@srft.nhs.uk**

Tel: **01706 517302**

Website: **http://www.pat.nhs.uk/get-involved/council-of-governors.htm**

Write to your Governor at:

Membership Department
Rochdale Infirmary
Whitehall Street
Rochdale, OL12 0NB

Group Council of Governors Register of Interests

All Governors are required to comply with the Code of Conduct for Governors and declare any interests that may result in a potential conflict of interest in their role as Governor. The register of interest is publicly available via the Council of Governors' Meeting Minutes on Salford Royal's website. In addition, the register can be obtained via the Group Secretary at the following address:

Group Headquarters
Salford Royal NHS Foundation Trust
Stott Lane
Salford, M6 8HD

Tel: **0161 206 3133**

Email: **foundation@srft.nhs.uk**

Personal data

It is a requirement of the Department of Health and Social Care Group Accounting Manual to provide information on personal data related incidents where these have been formally reported to the Information Commissioner's office.

During 2018/19, there were 9 serious incidents formally investigated and reported by the organisation, 3 of which were reported to the Information Commissioners Office. No action has been taken against Pennine in regards to the reported incidents. These included:

- Staff member looked up estranged sister's (a patient) details on medical records system
- Fire at electronic document management company units used by Pennine resulted in loss/destruction of patient records. Quantity of records not yet established
- Patient was discharged with discharge paperwork; however, this also included information about another patient, in error. Recipient reportedly approached the other patient to notify them of this incident

Statement regarding information relevant to external audit

All Directors of Pennine, and members of the Group CiC, have undertaken to abide by the provisions of the Code of Conduct for Board Level Directors; this includes ensuring that each Director at the time that this Annual Report is approved:

- So far as each director is aware, there is no relevant audit information of which the Trust's auditor is unaware *and*
- Each director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information

The provisions of the Code of Conduct also confirm, and directors have undertaken to have taken, all the steps that they ought to have taken as a director in order to do the things mentioned above and:

- Made such enquiries of his/her fellow directors and of the company's auditors for that purpose *and*
- Taken such steps (if any) for that purpose, as are required by his/her duty as a director of the company to exercise reasonable care, skill and diligence

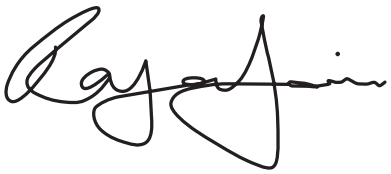
Statement of the Chief Executive's responsibilities as the accountable officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust.

The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- There are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- Value for money is achieved from the resources available to the Trust
- The expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- Effective and sound financial management systems are in place *and*
- Annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed: 

Date: *24 May 2019*

Raj Jain
Chief Executive

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- Make judgements and estimates which are reasonable and prudent
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State.

They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy.

By order of the Board.

Signed:

Date: *24 May 2019*

Raj Jain
Chief Executive

Signed:

Date: *24 May 2019*

Damien Finn
Finance Director

Annual Governance statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Pennine Acute Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Pennine Acute Hospitals NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Pennine Acute Hospitals NHS Trust (Pennine) has become part of an NHS Group established by Salford Royal NHS Foundation Trust (Salford Royal). The Northern Care Alliance NHS Group (NCA) was launched on 1 April 2017. Whilst Pennine and Salford Royal remain statutory bodies, the Boards of both organisations have delegated the exercise of significant functions to the Group Committees in Common (Group CiC). Group CiC comprises all members of the Salford Royal Board of Directors and the Chief Officers of the NCA's four care organisations: Oldham, Bury & Rochdale, North Manchester and Salford. Group Executive, Non-Executive Directors and Care Organisation Leadership Teams across the NCA are clear about their roles and responsibilities, including the key risks to the operational plan for which they are accountable.

As the Chief Executive, I am responsible for overseeing risk management across all organisational, financial and clinical activities. I am the Chairman of the Group Executive Risk and Assurance Committee (GRAC), which reports directly to Group CiC and has overarching responsibility for risk management including: the development and implementation of the Group's Assurance Framework and Risk Management Strategy; monitoring of all Group-level risks; overseeing the Group's Single Oversight Framework; and reviewing Care Organisation Assurance Framework/Risk Registers. An important enabler to fulfilling this responsibility has been the development of purposeful interaction between the GRAC and the Group's Audit Committee.

Audit Committee provides a key forum through which the Group's Non-Executive Directors bring independent judgement to bear on issues of risk management and performance. The constructive interface between Audit Committee and GRAC supports the effectiveness of the Group's systems of internal control.

Each of the NCA's Care Organisations has a Chief Officer with responsibility for the effective and efficient use of resources, including the proactive identification and mitigation of risks to the delivery of annual business plans. The Chief Officers each chair their Care Organisations Assurance and Risk Committee (COARC), which have responsibility for providing leadership to, and ensuring appropriate oversight of, the achievement of the Care Organisation's principal objectives, through the effective mitigation of risk and review of relevant assurance. The Oldham, Bury & Rochdale and North Manchester Care Organisations have all of the above arrangements in place.

The NCA has a single Risk Management Strategy in place covering all Care Organisations and Corporate Business Units, which are implemented via Group and Care Organisation governance structures. The Risk Management Strategy provides the framework for managing risk across the Oldham, Bury & Rochdale and North Manchester Care Organisations and at all levels within the Group. It is consistent with best practice and Department of Health guidance. The strategy provides a clear, systematic approach to the management of risks to ensure that risk assessment is an integral part of all clinical, managerial and financial processes. Risk management is supported in the following ways; a central NCA Risk Management Team, a centralised Health and Safety Team with support from Health and Safety Advisors and an Associate Director of Governance in place within each Care Organisation, supported by Governance Managers for each clinical division.

Pennine's improved capacity to handle risk was evidenced via the CQC Well-led Inspection (March 2018), which concluded that 'services were developing effective systems for identifying risks, planning to eliminate or reduce them and coping with both the expected and unexpected'. The NCA acknowledged that this process was at various stages of development across the services and continued to diligently review risk management systems during 2018/19. To identify areas for further improvement an internal audit to review risk maturity across the NCA was commissioned during 2018/19, the outcomes of which will be considered, and action taken where required, during 2019/20.

The NCA is a learning organisation and has robust systems in place that ensures good practice is identified and shared via corporate and divisional governance systems and newsletters. Learning from incidents, complaints, claims and mortality reviews is shared via multiple mediums to reach all staff groups. New and innovative methods of shared learning are being developed and tested throughout the organisation, using patient experience, incident reports and learning from deaths to develop a culture of organisational learning. The Oldham, Bury & Rochdale and North Manchester Care Organisations have strengthened their systems in place to receive and act upon National Patient Safety Alerts and recommendations during 2018/19 to ensure all reviews are robust.

The Group CiC receives assurances from the GRAC relating to the management of all serious untoward incidents, including Never Events. Learning from Experience and Patient Responsiveness Reports are also reported routinely to Group Risk and Assurance Committee and Group CiC.

The risk and control framework

Risk management requires participation, commitment and collaboration from all staff. The process starts with the systematic identification of risks via structured risk assessments. Throughout the NCA identified risks are documented on risk registers.

These risks are then analysed in order to determine their relative importance using a risk scoring matrix. Low scoring risks are managed by the area in which they are found, whilst higher scoring risks are managed at progressively higher levels within the organisation.

Risk control measures are identified and implemented to reduce the potential for harm. The potential consequence and likelihood of the risk occurring are scored along with the effectiveness of existing control measures. It is the sum of these scores which determines the level in the organisation at which the risk is reported and monitored to ensure effective mitigation.

Each Care Organisation within the NCA has in place a Board Assurance Framework/Corporate Risk Register (BAF/CRR), which is overseen by each Care Organisations' COARC. It directs management focus at Care Organisation level to the mitigation of significant risks. The Oldham, Bury & Rochdale and North Manchester Care Organisation BAF/CRRs inform the Northern Care Alliance NHS Group (NCA) BAF/CRR, which has been developed during 2018/19 by the NCA Group CiC, and managed via the GRAC.

Pennine seeks to reduce risk in so far as possible, however, it is understood that delivering healthcare carries inherent risks that cannot be eradicated completely.

Pennine therefore pursues assurance that controls continue to be operated for risks that cannot be reduced any further. On this basis, risks are tolerated in line with an organisational risk appetite.

The NCA's Assurance Framework is based on six key elements:

- Clearly defined principal objectives agreed with stakeholders together with clear lines of responsibility and accountability
- Clearly defined principal risks to the achievement of these objectives together with assessment of their potential impact and likelihood
- Key controls by which these risks can be managed, this includes involvement of stakeholders in agreeing controls where risks impact on them
- Management and independent assurances that risks are being managed effectively
- Board-level reports identifying that risks are being reasonably managed and objectives being met together with gaps in assurances and gaps in risk control
- Board-level action plans which ensure the delivery of objectives, control of risk and improvements in assurances

The workplan of committees within the NCA's Assurance Framework is linked so that the Group CiC is assured that there is an aligned independent and executive focus on strategic risk and assurance. Routine referral of issues exists between committees ensuring a respective understanding of risk and assurance concerns.

The Internal Audit Assurance Framework Review 2018/19 confirmed that 'the organisation's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board.'

Furthermore, the Group CiC has established and operates an oversight framework for each of its Care Organisations, called the Group Single Oversight Framework (Group SOF). The Group SOF provides assurance on delivery of the Care Organisation's Annual Plan objectives and supports quality and performance improvement. The five themes of the Group SOF reflect those of the NHS Improvement Framework:

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

The Group SOF segments Care Organisations, according to the scale of issues faced, and enables the Group CiC to determine the extent of support required by each Care Organisation. The Group SOF utilises an integrated reporting approach, including performance dashboards, board assurance frameworks, statements of assurance, annual plan reviews, well led reviews and CQC improvement plans.

Pennine's first Quality Improvement Strategy provides clear and ambitious quality goals; these have been monitored throughout 2018/19 via a quarterly Quality Improvement Dashboard and Progress Report provided to the Group CiC. At Care Organisation level, each Care Organisation has in place clear quality governance arrangements through the assurance framework committee structure.

This includes a monthly quality and clinical effectiveness committee which tracks performance against key quality indicators. The Quality Report, within this Annual Report and Accounts, describe quality improvements and quality governance in more detail.

The NCA has a Freedom to Speak Up (FTSU) Guardian to act in a genuinely independent and impartial capacity to support staff who raise concerns and will have access to the Chief Executive and the nominated Non-Executive Director for 'Freedom to Speak Up'.

Individuals will be supported by FTSU Care Organisations guardians; ensuring staff have easy access to practical support. Oldham and Bury & Rochdale Care Organisations have a lead guardian in place with a team of sub-guardians, and appointment of a North Manchester guardian will be made following interviews in April 2019. A quarterly report of all concerns raised and themes will be produced for the respective Care Organisations quality governance committees; summary information will be escalated to the COARC and the GRAC via the Care Organisation Statements of Assurance. The NCA FTSU Guardian also meets with the nominated Non-Executive Director on a quarterly basis.

A Group Self-Assessment against the Well-Led Framework for Governance was completed in 2018/19; key areas of strength and key developments to be undertaken in 2019/20 were identified. Aligning with reviews undertaken as part of the internal audit plan during 2018/19, Mersey Internal Audit (MIAA), conducted an independent review of the self-assessment to provide further assurance with respect to compliance with the Key Lines of Enquiry (KLOEs).

The outcome of this independent review, in summary, concluded that concluded that the position statements were comprehensive and presented a compelling and positive picture of the NCA. It added that the thoroughness and quality of the self-assessment placed the NCA in a strong and informed position in terms of selecting an external review approach that adds most value (if and when appropriate).

The Trust is fully compliant with the registration requirements of the CQC.

Pennine underwent a comprehensive assessment by the Care Quality Commission (CQC) between October 2017 and November 2017 culminating in the Trust being rated as 'requires improvement' from 'inadequate' in the previous assessment. Significant improvements had been made across all services in each Care Organisation within Pennine with some services improving by two ratings and no services rated as 'inadequate'.

Comprehensive action plans have been developed across each Care Organisation, along with an overarching Group action plan which is monitored via the Group Committees in Common (CiC).

A strong model of assurance through the Board Assurance Framework (BAF) has been implemented in each Care Organisation in order to monitor progress and identify risks associated with the implementation of each plan.

Further assurance is provided through the Nursing Assessment and Accreditation System (NAAS) which measures the quality of nursing care delivered by individuals and teams, it is based on the Essence of Care standards, key clinical indicators and each question is linked to Compassionate Care - The 6cs of: care, compassion, competence, communication, courage and commitment, whilst providing evidence for the CQCs Fundamental standards.

The introduction of NAAS has supported the Trust's aim of creating a culture of continuous improvement backed by robust governance and accountability arrangements from Board to Ward which ensures leaders are focused on the key risks to the delivery of excellent care.

In addition to the NAAS process a comprehensive programme of 'mock' CQC inspection have been implemented across those services which do not have a NAAS assessment undertaken, these include:

- Maternity services
- Diagnostics
- Outpatients
- Theatres

The outcomes of these inspections are reported by the service to the Group audit committee.

From April 2019 each service across each Care Organisation will be required complete an annual self-assessment against the CQC key lines of enquiry reporting outcomes through the Care Organisation Quality and risk Committees in order to provide assurance and identify risks locally against the CQC fundamental standards.

Dedicated Data Quality Teams pro-actively manage data quality within 'source' systems and provide appropriate training and guidance to the Care Organisation teams. Independent assurance regarding data quality is provided by regular monitoring using CHKS iCompare and SUS Dashboards, and independent external audits including the Data Security and Protection Toolkit self-assessment review by internal audit and external auditors, for example MIAA and Capita, who review the Trust's data and data systems.

Risks to data quality and data security are continuously assessed and added to the digital risk register, and score dependent, reviewed by the Informatics Management Board and escalated to Group Executive Risk and Assurance Committee where appropriate.

During 2018/19, the Group CiC ensured on-going assessment of in-year and future risks. Major risks related to:

- Planned income levels and expenditure controls
- Developing an effective productivity improvement and cost reduction strategy
- Remodelling the workforce to deliver new models of care
- Compliance with access standards
- IM&T clinical systems and technical infrastructure
- Estate investment to remedy safety risks identified in North East Sector Care Organisations

The Group CiC oversees the management of all major risks, which are actively addressed by the Group Executive Risk and Assurance Committee. Key controls and assurances, and any identified gaps are continually reviewed and action plans developed and progressed accordingly. Outcomes are confirmed via this process and reported routinely to the Group CiC, via the Group CiC's Integrated Performance Dashboard. Audit Committee reviews the Board Assurance Framework/Corporate Risk Register and commissions additional reviews where appropriate in order to provide necessary assurance to the Group CiC.

Risk management is embedded in the activity of the organisation. Care Organisations proactively identify risks through a programme of risk assessment which are recorded on the Care Organisations' risk registers. Care Organisations also retrospectively identify risk through adverse incident reporting, receipt and response to complaints and claims, patient and staff surveys and feedback, and concerns raised by the coroner.

Due to the devolved nature of risk management including the management and compliance of incident reporting and investigation at a local level, quality and quantity of incident reporting continues to improve and develop.

The NCA and each Care Organisation advocates a transparent reporting culture, combined with a fair blame culture which encourages openness and transparency.

During 2018/19, improvements have been made in incident management. Completion rates for incident investigations have improved, incident reporting has increased, serious incidents are now managed ahead of the national 60 day deadline (NCA operate a 45 working day deadline) to enable faster facilitation of Duty of Candour. Serious Incident Duty of Candour has been 100% for the Oldham, Bury & Rochdale and North Manchester Care Organisations throughout 2018/19. Learning from incidents remains a top priority for the Northern Care Alliance, evidenced within the Take 5 learning environment and the continued development of a Patient Care Alert process to share and action incident learning and intelligence across Care Organisations.

There is a focus within risk management on organisational learning to address key themes identified during mortality reviews and incident investigations, to enable continuous improvement to patient safety.

The NCA has in place risk share arrangements with its partners and public stakeholders to ensure that risks which impact across the system are managed appropriately. In addition to this, the serious incident investigation process ensures that those who are affected are engaged. The NCA has regular collective meetings with the Clinical Commissioning Groups (CCGs) that cover the Pennine footprint which ensures there are opportunities for public oversight of investigation processes and that learning takes place.

The Trust has assessed compliance with the NHS provider condition 4. Audit Committee reviewed the assessment in detail at its meeting on 24 May 2019 and confirmed that no material risks had been identified.

The Trust believes that effective systems and processes are in place to maintain and monitor the following conditions:

- The effectiveness of governance structures
- The responsibilities of directors and subcommittees
- Reporting lines and accountabilities between the board, its subcommittees and the executive team
- The submission of timely and accurate information to assess risks to compliance with the Trust's licence *and*
- The degree and rigour of oversight the board has over the Trust's performance.

These conditions are detailed within the Corporate Governance Statement, the validity of which is assured via the Audit Committee.

Pennine Acute NHS Hospitals Trust ensures that short, medium and long term workforce strategies, approaches and staffing systems are in place, which assures the Group Committees in Common that staffing processes are safe, sustainable and effective. The Trust complies with the newly established 'Developing Workforce Safeguards' recommendations which build on the National Quality Board's (NQB) guidance and has established a Clinical Workforce Safeguards Programme Board.

Staffing establishments are reviewed annually as part of the budget setting process and revised in year as a consequence of business planning. E-rostering is in place for nursing and is now being implemented for medical staff. Job plans for medical staff have been reviewed and validated through a scrutiny process led by the Medical Directors of each Care Organisation. Workforce forecasts have been determined in conjunction with workforce, finance and service managers.

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with.

This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The financial plan is approved by the Group CiC and the Pennine Board of Directors. It is subsequently submitted to NHS Improvement. The plan, relevant to each Care Organisation, includes forward projections and is monitored on a monthly basis by each Care Organisation's finance committee. Care Organisations provide a monthly Statement of Assurance to the GRAC, which confirms the sufficiency of plans for the effective use of resources. Key performance indicators and financial sustainability metrics are also reviewed monthly by the Group CiC.

Pennine's resources are managed within the framework set by the Group Governance Framework Manual, which includes Standing Financial Instructions. Financial governance arrangements are supported by internal and external audit to ensure economic, efficient and effective use of resources and monitored through Audit Committee.

Information Governance

Information governance and security risks are managed as part of the Trust risk management processes described above and assessed using the new Data Security & Protection Toolkit (DSPT) which has replaced the Information Governance Toolkit. The digital risk register includes all current information risks, with risks reviewed by the respective teams and exception reports and emerging serious risks reported to the Executive Digital Health Enterprise Committee, which in turn reports to GRAC.

In line with national requirements, digital incidents are assessed using the DSPT assessment criteria and reported through to the Department of Health via the DSPT Incident Reporting Tool. During 2018/19, there were 9 serious incidents formally investigated and reported by the organisation; three of which were reported to the Information Commissioners Office (ICO).

The incidents related to a staff member accessing estranged sister (a patient) details on the medical records system; fire at the electronic document management company units used by Trust which resulted in loss/destruction of patient records, the quantity of records is not yet established; and a patient being discharged with discharge paperwork, which also included information about another patient, in error. Appropriate internal actions were taken. The ICO has not requested that the Trust take any further action.

Pennine has worked within time constraints to have all systems and processes functioning at the correct level to support the General Data Protection Regulations/Data Protection Act which became law on 25 May 2018. All major themes have been completed with some work in regards to information asset management to be completed by September 2019.

In September 2018, Pennine experienced a major IT network failure, which resulted in the cancellation of around 600 operations and 50 non-urgent operations. Wards and departments reverted to paper based business continuity plans, which functioned effectively over the period of time. A full business continuity debrief was completed following the incident. Immediate action was taken to ensure the exact issue would not happen again, and additional support contracts have been established to reduce the impact of any further hardware incidents. A full refresh of the network has commenced, with the Group Committees in Common approving acceleration of the most impactful Local Area Network (LAN) elements of the infrastructure beginning in January 2019.

The Department of Health and Social Care has issued an Enforcement notice on the Trust due to key issues with the historical technical infrastructure and the cyber security risk under the NIS directive (Network & Information Systems). A comprehensive plan has been developed and actions have started. The actions from the enforcement notice have also been added to the current work on going to future proof the Pennine IM&T infrastructure.

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.

For 2018/19, Pennine has opted to follow NHS Improvement's (non-mandatory) recommendation that NHS Trusts should follow its requirements for Foundation Trusts. Therefore, Pennine has followed the 'Detailed Requirements for Quality Reports'. The Pennine Annual Quality Report 2018/19 has been developed in line with relevant national guidance and is supported internally through the Board Assurance Framework.

All data and information within the Quality Report has been reviewed via the Care Organisation Quality and Clinical Effectiveness Governance Committees and supported through the comprehensive documented three year Quality Improvement Strategy. The Group CiC regularly reviews the Quality Improvement Dashboard and progress against identified projects.

The NCA has an identified Quality Improvement Department with relevantly skilled individuals to support the execution of the Quality Improvement Strategy across the organisation.

Capability building in Quality Improvement techniques and skills has been and remains a key objective of the organisation. Staff at all levels are exposed to collaborative working or specific quality improvement educational programmes both internally and externally to ensure skills are developed and maintained.

The Quality Report 2018/19 has been reviewed through both internal and external audit processes and comments have been provided by local stakeholders including commissioners, patients and the local authority.

Following the CQC Inspection in 2016, a data quality improvement project to assure the quality and accuracy of elective waiting time data was initiated and monitored as part of the Pennine Improvement Plan. Significant progress was made during 2017/18 and improvements have continued in 2018/19 with reviews and updates to standard operating procedures for booking and scheduling teams and programmes of work to deliver improved reporting and solutions for the monitoring of elective waiting times. Any issues that are highlighted within the data are reported through to the Data Quality Team for investigation and are acted on appropriately

Review of effectiveness

As Accountable 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 Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the information provided in 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 a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust's Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

Internal Audit provides me with an opinion about the effectiveness of the assurance framework and the internal controls reviewed as part of the internal audit plan.

The Head of Internal Audit opinion for 2018/19 gave substantial assurance on the system of internal control in place during the year.

The Head of Internal Audit Opinion stated that "as recognised by Pennine there are significant risks with regards to the organisation's digital infrastructure, which has been reflected in the internal audit reviews undertaken in the area. This opinion acknowledges the governance and risk management arrangements the organisation has in place to manage this risk". Work undertaken by internal audit is reviewed as relevant by the Assurance Framework's Committees and the Audit Committee.

During 2018/19, twelve internal audit reviews were conducted, 3 received a substantial assurance opinion, 5 received a moderate assurance opinion and 4 received a limited assurance opinion including Deprivation of Liberty Safeguards, Management of Volunteers, Data Security and Protection Toolkit and Booking of Locum Doctors.

Where internal audit issued a limited assurance report the relevant Chief Officer and/or Care Organisation Director attended the Audit Committee to discuss the report and actions taken.

The Board Assurance Framework/Corporate Risk Register is presented to the GRAC on a quarterly basis and all significant risks are detailed within the monthly Group Integrated Performance Dashboard presented to the Group CiC. This provides me and the Group CiC with evidence of the effectiveness of controls in place to manage risks to achieve the organisations principal objectives.

My review is also informed by External Audit opinion; in May 2018 External Audit issued an unqualified audit opinion of the financial statement 2017/18 which included a going concern, and an 'except for' value for money conclusion; inspections carried out by the Care Quality Commission and other external inspections, accreditations and reviews.

The processes outlined below are well established and ensure the effectiveness of the systems of internal control through:

- GRAC review of the NCA BAF/CRR, including review of Care Organisation BAF/CRR
- Group CiC oversight of all significant risks
- Audit Committee scrutiny of controls in place
- Review of serious untoward incidents and learning by the Assurance Framework committees, including those for risk management and clinical effectiveness
- Internal audits of effectiveness of systems of internal control

Conclusion

This Annual Governance Statement requires me to consider whether there are any significant internal control issues facing the Trust.

The Group CiC has extensive and effective governance assurance systems in operation. These systems enable the identification and control of risks reported through the BAF/CRR. Internal and external reviews, audits and inspections provide sufficient evidence to state that no significant internal control issues have been identified during 2018/19, and that these control systems are fit for purpose.

Signed: 

Raj Jain

Date: *24 May 2019*

Chief Executive

Remuneration and staff report

As part of the Northern Care Alliance NHS Group (NCA) governance arrangements and as delegated by the Pennine Board of Directors, the Group Committees in Common has established the Nominations, Remuneration and Terms of Service (NRTS) Committee (utilising a Committees in Common approach). The NRTS Committee has primary regard to the nominations, remuneration and terms of service of Executive Directors.

A Nominations, Remuneration and Terms of Office (NRTO) Committee is also established by the Group's Council of Governors and has regard to the nominations, remuneration and terms of service of Non-Executive Directors. For the NHS Trust, this involves close liaison with NHSI.

The NCA currently reviewing its senior manager remuneration arrangements. The intention is to have the new Group arrangements in place during 2019/20.

During 2018, in line with recommendation received from NHS Improvement (NHSI) and Department of Health and Social Care (DHSC), a flat rate uplift of £2,075 was applied to the basic salaries of executive directors and senior leaders, where personal contribution had been assessed as 'successful' or above for the 2017/18 financial year. This mirrored the national Agenda for Change pay award provisions for staff on the maximum of bands 8c, 8d and 9. The uplift was applied from 1 October 2018. No bonus payments were awarded.

As described earlier in this year's Annual Report, Pennine Acute Hospitals NHS Trust has continued to receive managerial support from Salford Royal NHS Foundation Trust. The Chief Executive and Executive Nurse Director/Deputy Chief Executive have held formal executive responsibility at both organisations.

To reflect these arrangements the salaries of the Chief Executive and Executive Nurse Director have been split and paid equitably by Pennine Acute Hospitals NHS Trust and Salford Royal NHS Foundation Trust.

The NRTS Committee ensures that Executive Directors' remuneration is set appropriately, taking in to account relevant market conditions, and that Executive Directors and Senior Managers are appropriately rewarded for their performance against personal goals and objectives that are aligned to the organisation's principal objectives. The NRTS Committee reports directly to Group Committees in Common and has met its responsibilities during 2018/19 by:

- Determining succession plans for all Executive Directors
- Setting the role description, responsibilities and person specification for the Chief Executive of the Northern Care Alliance
- Determining and implementing a robust search and selection process for a new Chief Executive of the Northern Care Alliance
- Monitoring and evaluating the performance of the Chief Executive and Executive Directors and Chief Officers
- Determining appropriate remuneration, relative to individual and organisational performance
- Overseeing local remuneration and performance-related pay/bonus arrangements for the most senior managers (sub-Executive Director level)
- Evaluating the balance of skills, knowledge and experience on the Board (Group Committees in Common) and approving descriptions of roles, and appointment processes, for the appointment of Executive Directors/Chief Officers

The NRTS Committee is chaired by Pennine's Chairman (who is also the Chairman of Salford Royal and the NCA and all Non-Executive Directors (of Pennine and the NCA are members. Attendance during 2018/19 was as follows:

Mr James Potter	6/6
Mrs Diane Brown	5/6
Mrs Christine Mayer CBE	5/6
Mr John Willis CBE	5/6
Mr Kieran Charleson*	6/6
Professor Chris Reilly	6/6
Dr Hamish Stedman	5/6

* Non-executive Directors on the Salford Royal NHS Foundation Trust's Board of Directors, and the Northern Care Alliance NHS Group's Committees in Common

The Chief Executive attended the Committee in relation to discussions about Board composition, succession planning, remuneration and performance of Executive Directors. The Chief Executive was not present during discussions relating to his own performance, remuneration and terms of service.

The Chief Strategy and Organisational Development Officer provided employment advice and guidance, and withdrew from the meeting when discussions about his own performance, remuneration and terms of service were held. The Director of Corporate Services/ Group Secretary is the Committee Secretary.

The executive directors are employed on permanent contracts. The executive directors are required to give six months' notice of termination of employment.

There are no special guaranteed termination payments or compensation payments for early termination of executives. Executives are subject only to the same redundancy rights as all other employees of the Trust.

It has been confirmed via Audit Committee that this report provides information about named individuals in senior positions having authority or responsibility for directing or controlling the major activities of the Foundation Trust. They are members of the Board of Directors and/or Group Committees in Common and include, the chairman, the executive directors including the chief executive, the non-executive directors and the chief officers of the care organisations.

Salary and pension entitlements of senior managers

The Chief Executive has determined, for the purpose of the Annual Report and Accounts, those officers who have authority and/or responsibility for directing or controlling the major activities of the Trust, i.e. who influence decisions of the Trust as a whole rather than individual Care Organisations or divisions. These officers include all members of the Board of Directors and Group Committees in Common (voting and non-voting).

Executive Directors

Status	Name	Role	Remuneration proportion
Voting PAHT	Sir David Dalton	Chief Executive	50%
Voting PAHT	Mr D. Finn	Executive Director of Finance/Chief Officer, North Manchester Care Organisation	100%
Voting PAHT	Prof M. Makin	Executive Medical Director	100%
Voting PAHT	Mrs E. Inglesby-Burke CBE	Executive Director of Nursing	50%
Voting PAHT	Mr P. Crowley	Executive Director Pennine Transaction	100%

Chairman and Non-Executive Directors

Voting PAHT	Mr J. Potter	Chairman	See footnote
Voting PAHT	Mrs C. Mayer CBE	Non Executive Director	See footnote
Voting PAHT	Mr J. Willis CBE	Non Executive Director	See footnote
Voting PAHT	Mrs D. Brown	Non Executive Director	See footnote

Footnote 1: The delegation of the Board of Directors' powers to Group Committees in Common is described on page 142 of this Annual Report. All of the PAHT Board members are members of the Group Committees in Common, with the exception of Prof M Makin. The Group Committees in Common comprises all voting members of the Salford Royal NHS Foundation Trust Board of Directors and details of their remuneration for the 2018/19 financial year are included within the Salford Royal NHS Foundation Trust 2018/19 Annual Report. The following Care Organisation Chief Officers are also members of the Group Committees in Common:

Mr J. Sumner Chief Officer, Salford Care Organisation
Mr S. Taylor Chief Officer Bury & Rochdale Care Organisation
Mrs N. Firth Chief Officer Oldham Care Organisation
Mr D. Finn Chief Officer North Manchester Care Organisation

Footnote 2: Sir David Dalton receives 50% of his remuneration from PAHT (as detailed above) and 50% of his remuneration from SRFT (as detailed within SRFT's annual report). In total the remuneration for Sir David Dalton for the 2018/19 financial year is £249,209.

Footnote 3: Mrs E. Inglesby-Burke CBE receives 50% of her remuneration from PAHT (as detailed above) and 50% of her remuneration from SRFT (as detailed within SRFT's annual report). In total the remuneration for Mrs E. Inglesby Burke CBE for the 2018/19 financial year is £157,761.

Footnote 4: 50% of the Chairman's total remuneration is paid from PAT and 50% is paid from SRFT. Non-executive Directors, who are members of both the PAT and SRFT Board of Directors, receive £6k remuneration from PAT (in line with national NHS Trust NED remuneration) and the remainder of their remuneration from SRFT

Footnote 5: Mr P. Crowley commenced 1 December 2018

The following tables and the fair pay multiple, have been subject to external audit.

A) Remuneration

	2018-19						2017-18					
	(A)	(B)	(C)	(D)	(E)	(F)	(A)	(B)	(C)	(D)	(E)	(F)
Name and title	**Salary bands of £5000 £000**	**Taxable expense payments & taxable benefits total nearest £100 £000**	**Perform-ance pay & bonuses bands of £5000 £000**	**Long-term perform-ance pay & bonuses bands of £5000 £000**	**All pension-related benefits bands of £2500 £000**	**Total (A to E) bands of £5000 £000**	**Salary bands of £5000 £000**	**Taxable expense payments & taxable benefits total nearest £100 £000**	**Perform-ance pay & bonuses bands of £5000 £000**	**Long-term perform-ance pay & bonuses bands of £5000 £000**	**All pension-related benefits bands of £2500 £000**	**Total (A to E) bands of £5000 £000**
Sir D Dalton, Chief Executive Officer	125-130	6,400	0	0	80-82.5	210-215	115-120	1,000	0	0	30-32.5	145-150
D. Finn, Executive Director of Finance/ Chief Officer, North Manchester Care Organisation	155-160	-	0	0	-	155-160	155-160	-	0	0	-	155-160
Prof M. Makin, Executive Medical Director	180-185	-	0	0	-	180-185	175-180	-	0	0	-	175-180
E. Inglesby-Burke CBE, Executive Director of Nursing (from 1 August 2016)	75-80	2,800	0	0	0	80-85	70-75	2,800	0	0	20-22.5	95-100
P. Crowley, Executive Director Pennine Transaction (from 1 December 2018)	10-15	-	0	0	-	10-15	-	-	-	-	-	-
S. Taylor, Chief Officer, Bury & Rochdale Care Organisation	120-125	200	0	0	5-7.5	125-130	120-125	300	0	0	75-77.5	195-200
N. Firth, Chief Officer, Oldham Care Organisation (from 1 April 2018)	125-130	-	0	0	125-130	250-255	-	-	-	-	-	-
J. Potter, Chairman	35-40	-	0	0	-	35-40	35-40	-	0	0	-	35-40
C. Mayer CBE, Non Executive Director	5-10	-	0	0	-	5-10	5-10	-	0	0	-	5-10
J. Willis CBE, Non Executive Director (from 1 August 2016)	5-10	-	0	0	-	5-10	5-10	-	0	0	-	5-10
D. Brown, Non Executive Director (from 1 October 2016)	5-10	-	0	0	-	5-10	5-10	-	0	0	-	5-10
2017-18 leavers / changes												
J. Lenney, Executive Director of Workforce & OD (until 31 May 2017)	-	-	-	-	-	-	20-25	1,200	-	-	-	20-25
D. McLaughlin, Chief Officer, Oldham Care Organisation	-	-	-	-	-	-	120-125	4,100	-	-	30-32.5	155-160

Column (e) is pension related benefits - this is the increase in year of the annual pension and lump sum that the individual would be entitled to from the NHS Pension scheme at 31 March or retirement less any employee contributions.

Prof M. Makin and D Finn have opted out of the NHS pension scheme.

Taxable benefits relate to mileage rates paid in excess of HMRC rates.

B) Pension benefits

Name and title	Real increase in pension at pension age (Bands of £2500) £000	Real increase in pension lump sum at pension age (Bands of £2500) £000	Total accrued pension at pension age at 31 March 2019 (Bands of £5000) £000	Lump sum at pension age related to accrued pension at 31 March 2019 (Bands of £5000) £000	Cash equivalent transfer value at 31 March 2019 £000	Cash equivalent transfer value at 31 March 2018 £000	Real increase in cash equivalent transfer value £000
Sir David Dalton Chief Executive Offcer	7.5-10	25-27.5	110-115	340-345	2,726	2,241	417
E. Inglesby-Burke CBE Executive Director of Nursing	0	0	75-80	225-230	1,847	1,664	134
N. Firth Chief Officer, Oldham Care Organisation	0-2.5	0	50-55	125-130	1,014	873	114
S. Taylor Chief Officer, Bury & Rochdale Care Organisation	5-7.5	10-12.5	45-50	120-125	871	653	199

The above details for Sir D. Dalton and E. Inglesby-Burke are the full amounts and the same as in Salford's annual report. As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

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

The CETV figures, and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Fair pay disclosure

Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The mid-point banded remuneration of the highest paid director in Pennine Acute Hospital NHS Trust in the financial year 2018/19 was £182.5k (2017/18, £177.5k). This was 7.8 times (2017/18, 7.5 times) the median remuneration of the workforce, which was £23.4k (2017/18, £23.6k).

In 2018/19, 6 (2017/18, 7) employees received remuneration in excess of the highest paid director. Remuneration ranged from £184k to £223k (2017/18 £183k to £229k).

Total remuneration includes salary, non-consolidated performance-related pay (e.g. clinical excellence awards), benefits-in-kind as well as severance payments. For the purposes of reporting pay multiples remuneration does not include variable aspects of pay such as overtime, enhancements or additional waiting list payments. Remuneration does not include employer pension contributions and the cash equivalent transfer value of pensions. The median remuneration for the workforce as a whole has been derived from permanent employees only and annualised for the year for the effect of starters and part time staff.

Staff report

At the end of 2018/19 Pennine Acute Hospitals NHS Trust employed 10,177 people. Details of our workforce are provided below.

Average number of people employed by the Trust

	2018/19			2017/18		
	Total (FTE)	Permanently employed (FTE)	Other (headcount)	Total (FTE)	Permanently employed (FTE)	Other (headcount)
Medical and dental	771.29	462.21	309.08	743.23	459.94	283.28
Administration and estates	2730.46	2611.09	119.37	2442.64	2347.34	95.28
Healthcare assistants and other support staff	1735.01	1653.75	81.25	1606.92	1554.14	52.78
Nursing, midwifery and health visiting staff	2745.49	2644.33	101.16	2823.67	2746.74	76.93
Scientific, therapeutic and technical staff	984.73	953.80	30.93	992.39	966.13	26.26
Bank staff	0	0	334	514.70	0	0
Agency staff	0	0	0	522.29	0	0
Other	8	2	6	13	5	7
TOTAL	**8974.96**	**8327.17**	**647.79**	**9658.84**	**8079.29**	**541.53**

Inclusion and equality

Pennine recognises that delivering on inclusion and equality is a key driver to achieving the Trust's overall strategic aims. It gives us a real opportunity to place people at the centre of the work we undertake, recognising how actively involving individuals from diverse groups enables us to prioritise and address health and employment inequalities.

We have an executive lead for equality and diversity, recognising the need to ensure visible and accountable leadership at a board level.

Our Equality, Diversity and Inclusion (EDI) leadership approach is to empower the principle that all staff and managers have a responsibility to own and implement inclusion within their workplaces and as part of our service delivery. We continually work to embed robust systems that support everyone to deliver this agenda throughout their working lives.

We will continue to engage and involve our staff to ensure they have the necessary skills and confidence to understand the root causes of health and employment inequalities of protected groups, review their services to improve outcomes and enable them to support the diverse needs of service users and colleagues. The NCA has outlined its commitment to this agenda through ensuring Inclusion and Equality training is mandatory for all staff.

The NCA is fully committed to meeting the requirements of the Equality Act 2010 and the Public Sector Equality Duty. Pennine's monitoring of data/statistics and other relevant information can also be viewed on the website (*www.pat.nhs.uk*), which forms part of a single NCA Annual Equality Report.

This information enables Pennine to review and monitor outcomes for both its workforce and service user data by protected groups. It also includes the Trust's report on the Workforce Race Equality Standard (WRES) and Gender Pay Gap Report.

The NCA has committed to a four year EDI Strategy, and our "Inclusion Road Map" sets out a number of steps on our journey to becoming a Centre of Excellence for Inclusion across the NHS.

In year achievements

The NCA's senior leadership team signing a commitment with other Greater Manchester Public Sector Leaders on Workforce Race Equality this year gave a strong commitment that as an organisation we will drive a culture of transformation and improvement to ensure our workplaces are inclusive for all.

We are also proud to have been shortlisted for the Best Diversity Resource Award as part of the National Inclusive Companies Awards 2018. At the awards it was also announced that the NCA was included within the top 25 of the 'UKs Inclusive Employers Top 50' list, an improvement on where we placed at 39 in 2017.

Local community groups

The NCA has continued to work and engage with a number of community organisations over the last 12 months across underserved communities. As part of our work going into 2019/20 the EDI Team will be producing a database of local groups who work across the NCA footprint to support our future involvement of key stakeholders in our work.

Multi-faith care after death group

This group consists of representatives from the local communities surrounding our localities. The group's membership largely consists of the Jewish and Muslim faiths, due to previous service delivery priorities in relation to improving our end of life care provision. Pennine has been working with the group for nearly two years to improve the issues identified. As a result of the success of the group in collaboratively working together to improve services, development plans have been put in place to ensure the group's work is a platform which can be developed across wider areas. It has been agreed that the group in its existing form will come to an end, with a wider patient-experience focussed multi-faith group and an underserved communities health inequalities group to be developed in its place.

Accessible Information Standard

Pennine has implemented the Accessible Information Standard (AIS) and is continuing to embed the standard across all services through the AIS Action Plan, which sets out how Pennine will achieve the Standard both internally and in partnership with other NHS and Adult Social Care providers and commissioners. Implementation is monitored through a new Accessible Information Standard Implementation Committee.

Workforce Race Equality Standards (WRES)

The NCA has developed a Workforce Race Equality Strategy which, through its implementation, we hope will support in making significant progress in reducing the inequalities faced by our Black and Minority Ethnic (BAME) staff, as highlighted through the WRES Metrics.

As a demonstration of the recognition of the NCA's commitment to leading on this agenda within Greater Manchester and of the expertise within the EDI Team, we were successful in winning a £100,000 contract to provide a range of interventions and resources to transform workforce race equality across public sector organisations within the Greater Manchester Footprint. This includes the Police, Fire, Local Authorities and other NHS Organisations.

In 2018, two of our EDI Team members graduated as part of Cohort 1 of NHS England's National Workforce Race Equality Experts programme. We have continued to promote leadership development opportunities for BAME staff through leadership programmes such as Stepping Up and Ready Now. As part of our WRES action plan, we have also developed a network of Cultural Ambassadors as part of the Royal College of Nursing's promoted programme to reduce bias and inequalities in Disciplinary Panel decisions and recruitment. During 2019/2020 we will continue to recruit people to become Cultural Ambassadors and further integrate their roles within existing processes.

Equality Impact Assessments (EQIAs)

To help further embed inclusion across all our governance and decision making pathways, we have continued to develop our approach to Equality Impact Assessments in order to ensure that we are able to demonstrate how decision makers have considered the potential impact of decisions on under-served communities, including the protected characteristics from the Equality Act 2010, and what actions have been taken to ensure these impacts don't take place or are mitigated. This work has included the development of a single point of access for quality assurance of all newly completed EQIAs, coordination and support for Equality Champions, and the delivery of training and development for staff around the EQIA process.

We have built in a maximum four-week service delivery standard for quality assurance of EQIAs for our authors, to provide support around sustainable time lines in developing policies, leaflets and transformation programmes, and have provided a clear exception root to fast track documents or programmes where required.

Further training, coaching and resources will be developed to support both authors and Equality Champions during 2019/20.

Training and development

The NCA developed and delivered a series of training and awareness sessions throughout the year to improve outcomes for diverse groups. These have enabled staff to have face to face conversations with a number of representatives from diverse groups and develop practical ways to support these individuals.

During 2019/20 we will be reviewing our learning offer to ensure staff have access to the right range of courses and interventions to support the delivery of our four year Inclusion Road Map.

Future priorities and targets

Priorities for 2019/20 include:

- Design of the Race Equality Change Agents Programme Curriculum
- Launch of the NCA Inclusion Council
- Evaluation of previous Reverse Mentoring Programme and launch of 2019/20 cohorts
- Development of our Centre of Excellence for Inclusion "offer"

Performance and monitoring of these priorities will be undertaken by the development of a specific EDI Strategic Dashboard and through the Inclusion & Equality Committee, Inclusion Council and local governance structures. External assessment of our performance and development will be delivered through engagement with key stakeholders and the Equality Delivery System (EDS2/3).

Age band	2018/19		2017/18	
	Headcount	%	Headcount	%
16-21	66	0.64	62	0.63%
21-30	1,798	17.66	1,688	17.25%
31-60	7,469	73.39	7,348	75.09%
61-70	816	8.01	668	6.83%
Over 70	28	0.27	20	0.20%
TOTAL	**10,177**	**100%**	**9,786**	**100%**
Ethnic group				
White - British & Irish	7,980	78.41	7,891	80.64%
Asian	1,051	10.32	916	9.36%
White - Other	261	2.56	224	2.29%
Black	372	3.65	290	2.96%
Mixed	124	1.21	109	1.14%
Any other Ethnic Group	155	1.52	127	1.30%
Not Specified	204	2.00	203	2.07%
Chinese	30	0.29	26	0.27%
TOTAL	**10,177**	**100%**	**9,786**	**100%**
Gender				
Female	8,069	79.28	7,784	79.54%
Male	2,108	19.82	2,002	20.46%
TOTAL	**10,177**	**100%**	**9,786**	**100%**
Disabled				
No	5,483	53.87	4,510	46.09%
Not Declared	4,356	42.80	5,015	51.25%
Yes	348	3.41	261	2.67%
TOTAL	**10,177**	**100%**	**9,786**	**100%**

Sickness absence

In 2018/19 our aim was to reduce sickness by 1% across all Care Organisations.

Pennine has an established Health and Wellbeing Steering Group to oversee the Health and Wellbeing Strategy, which is underpinned by the NHSI Health and Wellbeing Framework.

Part of this strategy is for Pennine to achieve the Workplace Wellbeing Charter accreditation. Pennine now provides access to counselling, mental health advice and staff physiotherapy services as part of its Health and Wellbeing offering. Following extensive discussions with our trade union partners, a policy to have all staff with a musculoskeletal issue referred to the Physiotherapy Service has been introduced. Staff are seen in Occupational Health, and advice and adjustments to duties made.

Staff have fast access to a number of other clinical services such as when staff are referred to consultants within the Trust, along with healthy eating advice through dietetics.

The Occupational Health Service has introduced a service by which a phone call is made within 48 hours of a staff member being absent due to stress, in order to support their return to work and ensure that they are supported and signposted to relevant services.

Occupational Health Managers meet with HR Advisors and Clinical Leads on a monthly basis to discuss all sickness, in order to ensure that staff are supported sufficiently to be able to remain in work, or that plans are put in place to enable a return in some other capacity.

Sickness is reviewed with managers on a regular basis and Pennine has a number of supportive policies in place to assist staff to return to work or remain in employment.

We have an electronic return to work form to capture information from return to work interviews. Pennine's values and Disciplinary Rules underpin our expectations for staff behaviour, whilst we are explicit on attendance in terms of established triggers for formal intervention due to absences.

Staff sickness absence	2018/19	2017/18	2016/17	2015/16
Days lost - long term	108,399.48	102,930.34	101,324.28	109,416.05
Days lost - short term	56,894.48	57,753.70	52,924.86	50,692.80
Total days lost	**165,293.51**	**160,684.05**	**154,249.14**	**160,108.85**
Total staff years	**8,974.97**	**8,621.85**	**8,228.53**	**8012.51**
Average working days lost	18.08	18.64	18.75	19.98
Total staff employed in period (headcount)	10,177	9,420	9,084	8,627
Total staff employed in period with no absence (headcount)	2,889	2,764	2,825	2,720
Percentage staff with no sick leave	28.39%	29.34%	31.10%	31.53%

	2018/19	2017/18	2016/17	2015/16	2014/15
01 April	4.68%	4.69%	5.46%	5.72%	4.64%
02 May	4.56%	4.84%	5.01%	5.74%	4.89%
03 June	4.72%	4.94%	4.93%	5.61%	5.18%
04 July	5.23%	5.24%	5.32%	5.76%	5.23%
05 August	5.34%	5.22%	4.92%	5.48%	5.17%
06 September	5.18%	5.17%	4.70%	5.32%	5.78%
07 October	5.30%	5.47%	5.18%	5.93%	6.25%
08 November	5.37%	5.42%	5.60%	5.85%	6.08%
09 December	5.50%	5.77%	5.84%	6.08%	6.31%
10 January	5.74%	6.15%	5.86%	6.16%	6.61%
11 February	5.35%	5.02%	5.21%	5.95%	6.02%
12 March	4.92%	5.04%	5.14%	5.86%	5.55%

Systems are in place to allow for a timely and professional review of long term sickness leave, with referral to the Occupational Health Service. Managers are expected to make reasonable adjustments for staff to facilitate an early return to duty from long term sickness or to enable an employee who has acquired a disability to continue in work. The NCA recognises its duty to provide care to patients in an effective and economic manner and, where there is no reasonable prospect of a return to work, it may be appropriate to retire or dismiss employees who remain absent from work on an extended basis.

Engaging with our people

Pennine has policies on employing individuals with disabilities, long term conditions and those on ill health and disability redeployment, along with permanent adjustments in order to help maintain the employment of staff with disabilities or long term conditions. Pennine has a Single Equality Scheme and action plan and ensures that as a 'positive about disabled people' employer those applicants with a disability who apply for a post and meet the essential criteria are shortlisted.

Pennine has a specific engagement programme - The Pioneers Programme - which aims to embed staff engagement at team level and which provides the tools and techniques to allow bottom-up improvement initiatives designed and delivered by local teams.

Pennine systematically provides employees with information on matters of concern to them as employees:

- Staff are invited to attend the monthly Team Brief, receiving a briefing on key issues and developments; messages and information are then cascaded outwards to their wider teams
- Pennine have weekly e-newsletter, which is distributed to all staff on a weekly basis
- Regular and relevant information is posted for staff on Pennine's intranet, including a Performance Section
- Pennine holds engagement events across its sites, where the leadership teams will address any issues or concerns with staff
- Director drop-in surgeries also take place, providing the opportunity to find out more about the issues that matter most to our people

In addition, Pennine has an agreed Organisational Change Policy with trade union colleagues, which sets out a framework to consult and manage organisational change within Pennine. Formal consultation processes include managers meeting on a regular basis with trade union representatives. There are regular meetings of the Central Joint Negotiating Committee, the Joint Local Negotiation Committee and the Health and Safety Committee.

Values based appraisals - my contribution conversations introduced

In 2018/19 the NCA launched a major culture change programme underpinned by the introduction of a harmonised approach to coaching-based conversations called 'My Contribution'. This approach will ensure all staff:

1. Have regular, meaningful coaching conversations with their line manager
2. Have clear focus on how they contribute to patient care and have priorities and objectives aligned to strategic objectives
3. Have had an opportunity to discuss their career aspirations
4. Have agreed development plans that ensure they reach their potential and operate at the top of their license

The roll-out of this change in approach is being delivered through a range of tools and methods and it is anticipated all 3,000 team leaders and supervisors will have received training during 2019/20. The implementation and impact of this culture change is being evaluated and reported on through formal governance mechanisms, and Pennine will compare the National Staff Survey responses for 2019/20 to see if Pennine Acute has reversed the trend in respect of our less favourable results for the completion and quality of appraisals and the results in respect of learning and development.

Apprenticeships

The Government has pledged to deliver 3 million apprenticeship starts by 2020. The key to achieving this target was the introduction of the Apprenticeship Levy and the Public Sector targets. Apprenticeships are delivered internally by the People Development Team within the Learning and Organisational Development Department, and are externally sourced from expert providers including Higher Education Institutions.

The Apprenticeship Levy came into force in May 2017. On an annual basis, the NCA contributes 0.5% of the total pay bill to the Apprenticeship Levy. The number of new apprenticeship starts across the NCA will be reported to the government via the Apprenticeship Service on an annual basis.

Demographic factors present a real challenge for health education in the coming decade. The NCA will focus its effort towards supporting workforce planning by use of the levy funds based on the current demographics and resource challenges i.e. the numbers in the workforce eligible for retirement within the next five years, the % of its staff age 16 to 18 years old with no qualification, role enhancement and substitution. Apprenticeships will thus support Pennine in addressing the gaps in its workforce profile.

On an annual basis, Pennine pays approximately £1.7m into an account which can be used to pay for apprenticeship training. The levy is being used to fund a variety of apprenticeships from level 2 hospitality to degree level management apprenticeships.

The Enterprise Act (2016) states that 2.3% of the workforce should be apprenticeship starts (based on headcount). At the end of year one Pennine achieved 172 new apprenticeship starts against a public sector target of 217, and at the end of year 2 Pennine achieved 230 new apprenticeship starts against a public sector target of 233.

Helping our people stay healthy and safe

The Health and Safety Committees at the North East Sector Care Organisations meet regularly to provide a forum for managers and trade unions to work together to promote health and safety and improve the working environment, in order to aid a reduction in the number of serious incidents per year.

The below table describes the top 5 Health and Safety incidents reported during 2018/19.

Category	Total
Abuse verbal	426
Assault physical	351
Sharps/needlestick	224
Fall, slip or trip	167
Moving and handling	62

Countering fraud

Pennine has an established Counter Fraud Service that is committed to protecting valuable public funds from the risks of fraud, bribery and corruption and is supported by a proportionate investment in local counter services which aim to keep NHS fraud to an absolute minimum. The Counter Fraud Service is provided at a local level in-house by a professionally accredited and certified counter fraud practitioner, with support from Mersey Internal Audit Agency.

The in-house counter fraud practitioner is Pennine's nominated Lead Local Counter Fraud Specialist (Lead LCFS) and is responsible for counter fraud support NHS staff working at:

- North Manchester Care Organisation
- Oldham Care Organisation
- Bury and Rochdale Care Organisation

A counter fraud service was also provided to approximately 3,000 staff at the Lead Employer, North West Deanery, which was hosted by Pennine Acute Hospitals NHS Trust up until October 2018. However, after TUPE of the Lead Employer to St. Helen's NHS Foundation Trust, the counter fraud service to the Lead Employer is now provided by MIAA.

To comply with the NHS Counter Fraud Authority Standards for Providers, the Lead LCFS undertakes a variety of activities which aim to fully embed an anti-fraud culture throughout the organisation. This work is fully supported by the Chief Financial Officer, the Board and the Audit Committee. Monitoring takes place on a regular basis by the Group's Audit Committee in Common, which receives quarterly progress reports, an annual report, an annual plan and a fraud standards risk assessment.

A number of key tasks were undertaken and evaluated in a staff fraud survey in the last 12 months, to combat fraud, bribery and corruption in accordance with the NHS CFA Standards for Providers for Fraud, Bribery and Corruption, as shown below.

Inform and involve

The NCA has an agreed Counter Fraud Response Plan/Policy and Communications Strategy in place. Also in place are Counter-Fraud webpages on both the intranet and internet sites, which are used to publicise a variety of fraud related articles as well as other appropriate information appertaining to fraud, bribery and corruption.

Anti-Fraud hospital awareness visits are made during a fraud awareness month and presentations are delivered by the Lead LCFS at organised events in order to raise awareness of fraud, bribery and corruption and include interaction from attendees. Further, all new staff are encouraged at the NCA corporate Induction to complete anti-fraud e-Learning training and to declare at commencement of employment any secondary employment, external business interests or other interests that may conflict NHS commitments. This approach contributes towards creating and embedding a transparent anti-fraud culture and best probity practice across the organisation, and has seen over 2,500 staff receiving some form of anti-fraud awareness training by either E-learning or awareness visit events over the last 12 months.

Partnership working takes place with the HR Department, Internal Audit, Local Security Management Specialists, Information Security Management Governance, the Greater Manchester Police local neighbourhood community policing teams representing 4 hospital locality sites, and the Floyd Unit. This has continued to raise awareness around all criminal activity (including fraud and theft), increased the local profile of the Lead LCFS and promoted whistleblowing, thus informing our staff and the general public of the variety of safe and secure routes available to report all types of fraud concerns.

Prevent and deter

The Lead LCFS issues guidance and preventative material to staff and publicises outcomes of both local and national fraud investigations to inform staff of the consequences of committing fraud and deter people who may be tempted themselves. In the last 12 months, prevent and deter articles have appeared in the Weekly Bulletin, the Weekly Message and on the fraud display stand used at corporate induction and on hospital awareness visits.

The Lead LCFS reviews a variety of policies and procedures to ensure these are robust and help to minimise the opportunities for crime to occur, as well as contributing to maintaining an 'adequate procedures' defence in respect of fraud or bribery offences. An example of a fraud risk being responded to is 'working while sick', which remains the number one volume NHS fraud at both a national and local level. To address the risk, an online 'return to work form sickness absence form' was introduced in collaboration with HR, which contains a recommended anti-fraud declaration.

Pennine participates in the National Fraud Initiative exercise data-matches aimed at identifying fraudulent activities. Further pro-active exercises have taken place on conflicts of interest, sickness absence and overtime claims, aimed at identifying system outliers. Also, pre-employment checklists are required to be completed annually on both NHS employees and by agencies providing on-site services in patient areas. The Lead LCFS has a follow up process in place at Audit Committee to ensure that outstanding recommendations are followed up and actioned appropriately.

Hold to account

The Lead LCFS ensures that all reports of suspected fraud, bribery and corruption are recorded on the NHS CFA case management system, investigated, and redress sought where appropriate, so that money misappropriated through fraud, bribery and/or error can be recovered and put back into NHS resources for patient care.

The NCA is committed that, where fraud is found, all possible available sanctions will be taken against an offender, and that publicity will be sought internally via staff weekly bulletins and externally in local/national newspapers. This may include (as applicable to the case) internal disciplinary action, civil recovery action, prosecution and reporting dishonest registered practitioners to their professional regulatory body (e.g. GMC and NMC).

For example, in the last 12 months over £1,540 previously defrauded from the NHS Trust was recovered and a court confiscation order to recover £2,614 from an ex-employee NHS Pension was agreed by the NHS Pensions Agency. Further, 2 disciplinary sanctions were issued against staff who had each committed a low value fraud and publicity was placed in the staff weekly bulletin. During the year there were over 1000 intranet hits on staff fraud internal publicity articles.

Staff survey

The NCA's approach to staff engagement is described throughout the Annual Report. The 2018 staff survey was undertaken between October and December 2018 with the results being published by NHS England on 7 March 2019.

Pennine used the mixed mode method, providing staff with the opportunity to complete the survey online or by completing paper surveys provided where access to emails is limited. The Picker survey was sent to all staff across different divisions, directorates and professions throughout Pennine; 9,401 in total. The survey response rate was 34% (1% up on last year) with 3,167 staff completing the survey.

NHS staff survey results

From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those. The response rate to the 2018 survey was 34% (2017, 33%). Scores for each indicator together with that of the survey benchmarking group (combined acute and community trusts) are presented below.

	2018/19		2017/18		2016/17	
	Trust	Average	Trust	Average	Trust	Average
Equality, diversity and inclusion	9.1	9.2	9.0	9.2	9.1	9.3
Health and Wellbeing	5.7	5.9	5.9	6.0	5.7	6.1
Immediate Managers	6.6	6.8	6.4	6.8	6.4	6.8
Morale	6.0	6.2	-	-	-	-
Quality of appraisals	5.1	5.4	5.0	5.3	4.9	5.4
Quality of care	7.4	7.4	7.4	7.5	7.4	7.5
Safe environment - bullying and harassment	7.9	8.1	7.9	8.1	7.9	8.2
Safe environment - violence	9.5	9.5	7.9	9.5	7.9	9.5
Safety culture	6.5	6.7	6.4	6.7	6.2	6.7
Staff engagement	6.8	7.0	6.8	7.0	6.6	7.0

Compared to all Combined Acute & Community Trusts, Pennine was fourth (of 19) in the historic positive score league table, showing that our positive scores have improved significantly from last year. Pennine's results are within the parameters of best and worst national results for the 10 themes.

- Whilst there has been an upward trend for immediate managers theme (increased from 6.4 to 6.6) it is only 0.1 above the reported worst score; this will require attention in 2019
- Safe environment - Violence is another theme that will require particular attention in 2019; the score has remained the same but is only 0.2 above the worst organisation nationally
- Safety Culture (↑0.1) & Quality of Appraisals (↑0.1) are showing a small upward trend
- There has been a small downward trend for Equality, Diversity and Inclusion (↓0.1) and Health & Wellbeing (↓0.2)
- All other theme scores are comparable to last year's results

An important improvement in 2018 has been a cluster of improvements that suggest that staff at Pennine are feeling less pressured (not working additional unpaid hours + not unwell due to stress + able to meet conflicting demands). Together with an improvement in recognition for good work and being supported by management to receive learning & development, this suggests that Pennine will be perceived as a more positive place to work. Indeed, this is supported by the improvement from 59% in 2014 to 62% in 2018 of staff who often look forward to coming to work.

Less positive is the indication that, whilst the needs are being recognised, managers are not acting on learning and development needs. In addition, the number of staff receiving an appraisal has remained at 82%; something we plan to address this year, as has been outlined elsewhere in this report.

Finally, in this analysis of the results it is good to note that care of patients being the top priority of the organisation has risen steadily since 2014 from 62% to 71% this year; an increase of nearly 10%.

Future priorities and targets

The focus of our attention in 2019/20 in respect of staff engagement will be:

- Ensuring staff are as enthusiastic about their job as they are about coming to work, through 'My Contribution Conversations' (MCCs). These will help alleviate the time pressures felt by many, by ensuring managers support staff to prioritise. The MCCs will also enable managers to consult about key decisions that impact on staff
- Continuing the efforts to transform Pennine into a highly-reliable culture remains a priority, with the number of errors and near misses still seen of concern. Whilst reporting errors is positive, it is of concern that staff don't feel as confident as they should about what action will be taken. This will be addressed through the introduction of local staff engagement plans, working with senior leaders using local data to focus on teams that scored particularly poorly in this area

Trade union facility time

From 1 April 2017, public sector organisations are required to report on trade union facility time. Facility time is paid time off for union representatives to carry out trade union activities.

Table 1

Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full time equivalent employee number
74	9,012

Table 2

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	41
1%-50%	30
51%-99%	2
100%	1

Table 3

Percentage of pay bill spent on facility time

First column	Figures (£)
Provide the total cost of facility time	204,122.10
Provide the total pay bill	465,291,000.00
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time/total pay bill) x100	0.04%

Table 4

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period/total paid facility time hours) x100	5%

Expenditure on consultancy

Expenditure on consultancy during 2018/19 was £2.2m. This related to a review of corporate functions to facilitate economies of scale under Group that was performed by PA Consulting, and also a review of theatre productivity by Four Eyes Insight.

Off-payroll engagements

Pennine limits the use of off-payroll arrangements for highly paid staff. Care Organisation Director approval is required in all cases, and where the appointment of medical staff is to be made on a locum basis, approval is required from the relevant Divisional Managing Director or Divisional Chair and appointments are only made where they are compliant with the IR35 regulations.

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months:

No. of existing engagements as of 31 March 2019	0
Of which: No. that have existed for less than one year at time of reporting	0
No. that have existed for between one and two years at time of reporting	0
No. that have existed for between two and three years at time of reporting	0
No. that have existed for between three and four years at time of reporting	0
No. that have existed for four or more years at time of reporting	0

All new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months:

No. of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	1
Of which: Number assessed as within the scope of IR35 Number assessed as not within the scope of IR35	1
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

Off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019.

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.	14

An urgent requirement to cover the Managing Director role at Oldham Care Organisation to ensure stability of leadership and sufficient leadership capacity during the establishment and development of Care Organisation governance structures necessitated the requirement to appoint an interim Managing Director in an off payroll arrangement. Mr Matthew Powls was engaged between the period February 2018 until September 2018 following the secondment of Ms Donna McLaughlin.

Exit packages

During 2018/19, Pennine did agree exit packages.

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	9	16	16
£10,000-£25,000	0	1	1
£25,001-£50,000	0	0	0
£50,001-£100,000	0	1	1
£100,000-£150,000	1	0	1
£150,001-£200,000	0	0	0
Total number of exit packages by type	1	18	19
Total resource cost	**£139,000**	**£130,000**	**£269,000**

Exit packages: non-compulsory departure payments

	Agreements number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	2018/19 - 1 (2017/18 - 0)	2018/19 - £61 (2017/18 - £0)
Mutually agreed resignations (MARS) contractual costs	2018/19 - 0 (2017/18 - 0)	2018/19 - £0 (2017/18 - £0)
Early retirements in the efficiency of the service contractual costs	2018/19 - 0 (2017/18 - 0)	2018/19 - £0 (2017/18 - £0)
Contractual payments in lieu of notice	2018/19 - 17 (2017/18 - 20)	2018/19 - £69 (2017/18) - £101)
Exit payments following Employment Tribunals or court orders	2018/19 - 0 (2017/18 - 0)	2018/19 - £0 (2017/18 - £0)
Non-contractual payments requiring HMT approval	2018/19 - 0 (2017/18 - 0)	2018/19 - £0 (2017/18 - £0)
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	2018/19 - 0 (2017/18 - 0)	2018/19 - £0 (2017/18 - £0)

Redundancy and other departure costs have been paid in accordance with the provisions of the NHs pension scheme. Exit costs in this note are the full costs of departures agreed in the year.

Where the Pennine Acute Hospitals NHS Trust has agreed early retirements, the additional costs are met by the Pennine Acute Hospitals NHS Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

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Independent Auditor's report

Independent Auditor's report to the Directors of Pennine Acute Hospitals NHS Trust

Report on the Audit of the financial statements

Opinion

We have audited the financial statements of Pennine Acute Hospitals NHS Trust (the 'Trust') for the year ended 31 March 2019, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018/19.

In our opinion the financial statements:

- Give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended; *and*
- Have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018/19; *and*
- Have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Material uncertainty related to going concern

We draw attention to note 1.1 in the financial statements, which indicates that the Trust incurred a deficit of £65.4 million during the year ended 31 March 2019 and had a cumulative financial performance deficit of £111.4 million at this date. Since January 2018, the Trust has received £102.9 million of revenue support loans from the Department of Health and Social Care (DHSC) to support the payment of staff and suppliers. In January 2018 the Trust Board authorised an open-ended resolution to apply for revenue support loans as and when necessary in view of the fragile financial position of the Trust. The Trust anticipates that further revenue support loans will be required during 2019/20. As stated in note 1.1, DHSC has not, at the date of our report, confirmed this support.

As stated in note 1.1, in the Summer of 2017, NHS Improvement undertook the necessary work to determine the most appropriate long-term solution for Pennine Acute Hospitals NHS Trust. This work was completed taking into account the views of the Trust's commissioners. NHS Improvement determined that the preferred long-term solution for the Pennine Acute Hospitals NHS Trust is for the North Manchester part of the Trust to be acquired by Manchester University NHS Foundation Trust and for the remainder of the Trust to be acquired by Salford Royal NHS Foundation Trust. All affected organisations are in the process of developing the cases for this organisational change for submission to NHS Improvement.

These events or conditions, along with the other matters as set forth in note 1.1, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information

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

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

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- The parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018/19 and the requirements of the National Health Service Act 2006; *and*
- Based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

- We issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; *or*
- We refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; *or*
- We make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except that on 14 May 2018 we referred a matter to the Secretary of State under section 30(b) of the Local Audit and Accountability Act 2014 in relation to Pennine Acute Hospitals NHS Trust's breach of its break even duty for the three-year period ending 31 March 2018 ongoing breach for 2018/19.

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

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, except for the effects of the matters described in the basis for qualified conclusion section of our report, we are satisfied that, in all significant respects, Pennine Acute Hospitals NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Basis for qualified conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

- The Trust incurred a deficit of £128.2 million in 2018/19, which reduces to £65.4 million after impairments are deducted. This adjusted deficit figure is more than double that incurred in the prior year. The Trust was not eligible for Provider Sustainability Funding which contributed to the increase in the deficit;
- The Trust received £74.7 million of revenue support loans from the Department of Health and Social Care (DHSC) in 2018/19 to help it pay staff and suppliers. The Trust has set a deficit budget of £24.5 million for 2019/20 and will require further revenue support loans from DHSC during this period.

These matters identify weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures. They are evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

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

We are required under Section 21(1)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied.

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

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of Pennine Acute Hospitals NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Mark Heap
Key Audit Partner
for and on behalf of Grant Thornton UK LLP,
Local Auditor

4 Hardman Square
Spinningfields
Manchester
M3 3EB

Date: *24 May 2019*

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Annual accounts

Foreword to the accounts

The Pennine Acute Hospitals NHS Trust

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 2018/19 issued by the Department of Health and Social Care.

Raj Jain
Chief Executive
Date: 24 May 2019

Statement of comprehensive income for the year ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Income from patient care activities	5	608,751	597,515
Other operating income	6	51,707	64,413
Total income		**660,458**	**661,928**
Staff Costs	8	(465,291)	(440,185)
Other Costs		(315,538)	(242,947)
Operating expenses		**(780,829)**	**(683,132)**
Operating surplus/(deficit)		**(120,371)**	**(21,204)**
Finance costs:			
Investment income	12	240	84
Other gains and (losses)	13	(382)	(28)
Finance costs	14	(2,988)	(2,034)
Surplus/(deficit) for the financial year		**(123,501)**	**(23,182)**
Public dividend capital dividends payable		(4,747)	(8,115)
Retained surplus/(deficit) for the year		**(128,248)**	**(31,297)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments and reversals taken to the revaluation reserve		(73,663)	0
Net gains on revaluations taken to the revaluation reserve		0	35,459
Total comprehensive income for the year		**(201,911)**	**4,162**

The notes on pages 203 to 234 form part of these accounts.

Reported NHS financial performance position

	Note	2018/19 £000	2017/18 £000
Retained surplus/(deficit) for the year		(128,248)	(31,297)
Impairments		62,617	700
Donated Assets adjustment (difference between value of assets received and depreciation)		276	182
Reported NHS financial performance position - surplus/(deficit)		**(65,355)**	**(30,415)**

* Note: In 2018/19, Trust other operating income includes £0.9m Provider Sustainability Fund (PRF) income (2017/18 Sustainability & Transformation Fund - STF income £13.7m). Without this income, the Trust would have incurred a £66.3m deficit (2017/18 £44.1m deficit).

A Trust's Reported NHS financial performance position is derived from its Retained surplus/(Deficit), but adjusted for the following that are not part of the Trust's financial performance:

- Impairments to Property, plant and equipment.
- The net effect of donated assets. The value of donated assets received in the year is credited to other operating income. Depreciation on donated assets is charged to operating expenses. Where the value of donated assets received in any year is different from the ongoing cost of depreciation (either more or less) it results in an adjustment for financial performance purposes.

Statement of financial position as at 31 March 2019

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Property, plant and equipment	**15**	261,635	385,010
Intangible assets	**15**	5,737	6,542
Trade and other receivables	**19**	3,823	3,849
Total non-current assets		**271,195**	**395,401**
Current assets			
Inventories	**18**	6,093	7,211
Trade and other receivables	**19**	58,894	47,698
Cash and cash equivalents	**20**	3,059	11,391
Total current assets		**68,046**	**66,300**
Total assets		**339,241**	**461,701**
Current liabilities			
Trade and other payables/other liabilities	**21**	(77,837)	(75,684)
Borrowings	**22**	(3,956)	(3,234)
Provisions	**25**	(6,237)	(2,456)
Total current liabilities		**(88,030)**	**(81,374)**
Net current assets/(liabilities)		**(19,984)**	**(15,074)**
Total assets less current liabilities		**251,211**	**380,327**
Non-current liabilities			
Borrowings	**22**	(151,658)	(79,712)
Provisions	**25**	(8,636)	(9,549)
Total assets employed		**90,917**	**291,066**
Financed by taxpayers' equity:			
Public dividend capital		213,045	211,283
Retained earnings		(191,105)	(65,357)
Revaluation reserve		68,977	145,140
Total taxpayers' equity		**90,917**	**291,066**

Raj Jain
Chief Executive
Date: 24 May 2019

Statement of changes in taxpayers' equity for the year ended 31 March 2019

	Public dividend capital (PDC) £000	I&E Reserve £000	Reval'n reserve £000	Total £000
Balance at 31 March 2017	**210,357**	**(38,112)**	**113,733**	**285,978**
Changes in taxpayers' equity for 2017/18				
Retained surplus/(deficit) for the year	-	(31,297)	-	(31,297)
Public Dividend Capital received	926	-	-	926
Public Dividend Capital repaid	0	-	-	0
Transfers between reserves	-	4,052	(4,052)	0
Upward revaluation of land	-	-	0	0
Upward revaluation of buildings/dwellings	-	-	35,459	35,459
Balance at 31 March 2018	**211,283**	**(65,357)**	**145,140**	**291,066**
Changes in taxpayers' equity for 2018/19				
Retained surplus/(deficit) for the year	-	(128,248)	-	(128,248)
Public Dividend Capital received	1,762	-	-	1,762
Public Dividend Capital repaid	0	-	-	0
Transfers between reserves	-	2,500	(2,500)	0
Downward revaluation of land	-	-	(18,612)	(18,612)
Downward revaluation of buildings/dwellings	-	-	(55,051)	(55,051)
Balance at 31 March 2019	**213,045**	**(191,105)**	**68,977**	**90,917**

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Income & Expenditure (I&E) reserve

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

Statement of cash flow for the year ended 31 March 2019

	Note	2018/19 £000	2017/2018 £000
Cash flows from operating activities			
Operating surplus/(deficit)		(120,371)	(21,204)
Depreciation and amortisation (non cash)		23,025	22,557
Impairments and reversals (non cash)		62,617	700
Donated Assets received credited to income (non cash)		(36)	(119)
(Increase)/decrease in inventories		1,118	(437)
(Increase)/decrease in trade and other receivables		(9,234)	(2,210)
Increase/(decrease) in trade and other payables/other liabilities		1,919	(3,062)
Provisions utilised		(595)	(933)
Increase/(decrease) in non cash provisions		3,453	(1,610)
Net cash inflow/(outflow) from operating activities	**a**	**(38,104)**	**(6,318)**
Cash flows from investing activities			
Interest received		240	84
(Payments) for property, plant, equipment and intangibles		(34,695)	(16,993)
Proceeds from disposal of plant, property and equipment		71	163
Net cash inflow/(outflow) from operating activities	**b**	**(34,384)**	**(16,746)**
Net cash inflow/(outflow) before financing	**a+b**	**(72,488)**	**(23,064)**
Cash flows from financing activities			
Public dividend capital received		1,762	926
Public dividend capital repaid		0	0
Capital Investment Loans received (non DHSC) SALIX		500	0
Capital Investment Loans repayments to the DHSC		(3,234)	(3,249)
Revenue Support Loans received from DHSC		74,680	28,234
Interest paid		(2,385)	(1,961)
Dividends paid		(7,167)	(7,883)
Net cash inflow/(outflow) from financing	**c**	**64,156**	**16,067**
Net increase/(decrease) in cash and cash equivalents	**a+b+c**	**(8,332)**	**(6,997)**
Cash/cash equivalents at the start of the financial year		**11,391**	**18,388**
Cash/cash equivalents at the end of the financial year	**20**	**3,059**	**11,391**

Notes to the accounts

1 Accounting policies

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

1.1 Accounting convention, going concern

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

The accounts have been prepared on a going concern basis for accounting purposes in line with Department of Health & Social Care (DHSC) guidance. In the Summer of 2017, NHS Improvement undertook the necessary work to determine the most appropriate long term solution for Pennine Acute. This work was completed taking into account the views of Pennine Acute's commissioners.

NHS Improvement determined that the preferred long term solution for Pennine Acute is for the North Manchester part of the Trust to be acquired by Manchester University NHS Foundation Trust and for the remainder of the Trust to be acquired by Salford Royal NHS Foundation Trust. All organisations are in the process of developing the cases for this organisational change for submission to NHS Improvement.

The Trust incurred a £65.4m deficit (NHS financial performance) in 2018/19 with a cumulative financial performance deficit of £111.4m since 2002 (see note 29.1). Since January 2018, the Trust has received £102.9m of revenue support loans from DHSC to support the payment of staff and suppliers. In January 2018, the Trust Board authorised an open ended resolution to apply for revenue support loans as and when necessary in view of the fragile financial position of the Trust. Further revenue support loans will be necessary in 2019/20 as a result of a planned deficit of £24.5m (control total agreed with DHSC). These events and conditions indicate that a material uncertainty exists that may cast significant doubt over the Trust's ability to continue as a going concern. To date however, the Trust Board has not been refused revenue support funding and is confident that DHSC (as the ultimate body responsible for NHS Trusts) will continue to support the Trust until such time as a long term solution is put into effect.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Charitable Funds

Following Treasury's agreement to apply IAS 27 Consolidated and Separate Financial Statements to NHS Charities from 1 April 2013 (superseded by IFRS 10), the Trust has established that as the Trust is the corporate trustee of the linked NHS Charity, The Pennine Acute Hospitals and Other Related Charities *(Registration number 1050197)*, it effectively has the power to exercise control so as to obtain economic benefits. However, the transactions are immaterial in the context to the group and transactions have not been consolidated. Details of the transactions with the charity are included in the related parties note.

A separate annual report and accounts is prepared as required by the Charity Commission. This is published on the Charity Commission website and Trust website.

1.4 Critical accounting judgements and key sources of estimation uncertainty

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

Management has applied accounting policies as outlined in note 1.0 according to the Group Accounting Manual and has not made any critical judgements about the application of accounting policies that could have a significant effect on the amounts recognised in the financial statements.

There are no key assumptions, other than asset values and lives, concerning the future or key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

As at 31 December 2018, the Valuation Office Agency provided a valuation of the Trust's land and building assets (estimated financial value and estimated remaining useful life) applying a modern equivalent asset (MEA) method of valuation. The methodology employed to provide the valuation for 2018/19 has been on an optimised site basis with an alternative site where considered appropriate ie a valuation based on a modern equivalent asset and optimised site (suitable alternative site or otherwise) built to accommodate existing services. This valuation, based on estimates provided by a qualified professional, resulted in a decrease in the reported value of the Trust's land and building asset values. As a result, the carrying value of the Trust's land assets decreased by £27.9m and building assets decreased by £108.4m.

Other less significant areas of judgement and estimation techniques (e.g. depreciation) have been disclosed in the Trust's accounting policies and in the notes to the financial statements, as required by IFRS.

1.5 Revenue

1.5.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3(b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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

Revenue from NHS contracts

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

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges, effects of penalties, readmissions and CQUIN from commissioners are expected to be upheld, the Trust either reflects this in the transaction price and derecognises the relevant portion of income or provides for the possibility of a reduction in revenue.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.5.2 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.

1.5.3 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.6 Employee benefits

1.6.1 Short-term employee benefits

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

1.6.2 Retirement benefit costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme. Employer's pension cost contributions are charged to operating expenses as and when they become due.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

Local Government Pension Scheme

A small number of employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. These employees transferred to the Trust as part of service changes in September 2015. The Trust joined the Greater Manchester Local Government Pension Scheme for administrative purposes with the former employer (Rochdale MBC as sponsor). As such, the scheme is a "closed" scheme ie there are no new entrants and the Trust follows the lead of Rochdale MBC (sponsor). Pension contributions are charged to expenditure and no account is taken of the assets or liabilities of the scheme, this is the responsibility of Rochdale MBC as sponsor. The amounts involved are insignificant.

1.7 Expenditure on other goods and services

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

1.8 Property, plant and equipment

1.8.1 Recognition

Property, plant and equipment is capitalised if:

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

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

1.8.2 Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values are determined as follows:

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

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Until 31 March 2008, the depreciated replacement cost of specialised buildings was estimated for an exact replacement of the asset in its present location. After that date HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

As at 31 December 2018, a valuation of the Trust's land and building assets (estimated financial value and estimated remaining useful life) was undertaken applying a modern equivalent asset (MEA) method of valuation. The valuation was undertaken by S Hall, MRICS, a RICS registered valuer and senior surveyor with the DVS Property Services arm of the Valuation Office Agency. The methodology employed to provide the valuation for 2018/19 has been on an optimised site basis with an alternative site where considered appropriate ie a valuation based on a modern equivalent asset and optimised site (suitable alternative site or otherwise) built to accommodate existing services. This valuation, based on estimates provided by a qualified professional, resulted in a decrease in the reported value of the Trust's land and building asset values. As a result, the carrying value of the Trust's land assets decreased by £27.9m and building assets decreased by £108.4m.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Plant and machinery, fixtures and other equipment is written off over their remaining useful lives or carried at their depreciated historic cost as this is not considered to be materially different from current value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

1.8.3 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 Intangible assets

1.9.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use
- The intention to complete the intangible asset and use it
- The ability to sell or use the intangible asset
- How the intangible asset will generate probable future economic benefits or service potential
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.9.2 Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.10 Depreciation, amortisation and impairments

Freehold land and properties under construction are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure.

Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments (eg the Department of Health and Social Care) may not exceed the limits that they have been set. AME budgets are set by Treasury and may be reviewed with departments in the run up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.11 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is only recognised where conditions attached to the donation preclude immediate recognition of the gain.

1.12 Government grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is only recognised where conditions attached to the grant preclude immediate recognition of the gain.

1.13 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.14 Leases

Leases are classified and accounted for as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee and the value of the asset is greater than £50,000. All other leases are classified as operating leases.

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value, or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight line basis over the lease term.

1.15 Inventories

Inventories are valued at the lower of cost and net realisable value using either the first-in first-out (manually recorded inventories) or weighted average (computerised inventories) cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of inventories.

Manually recorded inventories are counted once a year. Computerised inventories are the subject of rolling counts during the year. Certain inventories on wards and departments (including sterile supplies) are covered by a materials management topping up system. The level of materials management inventories held by wards and departments are estimated using a formula. Likewise, the value of ward/department drug inventories are estimated using a formula. Other ward and department inventories with a value less than £10,500 (per ward/department) are not included in the inventories balance.

1.16 Cash and cash equivalents

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

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

1.17 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.18 Clinical negligence costs

NHS Resolution (formerly NHS Litigation Authority - NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 25.

1.19 Non-clinical risk pooling

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

1.20 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.21 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Other than trade receivables and other receivables (relating to the injury cost recovery scheme) the Trust does not have any other financial assets.

1.21.1 Impairments

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

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

1.22 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Other than payables, borrowings and provisions the Trust does not have any other financial liabilities.

1.23 Value Added Tax

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

1.24 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise. The Trust has very few foreign currency transactions.

1.25 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in note 31 to the accounts.

1.26 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in NHS Trusts. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, Trusts. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

An annual charge, reflecting the cost of capital utilised by trusts, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (3.5%) on the average carrying amount of all assets less liabilities, except for donated assets, cash balances with the Government Banking Service (GBS) and any PDC dividend balance receivable or payable. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

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

1.27 Losses and special payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, excluding provisions for future losses and including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.28 Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust's or where the subsidiary's accounting date is before 1 January or after 30 June.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

2 Accounting Standards

IFRS 9 and IFRS 15 have been adopted in line with the Government Accounting Manual (GAM).

2.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018. IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost.

2.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

2.3 Accounting Standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018/19. These standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019/20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- 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 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

3 Operating segments

All of the Trust's activities are in the provision of healthcare, which is an aggregate of all the individual specialty components included therein, and the large majority of the Trust's income originates with the UK Government. The majority of expenses incurred are payroll expenditure on staff involved in the delivery or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish the delivery of healthcare. The activities which earn income and incur expenses are, therefore, of one broad combined nature and, therefore, on this basis one segment of 'healthcare' is deemed appropriate.

The operating results of the Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker which is the overall Trust Board and which includes senior professional non-executive directors. The Trust Board review the financial position of the Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a single operating segment under IFRS8.

The finance report considered monthly by the Trust Board contains summary figures for the whole Trust together with divisional budgets and their cost improvement positions. The statement of financial positions (balance sheet), statement of comprehensive income (I&E), cash flow statement and cash flow forecasts are considered for the whole Trust in total only. The Board as chief operating decision maker, therefore, only considers one segment of healthcare in its decision making process.

The single segment of 'healthcare' has been identified as consistent with the core principles of IFRS8 which is to enable users of financial statements to evaluate the nature and financial effects of business activities and economic environments.

4 Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material.

	2018/19 £000	2017/18 £000
Car Parking Charges		
Income	**3,313**	2,915
Full cost	**2,913**	2,701
Surplus/(deficit)	**400**	214
Catering		
Income	**2,904**	2,735
Full cost	**2,466**	2,356
Surplus/(deficit)	**438**	379
DWP Assessments		
Income	**773**	1,985
Full cost	**1,230**	2,288
Surplus/(deficit)	**(457)**	(303)
Laundry		
Income	**1,646**	1,468
Full cost	**1,597**	1,424
Surplus/(deficit)	**49**	44

Income of £8,636k has been included in note 6 'other operating income' and full cost of £8,206k has been included in note 8.1 within the relevant expense headings.

5 Income from patient care activities

5.1 Income from patient care activities (by nature)

	2018/19 £000	2017/18 £000
Acute services		
Elective income	**81,787**	77,421
Non-elective income	**207,045**	195,502
First outpatient income	**38,640**	36,189
Follow up outpatient income	**30,076**	28,959
A&E income	**37,576**	34,970
High cost drugs income from commissioners (excluding pass-through costs)	**37,365**	33,646
Other NHS clinical income	**124,944**	127,031
Acute services total	**557,433**	533,718
Community services		
Income from CCGs and NHS England	**30,935**	35,422
Income from other sources (e.g. local authorities)	**5,711**	5,705
Community services total	**36,646**	41,127
Other services		
AFC pay award central funding from DHSC	**6,279**	0
Private patient income	**12**	44
Other clinical income	**8,381**	22,626
Total income from patient care activities	**608,751**	597,515

5.2 Income from patient care activities (by source)

	2018/19 £000	2017/18 £000
NHS England	**83,818**	96,098
Clinical Commissioning Groups (CCGs)	**503,006**	489,394
Foundation Trusts	**4,737**	618
Local authorities	**5,868**	6,114
Department of Health & Social Care (DHSC)	**6,530**	211
Sub Total - Main Commissioners	**603,959**	592,435
Non NHS :		
Private patients	**12**	44
Overseas patients (non-reciprocal)	**1,360**	971
Injury costs recovery	**3,222**	3,060
Other	**198**	1,005
	608,751	597,515

Injury cost recovery income is subject to a provision for impairment of receivables of 4% to reflect expected rates of collection based on information relevant to the Trust.

6 Other operating income

	2018/19 £000	2017/18 £000
Education, training and research	**18,728**	18,482
Donated assets included in property, plant and equipment (SOFP)	**36**	119
Non-patient care services to other bodies	**11,357**	12,277
Provider Sustainability/Sustainability Transformation Fund income	**911**	15,720
Income generation (see note 4)	**8,636**	9,748
Other income	**12,039**	8,067
Acute services total	**51,707**	64,413

6.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2018/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	**5,619**
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	**0**

7 Overseas visitors (relating to patients charged directly by the Trust)

	2018/19 £000	2017/18 £000
Income recognised this year	**1,396**	971
Cash payments received in-year	**84**	62
Amounts added to provision for impairment of receivables	**779**	618
Amounts written off in-year	**26**	0

8 Operating expenses

8.1 Operating expenses

	2018/19 £000	2017/18 £000
Services from NHS and DHSC bodies	**11,221**	10,181
Services from non-NHS and non-DHSC bodies	**24,701**	7,721
Staff and executive directors costs	**465,291**	440,185
Remuneration of non-executive directors	**59**	63
Supplies and services - clinical (excluding drugs costs)	**47,733**	48,463
Supplies and services - general	**13,731**	16,634
Drug costs (drugs inventory consumed/ purchase of non-inventory drugs)	**48,761**	55,868
Inventories write down	**113**	47
Consultancy services	**2,166**	236
Establishment	**9,234**	9,763
Premises	**20,861**	20,411
Business Rates	**3,697**	3,831
Transport	**1,390**	1,267
Depreciation	**20,830**	19,727
Amortisation	**2,195**	2,830
Net impairments of property, plant and equipment	**62,617**	700
Increase/(decrease) in provision for impairment of receivables	**823**	556
Change in provisions discount rate(s)	**(157)**	84
Audit fees payable to the external auditor:		
audit services- statutory audit	**90**	90
other auditor remuneration (external auditor only - quality accounts)	**8**	8
Internal Audit fees	**132**	134
Clinical negligence premium	**25,851**	28,961
Legal Fees	**1,236**	896
Insurance	**648**	696
Education and Training	**1,017**	1,164
Security Services	**2,000**	1,911
Interpretation Services	**359**	380
Clinical waste	**462**	473
Professional Fees (other external contracts)	**4,528**	3,517
Other	**9,232**	6,335
Total operating expenses	**780,829**	683,132

8.2 Limitation on auditors liability

There is £2m limitation on auditor's liability for external audit work carried out for 2018/19 (£2m 2017/18).

8.3 Research and Development (R&D)

Note 8.1 above includes R&D costs of £856k spread across various expenditure lines (2017/18 £307k).

9 Operating leases

9.1 As lessee

	2018/19 £000	2017/18 £000
Payments recognised as an expense		
Minimum lease payments	**2,290**	2,252
Total future minimum lease payments		
Payable:		
Not later than one year	**1,809**	1,988
Between one and five years	**1,694**	3,738
After 5 years	**-**	0
Total	**3,503**	5,726

9.2 As lessor

The Trust does not have any significant operating leases as lessor.

10 Employee benefits

	2018/19 £000	2017/18 £000
Salaries and wages	**315,786**	296,743
Social Security Costs	**30,120**	30,856
Apprenticeship levy	**1,584**	1,570
Employer contributions to NHS Pension scheme/other	**38,127**	37,971
Termination benefits	**269**	268
Temporary staff (external bank, agency, contract)	**79,758**	73,195
Acute staff costs	**465,644**	440,603
Of the total above:		
Charged to capital	**353**	418
Employee benefits charged to revenue	**465,291**	440,185
	465,644	440,603

10.1 Ill health retirements

	2018/19 £000	2017/18 £000
No. of persons retired on ill health grounds	**1**	5
Total additional pension liabilities accrued in year £000s	**12**	464

10.2 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at *www.nhsbsa.nhs.uk/pensions*. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

11 Better Payment Practice Code

11.1 Better Payment Practice Code - measure of compliance

	2018/19		2017/18	
	Number	**£000**	Number	£000
Total Non-NHS trade invoices paid in the year	**121,866**	**425,350**	122,195	403,763
Total Non NHS trade invoices paid within target	**111,470**	**380,620**	108,717	376,024
Percentage of Non-NHS trade invoices paid within target	**91%**	**89%**	89%	93%
Total NHS trade invoices paid in the year	**4,021**	**40,066**	3,823	27,418
Total NHS trade invoices paid within target	**3,472**	**35,889**	3,374	24,586
Percentage of NHS trade invoices paid within target	**86%**	**90%**	88%	90%

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

In addition to the Better Payment Practice Policy, the Trust signed up to the Prompt Payment Code (PPC) in March 2010.

The Prompt Payment Code is a payment initiative developed in 2009 by Government with The Institute of Credit Management (ICM) to "tackle the crucial issue of late payment and help small businesses." Details of the code can be found at *www.promptpaymentcode.org.uk.*

11.2 The Late Payment of Commercial Debts (Interest) Act 1998 / Public Contract Regulations 2015

	2018/19 £000	2017/18 £000
Late payment charges	**0**	32

12 Investment income

	2018/19 £000	2017/18 £000
Interest income:		
Bank accounts	**240**	84

13 Other gains and losses

	2018/19 £000	2017/18 £000
Gain/(loss) on disposal of property, plant and equipment	**(382)**	(28)

14 Finance costs

	2018/19 £000	2017/18 £000
Interest on capital investment loans	**1,810**	1,929
Interest on revenue support loans	**1,168**	48
Interest on late payment of commercial debt	**0**	32
Unwinding of discount factor (provisions)	**10**	25
Total	**2,988**	2,034

15a Property, plant and equipment (PPE)/Intangibles

2018/19

	Land	Buildings excluding dwellings	Dwellings	AUC and POA*	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total PPE	Intangibles Computer Software - purchased
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2018	46,072	323,940	684	1,128	100,299	214	20,147	3,754	496,238	23,212
Additions purchased	-	6,240	-	6,385	11,102	11	10,327	87	34,152	1,390
Additions donated	-	-	-	-	36	-	-	-	36	-
Reclassifications	-	504	-	(504)	-	-	-	-	0	-
Disposals	-	(405)	-	-	(5,685)	(37)	-	-	(6,127)	-
Revaluation/indexation	(18,612)	(54,949)	(102)	-	-	-	-	-	(73,663)	-
Impairments	-	-	-	-	-	-	-	-	0	-
At 31 March 2019	**27,460**	**275,330**	**582**	**7,009**	**105,752**	**188**	**30,474**	**3,841**	**450,636**	**24,602**
Depreciation** at 1 April 2018	0	24,970	38	-	69,707	163	14,011	2,339	111,228	16,670
Disposals	-	(161)	-	-	(5,476)	(37)	-	-	(5,674)	-
Revaluation/indexation	-	-	-	-	-	-	-	-	0	-
Impairments	9,305	53,312	-	-	-	-	-	-	62,617	-
Charged during the year	-	11,886	17	-	6,804	24	1,775	324	20,830	2,195
Depreciation at 31 March 2019	**9,305**	**90,007**	**55**	**-**	**71,035**	**150**	**15,786**	**2,663**	**189,001**	**18,865**
Net book value										
Purchased	16,905	183,819	527	7,009	34,108	34	14,655	1,177	258,234	5,737
Donated	1,250	1,504	-	-	609	4	33	1	3,401	-
Total at 31 March 2019	**18,155**	**185,323**	**527**	**7,009**	**34,717**	**38**	**14,688**	**1,178**	**261,635**	**5,737**
Asset financing										
Owned	18,155	185,323	527	7,009	34,717	38	14,688	1,178	261,635	5,737
Finance leased	-	-	-	-	-	-	-	-	0	0
Private finance initiative	-	-	-	-	-	-	-	-	0	0
Total 31 March 2019	**18,155**	**185,323**	**527**	**7,009**	**34,717**	**38**	**14,688**	**1,178**	**261,635**	**5,737**

15a.1 Revaluation reserve balance for property, plant & equipment

	Land	Buildings excluding dwellings	Dwellings	AUC and POA*	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total PPE
	£000	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2018	24,186	117,557	447	N/A	2,852	9	0	89	145,140
Movements	(18,656)	(57,086)	(126)	N/A	(285)	(1)	-	(9)	(76,163)
At 31 March 2019	**5,330**	**60,471**	**321**	**N/A**	**2,567**	**8**	**0**	**80**	**68,977**

*AUC - assets under construction, POA - payments on account. **Amortisation for intangible assets.

The net book value of PPE disposals during the year was **£453k (Cost £6,127k less depreciation £5,674k).**

15b Property, plant and equipment (PPE)/Intangibles

2017/18

	Land	Buildings excluding dwellings	Dwellings	AUC and POA*	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total PPE	Intangibles Computer Software - purchased
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	46,092	278,428	640	2,903	95,752	260	17,493	3,559	445,127	22,253
Additions purchased	-	7,286	-	1,128	7,690	-	2,654	195	18,953	959
Additions donated	-	-	-	-	119	-	-	-	119	-
Reclassifications	-	2,903	-	(2,903)	-	-	-	-	0	-
Disposals	(20)	-	(92)	-	(3,262)	(46)	-	-	(3,420)	-
Revaluation/indexation	-	35,323	136	-	-	-	-	-	35,459	-
Impairments	-	-	-	-	-	-	-	-	0	-
At 31 March 2018	**46,072**	**323,940**	**684**	**1,128**	**100,299**	**214**	**20,147**	**3,754**	**496,238**	**23,212**
Depreciation** at 1 April 2017	-	13,583	29	-	65,993	176	12,254	1,996	94,031	13,840
Disposals	-	-	(6)	-	(3,178)	(46)	-	-	(3,230)	-
Revaluation/indexation	-	-	-	-	-	-	-	-	0	-
Impairments	-	700	-	-	-	-	-	-	700	-
Charged during the year	-	10,687	15	-	6,892	33	1,757	343	19,727	2,830
Depreciation at 31 March 2018	**0**	**24,970**	**38**	**-**	**69,707**	**163**	**14,011**	**2,339**	**111,228**	**16,670**
Net book value										
Purchased	44,822	297,297	646	1,128	29,797	43	6,099	1,414	381,246	6,542
Donated	1,250	1,673	-	-	795	8	37	1	3,764	-
Government granted	-	-	-	-	-	-	-	-	0	0
Total at 31 March 2018	**46,072**	**298,970**	**646**	**1,128**	**30,592**	**51**	**6,136**	**1,415**	**385,010**	**6,542**
Asset financing										
Owned	46,072	298,970	646	1,128	30,592	51	6,136	1,415	385,010	6,542
Finance leased	-	-	-	-	-	-	-	-	0	0
Private finance initiative	-	-	-	-	-	-	-	-	0	0
Total 31 March 2018	**46,072**	**298,970**	**646**	**1,128**	**30,592**	**51**	**6,136**	**1,415**	**385,010**	**6,542**

15b.1 Revaluation reserve balance for property, plant & equipment

	Land	Buildings excluding dwellings	Dwellings	AUC and POA*	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total PPE
	£000	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2018	24,186	85,967	386	N/A	3,092	10	0	92	113,733
Movements	-	31,590	61	N/A	(240)	(1)	-	(3)	31,407
At 31 March 2019	**24,186**	**117,557**	**447**	**N/A**	**2,852**	**9**	**0**	**89**	**145,140**

*AUC - assets under construction, POA - payments on account. **Amortisation for intangible assets.

The net book value of PPE disposals during the year was **£190k (Cost £3,420k less depreciation £3,230k).**

15.1 Property, plant and equipment (PPE)/ Intangibles *continued*

Donated Assets

During the year the Trust received medical equipment from the charity with a total value of £36k

Asset Revaluations

As at 31 December 2018, the Valuation Office Agency provided a valuation of the Trust's land and building assets (estimated financial value and estimated remaining useful life) applying a modern equivalent asset (MEA) method of valuation. The methodology employed to provide the valuation for 2018/19 has been on an optimised site basis with an alternative site where considered appropriate ie a valuation based on a modern equivalent asset and optimised site (suitable alternative site or otherwise) built to accommodate existng services. This valuation, based on estimates provided by a qualified professional, resulted in a decrease in the reported value of the Trust's land and building asset values. As a result, the carrying value of the Trust's land assets decreased by £27.9m and building assets decreased by £108.4m.

Asset Lives

There have been minor changes during the year in the lives applied to the Trust assets.

	Minimum	Maximum
Buildings excluding dwellings	**5**	33
Dwellings	**25**	44
Plant & machinery	**5**	10
Transport equipment	**2**	13
Information technology	**3**	5
Furniture and fittings	**5**	10

There has been no compensation from third parties for assets impaired included in the Trust's surplus.

The Trust has no temporary idle assets.

The gross carrying amount of fully depreciated assets (plant & machinery) still in use is £64.9m (2017/18 £61.7m).

15.2 Intangible assets

There have been no revaluations to intangible assets during the year and there are no revaluation balances held for intangibles.

For all purchased software the Trust applies a finite life of between 3 and 5 years.

The Trust still has fully amortised purchased software in use with a replacement cost of £13m (2017/18 - £11.4m).

16 Impairments

As part of the District Valuer's revaluation of land and buildings using an optimised site (alternative or otherwise) MEA model, an impairment of £62.6m has been charged to operating expenses. Such impairments are managed overall by the Department of Health & Social Care on an annual basis as part of Annually Managed Expenditure totals (AME).

17 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	**6,775**	1,085
Intangible Assets	**-**	-

18. Inventories

18.1 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	1,770	1,941
Consumables	4,082	5,035
Energy	241	235
Total	**6,093**	7,211

18.2 Inventories recognised in expenses

	31 March 2019 £000	31 March 2018 £000
Inventories recognised as an expense in the period	36,678	38,226
Write-down of inventories (including losses)	113	47

19 Trade and other receivables

19.1 Trade and other receivables

	Current 31 March 2019 £000	Non-current 31 March 2019 £000	Current 31 March 2018 £000	Non-current 31 March 2018 £000
Contract Receivables (IFRS 15): invoiced	46,671	-	-	-
Contract Receivables (IFRS 15): not invoiced	4,569	5,503	-	-
Trade receivables (comparative only)	-	-	27,577	5,401
Accrued income & prepayments	5,474	-	15,373	-
Provision for the impairment of receivables	(2,671)	(1,680)	(2,033)	(1,552)
VAT	2,915	-	2,173	-
PDC receivable	1,936	-	-	-
Other receivables	0	0	4,608	-
Total	58,894	3,823	47,698	3,849
Of which receivables from NHS and DHSC group:	40,072		28,572	

The vast majority of trade is with Clinical Commissioning Groups (CCGs) and NHS England (Specialised Commissioning), as commissioners for NHS patient care services. As CCGs and NHS England are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

19.3 Allowance for credit losses of contract receivables

	31 March 2019 £000	31 March 2018 £000
Balance at 1 April	**(3,585)**	(3,141)
Amount written off during the year	**57**	112
Amount recovered during the year	**142**	62
(Increase)/decrease in receivables impaired	**(965)**	(618)
Balance at 31 March	**(4,351)**	(3,585)

The allowance mainly relates to overseas visitors and injury cost recovery receivables.

20 Cash and cash equivalents

	31 March 2019 £000	31 March 2018 £000
Balance at 1 April	**11,391**	18,388
Net change in year	**(8,332)**	(6,997)
Balance at 31 March	**3,059**	11,391
Made up of:		
Cash with Government Banking Services	**3,034**	11,366
Cash in hand	**25**	25
Cash/cash equivalents in statement of financial position	**3,059**	11,391
Cash/cash equivalents as in statement of cash flows	**3,059**	11,391

21 Trade and other payables

	Current	
	31 March 2019 £000	31 March 2018 £000
Trade payables	**16,343**	9,887
Capital payables	**7,958**	7,111
Accruals	**39,282**	44,367
Accrued interest on loans*	**N/A**	129
Social security costs	**4,015**	(280)
Income Tax (on behalf of employees)	**4,826**	375
NHS Pension contributions	**529**	7,153
PDC dividend payable	**0**	484
Other	**1,088**	839
Total	**74,041**	70,065
Of which payables to NHS and DHSC group:	**11,486**	12,460

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 22. IFRS 9 is applied without restatement therefore comparatives have not been restated.

21.1 Other Liabilities (deferred income)

	Current	
	31 March 2019 £000	31 March 2018 £000
Deferred income at 31 March	**3,796**	5,619

22 Borrowings

	Current 31 March 2019 £000	Current 31 March 2018 £000	Non-current 31 March 2019 £000	Non-current 31 March 2018 £000
Loans from:				
DHSC capital investment - principal	**3,234**	3,234	**48,244**	51,478
DHSC capital investment - interest accrual	**76**	N/A	**-**	-
SALIX capital investment loan - principal	**0**	0	**500**	-
DHSC revenue support loans - principal	**0**	0	**102,914**	28,234
DHSC revenue support loans - interest accrual	**646**	N/A	**-**	-
Total	**3,956**	3,234	**151,658**	79,712
Total current and non current	**155,614**	82,946		

In 2009/10, the Trust secured a loan of £42.050m over 25 years from the Department of Health & Social Care (DHSC) to support the Womens & Children development at North Manchester General Hospital and the additional capacity development (above Radiotherapy) at the Royal Oldham Hospital. This was drawn down in 2009/10 and 2010/11. In 2011/12 the Trust secured a loan of £36m to support Womens & Children development at the Royal Oldham Hospital. £18m of this loan was drawn down in 2011/12, £15m drawn in 2012/13 and £3m drawn in 2013/14.

In 2018/19 the first instalment of an interest free capital investment loan was received from SALIX (sponsored by UK Government) to support energy efficiency initiatives.

In 2017/18 the Trust's financial deficit meant that a series of revenue support loans were necessary from DHSC in the latter part of the year. Revenue support loans will be continue to be required while the Trust is in a deficit position.

Under IFRS 9, DHSC loans are now required to be measured at amortised cost rather than historic cost. The effective interest rate is the nominal rate applied to each loan by DHSC. In practical terms therefore the impact of this change is that DHSC interest accruals should now be included in the value of the loan rather than a separate accrual in payables. As IFRS 9 is not applied retrospectively, the prior year should not be restated.

Loans - repayment of principal falling due in:

	DHSC Capital £000	DHSC Revenue £000	SALIX Capital £000
0-1 years	3,234	0	0
1-2 years	3,234	28,234	500
3-5 years	9,702	74,680	0
> 5 years	35,308	0	0
Total	51,478	102,914	500

24 Finance lease obligations

The Trust does not have any material finance lease obligations as lessor or lessee..

The Trust granted the Christie NHS Foundation Trust a 40 year lease for the Oldham satellite centre for use of part of the building located on land owned by Pennine Acute Hospitals NHS Trust. This was paid for up front and in full in March 2010. The Christie include the value of their part of the building in their accounts. No value is included in the accounts of Pennine Acute Hospitals.

25 Provisions

	Current 31 March 2019 £000	Non-current 31 March 2019 £000	Current 31 March 2018 £000	Non-current 31 March 2018 £000
Pensions relating to other staff	**334**	**1,981**	246	2,411
Legal claims	**254**	**127**	122	244
Restructurings	**139**	**1,656**	112	1,765
Redundancy	**320**	**0**	320	0
Other	**5,190**	**4,872**	1,656	5,129
Total	**6,237**	**8,636**	2,456	9,549

	Pensions relating to other staff £000	Employers & Public Liability Legal Claims £000	Restructurings £000	Redundancy £000	Other £000	Total £000
At 1 April 2018	2,657	366	1,877	320	6,785	**12,005**
Arising during the year	80	228	56	-	4,412	**4,776**
Used during the year	(241)	(89)	(115)	-	(318)	**(763)**
Reversed unused	(157)	(124)	-	-	(717)	**(998)**
Change of discount rate	(26)	-	(25)	-	(106)	**(157)**
Unwinding of discount	2	-	2	-	6	**10**
At 31 March 2019	**2,315**	**381**	**1,795**	**320**	**10,062**	**14,873**
Expected timing of cash flows:						
Within one year	334	254	139	320	5,190	**6,237**
Between one and five years	789	127	555		1,177	**2,648**
After five years	1,192	0	1,101	0	3,695	**5,988**

Pensions relating to other staff refer to pre 1995 early retirements. The restructurings provision relates to the costs of restructuring associated with the creation of Pennine Acute Hospitals NHS Trust from the four predecessor Trusts in April 2002 (Bury, Rochdale, Oldham and North Manchester). Other provisions relate mainly to permanent injury benefits payable, contract issues and changes to pay.

£456m is included in the provisions of the NHS resolution (formerly NHS Litigation Authority NHSLA) in respect of clinical negligence liabilities of the Trust (31/03/18 £375m).

26 Contingencies

26.1 Contingent liabilities

	2018/19 £000	2017/18 £000
The Trust's liability to third parties (public and employers) under the scheme operated by NHS Resolution (formerly NHS Litigation Authority)	**241**	209

26.2 Contingent assets

The Trust does not have any contingent assets.

27 Events after the reporting period

There are no events after the reporting period to report.

28 Financial instruments

28.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with commissioners for example, Clinical Commissioning Groups and NHS England and the way those commissioners are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of directors. Trust treasury activity is subject to audit by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1-25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. In addition, the Trust currently borrows from government to support it's working capital position while it is experiencing an I&E deficit using the revenue loan facility. Interest on any revenue loans is currently charged at 1.5% for the duration of the loan (if the Trust has agreed it's plan control total - otherwise 3.5%). The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with NHS England and Clinical Commissioning Groups (CCGs), which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internal funds or within its prudential borrowing assessment via NHS Improvement. Revenue support loans are available from the Department of Health & Social Care whilst the Trust is in deficit. The Trust is not, therefore, exposed to significant liquidity risks.

28.2 Carrying values of financial assets

	Loans and receivables £000	Total book value £000
Assets as per SoFP as at 31 March 2019		
Trade and other receivables excluding non financial assets	52,392	52,392
Cash and cash equivalents at bank and in hand	3,059	3,059
Total at 31 March 2019	**55,451**	**55,451**
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non financial assets	34,864	34,864
Cash and cash equivalents at bank and in hand	11,391	11,391
Total at 31 March 2018	**46,255**	**46,255**

Items not included above are:

	2018/19 £000	2017/18 £000
Prepayments	**5,474**	7,461
Injury Cost Recovery (incl above from 2018/19 per Treasury direction)	**N/A**	7,049
VAT receivable	**2,915**	2,173
PDC dividend receivable	**1,936**	0
Total	**10,325**	16,683

28.3 Carrying value of financial liabilities

	Other financial liabilities £000	Total book value £000
Liabilities as per SoFP as at 31 March 2019		
Borrowings excluding finance lease and PFI liabilities	155,614	155,614
Trade and other payables excluding non financial liabilities	65,200	65,200
Provisions under contract	14,873	14,873
Total at 31 March 2019	**235,687**	**235,687**
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance lease and PFI liabilities	82,946	82,946
Trade and other payables excluding non financial liabilities	69,486	69,486
Provisions under contract	12,005	12,005
Total at 31 March 2018	**164,437**	**164,437**

Items not included above are:

	2018/19 £000	2017/18 £000
Deferred income	**3,796**	5,619
Social security and other taxes payable	**8,841**	95
PDC dividend payable	**0**	484
Total	**12,637**	6,198

28.4 Maturity of financial liablilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	**75,393**	75,176
In more than one year but not more than two years	**32,998**	36,133
In more than two years but not more than five years	**86,000**	11,133
In more than five years	**41,296**	41,995
Total	**235,687**	**164,437**

28.5 Fair values of financial assets at 31 March 2019

The fair value of all assets and liabilities is reported as being equal to their book value which the Trust considers to be materially the same as the fair value.

29 Financial performance targets

29.1 Breakeven Performance

	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
Turnover	567,664	582,684	591,544	643,739	661,928	658,238
Retained surplus/(deficit) for the year	(7,384)	(6,727)	(22,493)	(3,115)	(31,297)	(128,248)
Adjustments for Impairments	7,057	6,533	2,750	654	700	62,617
Adjustments for donated assets	380	208	(205)	49	182	276
Break-even in-year position	**53**	**14**	**(19,948)**	**(2,412)**	**(30,415)**	**(65,355)**
Break-even cumulative 2002/03 to 2012/13	6,694	-	-	-	-	-
Break-even cumulative position	**6,747**	**6,761**	**(13,187)**	**(15,599)**	**(46,014)**	**(111,369)**
Materiality test (i.e. is it equal to or less than 0.5%):	%	%	%	%	%	%
In-year position as a % of turnover	0.0	0.0	(3.4)	(0.4)	(4.6)	(9.9)
Cumulative as a % of turnover	1.2	1.2	(2.2)	(2.4)	(7.0)	(16.9)

The Trust achieved a small surplus in 2013/14, 2014/15 and deficit in 2015/16, 2016/17, 2017/18 and 2018/19.

29.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on 3.5% of the actual (rather than forecast) average relevant net assets and, therefore, the actual capital cost absorption rate is automatically 3.5%.

29.3 External financing

The Trust is given an external financing limit which it is not permitted to overshoot.

	2018/19 £000	2017/18 £000
External financing limit	**84,099**	33,025
Cash flow financing	**82,040**	32,908
Other capital receipts	**0**	0
External financing requirement	**82,040**	32,908
Undershoot/(overshoot)	**2,059**	117

29.4 Capital Resource Limit

The Trust is given a capital resource limit which it is not permitted to overshoot.

	2018/19 £000	2017/18 £000
Gross capital expenditure	**35,578**	20,031
Less: book value of assets disposed of	**(453)**	(190)
Less: donations towards the acquisition of non-current assets	**(36)**	(119)
Charge against the capital resource limit	**35,089**	19,722
Capital resource limit	**35,103**	21,073
(Over)/Undershoot against the capital resource limit	**14**	1,351

30 Related party transactions

The Pennine Acute Hospitals NHS Trust is a healthcare body created by Parliament in a Statutory Instrument in 2002. The ultimate parent body is the Department of Health & Social Care (DHSC) and UK Government.

During the year no Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with The Pennine Acute Hospitals NHS Trust.

The Pennine Acute Hospitals NHS Trust has had a significant number of material transactions with DHSC and other entities for which DHSC is regarded as the parent Department. These entities include:

- NHS England
- Health Education England
- NHS Resolution
- NHS Business Services Authority
- NHS Pensions Agency

Clinicial Commissioning Groups:

- NHS Heywood, Middleton and Rochdale CCG
- NHS Oldham CCG
- NHS Manchester CCG
- NHS Bury CCG
- NHS East Lancashire CCG
- NHS Salford CCG
- NHS Tameside and Glossop CCG

NHS Foundation Trusts:

- Salford Royal NHS Foundation Trust
- Manchester University NHS FT
- Greater Manchester Mental Health NHS FT
- Pennine Care NHS Foundation Trust

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with HMRC, Bury/Oldham/Rochdale MBCs and Manchester Council. Included within expenditure of the Trust is the cost of the management charge agreed between Salford and Pennine Acute as part of Salford's management oversight of Pennine Acute.

Pennine Acute Hospitals Charity

The Trust has also received donations from a number of charitable funds, which include the Pennine Acute Hospitals Charity. The Pennine Acute Trust Board is the corporate trustee of the charity. The financial information of the charity is not consolidated within the Trust's accounts (see accounting policies note 1.4). The majority of expenditure relates to the Pennine Acute Hospitals NHS Trust. A summary of the key unaudited financials of the Pennine Acute Hospitals Charity (registered number 1050197) is shown below:

	2018/19 £000	2017/18 £000
Statement of Financial Activities (SOFA)		
Total Income	**349**	237
Total Expenditure	**(525)**	(354)
Gains/(losses) on revaluation of investments	**100**	(88)
Net movement in funds	**(76)**	(205)
Statement of Financial Position (SOFP)		
Investments	**3,182**	3,104
Cash	**621**	542
Receivables	**45**	41
Payables	**(277)**	(54)
Net assets/liabilities	**3,571**	3,633

31 Third party assets

The Trust held £10k cash and cash equivalents at 31 March 2019 (£11k at 31 March 2018) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

32 Losses and special payments

The total number of losses in 2018/19 and their total value was as follows:

	Total value of cases £000	**Total number of cases £000**
Losses	195	174
Special payments	178	171
Total losses and special payments	**373**	**345**

The total number of losses in 2017/18 and their total value was as follows:

	Total value of cases £000	**Total number of cases £000**
Losses	180	194
Special payments	221	182
Total losses and special payments	**401**	**376**

Finance glossary

Accruals accounting

Accruals accounting recognises assets or liabilities when goods or services are provided or received - whether or not cash changes hands at the same time. Also known as 'the matching concept', this form of accounting ensures that income and expenditure is scored in the accounting period when the 'benefit' derived from services is received or when supplied goods are 'consumed', rather than when payment is made.

Agreement of balances AOB

Agreement of balances is the term used by the NHS and Government that covers the national checking of inter organisation (or "company") balances. This is necessary when consolidated accounts of all the organisations under a single organisations "control" are prepared. For example, the Government consolidates the accounts of all government departments and public sector organisations. Therefore, the relative debtor (receivable) and creditor (payable) balances as well as the respective income and expenditure amounts between organisations should be the same on both sides and effectively cancel each other out at a national (consolidated) level.

Amortisation

The process of charging the cost of an asset over its useful life as opposed to recording its cost as a single entry in the income and expenditure account. Usually refers to intangible assets eg computer software. Similar in effect to depreciation.

Breakeven

Breakeven is the term used to indicate that an organisation has balanced its income with its expenditure.

Capital (property, plant and equipment)

Expenditure on the acquisition of land and premises, individual works for the provision, adaptation, renewal, replacement and demolition of buildings, items or groups of equipment and vehicles, etc. In the NHS, expenditure on an item is classified as capital if it is in excess of £5,000.

Capital Charges

Capital charges are a way of recognising the costs of ownership and use of capital assets and comprise depreciation and interest/target return on capital.

Capital Resource Limit (CRL)

A control set by the Department of Health & Social Care (DHSC) onto NHS Trusts (not Foundation Trusts) to limit the level of capital expenditure that may be incurred in year.

Clinical Commissioning Group (CCG)

From the 1 April 2013, Clinical Commissioning Groups are responsible for commissioning health services for its population and receives its resources annually from the Department of Health & Social Care under the auspices of NHS England.

Cost of capital

A charge on the value of assets tied up in an organisation, as a measure of the cost to the economy.

Commissioners

Commissioners is a term used to cover those organisations who commission services from NHS Trusts or other providers (eg private sector). Primary Care Trusts (PCTs) were the main commissioners in the NHS until March 2013. From 1 April 2013, commissioning responsibilities were taken over by NHS England, Clinical Commissioning Groups (CCGs) and Local Authorities

Creditor

This is the term used to describe a person or organisation that you owe money to. The modern terminology for accounting is payables.

Current assets

Receivables (debtors), inventories (stocks), cash or similar, whose value is either, or can be converted into cash within the next twelve months.

Debtor

This is the term used to describe a person or organisation that owes you money. The modern terminology for accounting is receivables.

Depreciation

The measure of the wearing out, consumption or other loss of value of property, plant or equipment whether arising from use, passage of time or obsolescence through technology, and market changes.

External Financing Limits (EFLs)

The External Financing Limit (EFL) is a fundamental element of the NHS Trusts financial regime (not Foundation Trusts). It is a cash based public expenditure control set by DHSC and a trust's access to all sources of external finance. The EFL represents the excess of its approved level of capital spending over the cash a trust can generate internally (mainly surpluses and depreciation), essentially controlling the amount of "externally" generated funding.

Foundation Trust

NHS Foundation Trusts are not-for-profit, public benefit corporations. They are part of the NHS and provide over half of all NHS hospital and mental health services. NHS Foundation Trusts are a result of the Government's drive to devolve decision making from central to local organisations and communities.

They provide and develop healthcare according to core NHS principles - free care, based on need and not ability to pay.

Foundation Trusts are regulated by NHS Improvement (an amalgamation of Monitor and the Trust Development Authority).

For more information see the website *www.improvement.nhs.uk*

Impairments

Impairments generally relate to property, plant and equipment and represent the loss of value of property, plant and equipment below that recorded in the accounts of the organisation. Impairment occurs because something has happened to the property, plant or equipment itself or to the economic environment in which it is used.

Indexation

A process of adjusting the value, normally of property (mainly buildings) to account for inflation.

Intangible asset

Software licence or some other right, which although invisible provides value to the organisation from its use. More commonly includes goodwill or brand values in the private sector.

International Financial Reporting Standards (IFRS)

From 2009/10 all public bodies, including the NHS, prepare their accounts under International Financial Reporting Standards (IFRS).

Market Forces Factor (MFF)

MFF is a composite index of geographical cost variations in land, buildings, equipment and staff pay (including London weighting). MFF is paid by commissioners as a percentage add-on to the national tariff. This helps to even out the purchasing power of commissioners of NHS services (mainly Primary Care Trusts) and allows the use of a national tariff across the country.

Payables

This is a term used to describe the money you owe to a person or organisation. A more traditional phrase is debt (for the money) or, for the person or organisation: creditor(s).

Payment by Results (PbR)

Payment by results (PbR) is the system by which trusts are paid for the majority of the work they do. The system is managed by DHSC.

Primary Care Trust (PCT)

Until 31 March 2013, Primary Care Trust were responsible for commissioning health services for its population and received its resources annually from the Department of Health & Social Care. Some PCTs also provided some services itself eg community nursing.

Provisions

Provisions are made when an expense is probable but there is uncertainty about how much or when payment will be required, e.g. estimates for employers or public liability. Provisions are included in the accounts to comply with the accounting principle of prudence. An estimate of the likely expense is charged to the income & expenditure account as soon as the issue comes to light, although actual cash payment may not be made for many years. The expense is matched by a balance sheet provision entry showing the potential liability of the organisation.

Prudential Borrowing Code (PBC)

A framework that allows NHS Trusts to manage their capital positions within their ability to service the resulting financial obligations. The PBC is based upon a series of financial tests, which determine prudent capital positions relative to their revenues and costs.

Prudential Borrowing Limit (PBL)

The PBL is calculated by reference to the rules contained in the PBC and represents the total borrowing (from all sources) that an NHS Trust can service based on its current financial performance.

Public Dividend Capital (PDC)

PDC is similar to company share capital. It represents the value of the assets employed by a Trust at its formation plus any further issue or repayment of capital in subsequent years from/to the Department of Health & Social Care.

Receivables

This is the term used to describe money that is owed to you by a person or organisation. A more traditional phrase is debtor(s).

Statement of comprehensive income

The statement of comprehensive income is the IFRS equivalent of the income and expenditure account/ statement of totals gains and losses (UK GAAP).

Statement of financial position

The statement of financial position is the IFRS equivalent of the balance sheet (UK GAAP).

Tariff

The tariff is the unit price the Trust is paid for the activity it delivers. For the majority of work a national mandatory tariff is used throughout the NHS. The Department also issues non mandatory tariffs for some activity. Some activity is not covered by either a mandatory or non mandatory tariff in which case a local tariff can be negotiated with commissioners.

Working Capital

Working capital is the current assets and liabilities (receivables, inventories, cash and payables) required to facilitate the operation of an organisation.

Contacting the Trust

The Trust welcomes feedback from patients about its services. There are a number of different ways in which you can contact us or give us your views.

If you have an issue which you wish to raise about your care then you should initially discuss this with the ward or departmental staff in the area you are being cared for. Local staff are usually best placed to be able to answer questions about your own care, or those of your relatives.

We recognise that in some circumstances patients or relatives may prefer to discuss the matter with someone not directly involved in their care. In those circumstances you can also contact the Patient Advice and Liaison Service (PALS) on:

Tel: **0161 604 5897**

You can also email: **pals@pat.nhs.uk**

Social Media

You can follow the Trust and its news and events on Twitter @PennineAcuteNHS

Report Publication

The Annual Report, Quality Report and Annual Accounts are published on line at *www.pat.nhs.uk*

A printed copy is available free of charge, and in different formats, by contacting the Communications Department on:

Tel: **0161 918 4284**

or email: **enquiries@pat.nhs.uk**

The Pennine Acute Hospitals NHS Trust

The Pennine Acute Hospitals NHS Trust,
North Manchester General Hospital,
Delaunays Road
Crumpsall, M8 5RB

0161 624 0420

www.pat.nhs.uk

@PennineAcuteNHS

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