The Pennine Acute Hospitals NHS Trust was established in April 2002 and manages hospitals in Bury, North Manchester, Oldham and Rochdale. Serving a population of approximately 800,000, the Trust is one of the largest non-teaching in the country.

It employs a staff of 10,000 across five hospital sites:
- Fairfield General Hospital, Bury
- North Manchester General Hospital
- The Royal Oldham Hospital
- Rochdale Infirmary
- Birch Hill Hospital, Rochdale

The Trust has four divisions:
- Surgery
- Medicine
- Women and children’s, and
- Diagnostics and clinical support

In addition, it has directorates providing support for:
- Human resources
- Facilities
- Modernisation and performance
- Planning
- Finance
- Information and management technology
- Governance
- Research and development

In addition to providing general district hospital services and a range of specialities, the trust provides specialised care for patients with AIDS/HIV at North Manchester General Hospital and for patients requiring hospital haemodialysis at North Manchester General and Birch Hill Hospitals.

The Trust is proud of the career opportunities it provides through first class education, links with local universities, a wide range of specialisms, cultural diversity and an environment of continuous support.

Further information about the Trust can be found on page 39.
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairman’s foreword</td>
<td>4</td>
</tr>
<tr>
<td>Chief Executive’s report</td>
<td>5</td>
</tr>
<tr>
<td>Mission statement, strategic aims, principles and values</td>
<td>6</td>
</tr>
<tr>
<td>Performance ratings</td>
<td>7</td>
</tr>
<tr>
<td>Activity</td>
<td>8</td>
</tr>
<tr>
<td>Working in partnership</td>
<td>10</td>
</tr>
<tr>
<td>Governance directorate</td>
<td>11</td>
</tr>
<tr>
<td>Compliments, concerns and complaints</td>
<td>13</td>
</tr>
<tr>
<td>Diagnostic and clinical support division</td>
<td>15</td>
</tr>
<tr>
<td>Facilities directorate</td>
<td>18</td>
</tr>
<tr>
<td>Human resources directorate</td>
<td>19</td>
</tr>
<tr>
<td>Medicine division</td>
<td>22</td>
</tr>
<tr>
<td>Modernisation and performance directorate</td>
<td>24</td>
</tr>
<tr>
<td>Surgery division</td>
<td>25</td>
</tr>
<tr>
<td>Women and Children's division</td>
<td>27</td>
</tr>
<tr>
<td>Finance report</td>
<td>29</td>
</tr>
<tr>
<td>Charitable funds</td>
<td>37</td>
</tr>
<tr>
<td>Trust board members</td>
<td>38</td>
</tr>
<tr>
<td>Further information</td>
<td>39</td>
</tr>
</tbody>
</table>
Chairman’s foreword

I am writing these words one day after attending a special event to mark the success of 800 Trust staff in achieving a range of nationally-accredited qualifications.

This annual report is another way of highlighting achievements of the Trust as a whole, and the Board believes that the last year has certainly been one of progress.

The updates from our divisions and departments all speak of real achievements, while also highlighting the way in which staff are consistently putting patients at the centre of everything that they do.

For many staff, that is a frontline, direct involvement. For others, it involves providing support services, which patients and the public may not even be aware of, but without which the Trust could not function. We have staff working in dozens of different roles, but everyone’s work comes down to one purpose – putting patients first.

I believe that the next stage of the Trust’s development will challenge us to expand this approach to the planning of future services, to put the patient at the heart of that process too.

Of course, the Trust already has numerous links with patient support groups, voluntary organisations, individual volunteers, community bodies and other representative organisations, including the independent Patient and Public Involvement Forum. We are continuing to build on the links that are already in place. Our patient and public involvement strategy recognises that much good work has been done in this area by the Trust already.

However, there is a national NHS agenda of, more than ever before, striving to fully involve patients and their families in steering how health services are developed.

The Emerging Vision document was published earlier this year, giving an overview of the general direction in which the Trust and our local Primary Care Trusts envisage services developing.

There are several themes running through the Emerging Vision document, and one of those is the need to fully involve staff, patients and the public in the process of planning services.

The publication of that document is, in itself, a key stage in that process. It sets out the general thinking on the future direction of both hospital and community-based services in the area. From the hospital’s perspective, it gives a range of commitments about core services and the future of each site, while setting out areas of development. What it does not contain is detailed proposals on services. Nor should it. We should be developing these details, discussing and testing them with staff, patients and public alike. It is through this partnership approach that we will increase each others’ understanding of the issues facing us both, and of the changes which will enable the Trust to best provide for patients’ needs.

The Emerging Vision document kickstarts this debate. I would invite anyone reading this report to read that document as well, and to take up its challenge to get involved in this work. If we have this involvement, we can build our plans and future developments using the wide range of knowledge and experience which such an approach offers us. Then I am very confident that the Trust’s future annual reports will have even more successes to report.

Steven Price, Chairman
In many ways, the awarding of a two-star rating to the Trust this year can be seen as a reflection of the broader progress which we have been making since our formation.

With several major projects being confirmed and the publication of proposals relating to our general future direction, I believe that we have now found our feet and have set some clear pointers for the way forward.

Naturally, much remains to be done - this is only the start of the process. However, I believe that the Trust now has a strong foundation on which to base our efforts to constantly improve the quality of healthcare which we provide for patients.

There has been a great deal of effort involved by staff from all divisions and departments to bring us to this point, while at the same time continuing to meet patients’ demands.

And it has not been an easy journey. We are one of the largest Trusts in the country, seeing patients 1,000,000 times a year, and with 10,000 staff spread over our sites. There are major benefits – and some drawbacks – in being such a complex organisation.

But I truly believe that we have now prepared the groundwork to properly serve patients for years to come, and to meet the challenges facing not just us, but the whole of the NHS.

This is not something which the Trust can – or should – do on its own. We need to ensure the involvement of staff and patients in this work, just as we need to ensure the involvement of partner organisations, both in the NHS and in other areas, and of the communities which we serve.

At the end of the day, all this work is needed for just one reason – to improve our care for patients. And that is not just a systems issue, but comes down to the individual efforts made by individual members of staff.

I am constantly aware of the continual dedication which the Trust’s staff bring to their roles. They face great pressures, and yet time after time I have been impressed with their efforts made to put patients first, in countless ways.

In many ways these are quiet successes. They will rarely make newspaper headlines, but they make the difference where it counts – in improving the lives of those patients. I hear about these successes when I visit wards or when I receive letters of thanks from grateful patients or their families. I am pleased to say that I get a regular flow of these letters.

Keeping up with – or exceeding – patients’ expectations – will remain a constant challenge for our future. For the NHS, it always will. Whatever role an individual member of staff has, it can always be traced through to helping patients, whether directly, or by supporting those staff who provide care directly. It is a team effort, and it is through continued team work that the Trust will successfully face its future challenges.

I would like to thank all the Trust’s staff for their efforts so far – and thank them in advance for their efforts yet to come.

Chris Appleby, chief executive
**Mission statement**

The Trust’s mission statement is:

“To provide the general hospital services required by the population of North East Greater Manchester (including appropriate specialist services). The services will be of high quality, effective, responsive to demand and accessible to all.

Caring and skilled staff are vital to good patient care and the Trust will value, respect, train and fairly reward its staff”.

**Strategic Aims**

- to work with other health and social care partners to provide seamless, comprehensive healthcare;
- to be the provider of choice for secondary care services for the local population;
- to provide enhanced secondary care services and tertiary services where appropriate;
- to develop teaching provision for both undergraduate and postgraduate medical staff and other clinical staff, together with research and development facilities and activity in conjunction with local universities;
- to achieve the aims and targets of the NHS Plan including quicker and easier access to services, improved outcomes and quality of care and a reduction in health inequalities;
- to continually improve the quality of patient care and treatment through the clinical governance process;
- to recruit, develop, train and retain caring and skilled staff who will be treated with respect, given equal opportunities and be fairly rewarded;
- to maintain the financial viability of the Trust by improved efficiency and effectiveness (using benchmarking and economies of scale where appropriate) and ensuring that high quality services are provided cost effectively;
- to act with probity, openness and to publicly account for the Trust’s decisions and actions.

**Principles and Values**

The Trust has established a set of guiding principles/values which will underpin the Trust’s view on any future proposals:

- high quality outcomes;
- appropriateness of setting (ie primary, secondary, tertiary, community);
- ease of access (time and location);
- ease of use;
- consistent reliability;
- flexible to demand change;
- patient/staff safety;
- consistency with national legislation, plans, priorities and targets;
- economy and efficiency.

In 2003/04 the Trust worked to achieve these aims through the objectives set in its Business Plan relating to the following and referred to in the various sections of this report:

- service delivery;
- financial stability;
- capital programme;
- staffing;
- governance;
- partnership working and communications;
- information management and technology.

A review of achievement of the Business Plan objectives is part of the process of preparation for the following year’s plan.
The Trust was awarded a two-star rating for 2003/04 by the Healthcare Commission, which found that its performance met or beat the national average in 11 out of 12 key targets.

The assessment represents an improvement from its previous rating, with two stars indicating “mostly high levels of performance”.

Chief executive Chris Appleby, in a thank-you memo to all staff, described the rating as “a real achievement by our staff, who have worked hard throughout the year, in the face of great pressures, to deliver real improvements to the patients they serve.

“While huge thanks are due to our frontline staff, we also want to extend that gratitude to the support teams and behind-the-scenes staff, who keep the organisation running so smoothly.”

Key target results
Results for key targets are noted below. In addition, the Trust has 30 other targets. Details of results in all categories are available from the Trust’s entry on http://ratings2004.healthcarecommission.org.uk/

The Trust matched or beat the national average or the target in the following categories:

Waiting and referral times
Waiting times (over nine months, and over 12 months – two categories)
• Out of more than 67,000 patients, the Trust had just four patients in these categories. Last year it had more than 450.

GP referrals (waiting over 21 weeks, and over 17 weeks – two categories)
• Out of nearly 115,000 referrals, all except two were seen within the timeframes. Last year, the figure for referrals in these categories was 629.

Trolley waits
Out of 39,500 admissions, three patients waited more than 12 hours, compared with last year’s figure of 35.

A&E patients
The percentage of patients admitted or discharged after visiting Trust A&E units or local walk-in centres within four hours was 92.99 per cent. This figure was better than the national average of 91.35 per cent, and represented around 226,000 patients. The figure for last year was 71.2 per cent, and the rise to 92.99 came against a backdrop of an increasing number of patients attending the Trust’s A&E units. These figures were measured by the commission over a nine-month period.

Improving Working Lives
The Trust met the rating requirement by gaining ‘practice’ status in this NHS initiative, which promotes staff involvement and benefits. It is seen as a key part of efforts to recruit and retain NHS staff.

Hospital cleanliness
The Trust’s “weighted average cleanliness” score met the national average – this was a continuation of its rating from the previous year.

Financial management
The Trust balanced its budget last year, in line with national requirements.

Electronic booking for outpatients and elective patients (two targets)
The Trust beat the national target of 66 per cent in both categories – outpatients was 77.2 per cent and elective patients was 87.9 per cent. These were not targets last year, but at the start of this year, the figures were 21 per cent for outpatients and 34 per cent for elective patients, indicating a very sharp rise in-year.

The Trust was below the national average on the following assessment:

Seeing suspected cancer referrals within two weeks
The Trust’s figures were 95.49 per cent, compared with the national average of 99.68 per cent. Specific action plans have already been introduced to increase this figure.

The Trust is committed to working to continue to improve its performance against the national criteria.
The Trust is constantly looking for ways to improve access to its services. Maintaining high standards of care and providing a quality service for patients is always at the forefront of any new initiative, and this work has continued in a number of key areas -

**Accident and emergency services**

The Trust has developed an emergency care network, encompassing the four hospital sites and including health care partners from Primary Care, Ambulance Service, walk-in centres, NHS Direct, Mental Health and Social Services. The aim of this network is to ensure that patient needs are met with the right care, delivered by the right professional, in the right place and to provide a seamless service between organisations, reducing any delays and duplication.

Working alongside the emergency care network, the emergency services collaborative, which is a national modernisation initiative, has actively improved access to accident and emergency services. Developments have centred around not only improving emergency care access itself, but developing schemes and services that will reduce the need for emergency attendance and admission to hospital.

The Emergency Services Collaborative has involved nearly 250 staff, and a patient user forum, developing over 100 service improvements.

---

**Activity**

Despite ever increasing demands on services, the Trust met all key activity targets in 2003/04. These achievements are illustrated in the following graphs:-

**Patient Activity**

The Trust met all key activity targets in 2003/04. These achievements are illustrated in the following graphs:-

- Total inpatient waiting list
- Inpatients waiting 9 months or more
- Outpatients waiting 17 weeks or more for a first appointment
- Percentage of A&E patients waiting less than 4 hours
Last year 240,000 patients attended Trust accident and emergency departments, up 6.5 per cent on the previous year, with an 11 per cent increase in those patients who subsequently required admission. Despite this additional workload, access to accident and emergency services improved by 14.5 per cent. This resulted in 45,266 more patients being seen within four hours this year compared with the previous year.

**Bed management**
The efficient use of hospital beds is crucial and central to the provision of high quality care. The Trust has to ensure that both emergency and planned patients are allocated beds according to clinical priority, as well as meeting the targets set for waiting times in accident and emergency.

Re-structuring of the bed management service has further improved communications, speeded up decision making and has resulted in a greater ability to forward plan and deal with anticipated bed pressures.

**Patient booking**
During the year the Trust has developed and implemented its strategic plans for moving towards a fully booked service. The Government’s key milestones for the booking of appointments and admissions have been met. In particular, the booking of outpatient clinic referrals was extended across the Trust within excess of 75 per cent of new patients being offered a choice as to the time and date of their appointment. Similar arrangements were also put in place for daycase patients and inpatients.

This facility offers much greater flexibility for patients, giving them the opportunity to book appointment times convenient to them. The development provides a firm foundation for a fully-booked service when patients will be able to book outpatient appointments when they see their general practitioner.

The aim in the coming year is to ensure that all patients referred for assessment or treatment have a say in the time of their admission to enable them to properly prepare for their treatment.

**Waiting time in clinics**
During quarter two in 2003/04 over 85 per cent of patients were seen within 30 minutes of their appointed time, which shows a six per cent improvement from the same time last year. Annually the percentage seen within 30 minutes continues to increase.
Strategic Health Authority and clinical networks - the Trust works within national policy guidance and the financial regimes set by the NHS. It is part of the health economy of Greater Manchester and works within and contributes to the policy and guidance produced by the Strategic Health Authority and its clinical networks.

Primary Care Trusts - the Trust’s main commissioners are the five Primary Care Trusts in the North East of Greater Manchester (Oldham, Bury, Rochdale, Heywood and Middleton, and North Manchester PCTs). The Trust works in collaboration with the local PCTs to improve the patient experience, to provide seamless healthcare for local populations, to improve health and to reduce health inequalities.

Local Authorities - the Trust has no services which are currently jointly managed or have joint budgetary arrangements with Local Authorities. However, the Trust works closely with Local Authorities, particularly Social Service Departments, on the provision of a range of services, including those related to hospital social work provision, hospital admission and discharge arrangements, intermediate care and a range of services for different patient/client groups and conditions.

The Trust also co-operated closely on the establishment of Local Authority Health Overview and Scrutiny Committees.

Local Strategic Partnerships - the Trust is involved in the work of Local Strategic Partnerships in the four local authority areas in the North East of Greater Manchester. Along with local PCTs the Trust’s involvement has particularly been focused on partnership groups dealing with health and social care, health inequalities and social cohesion. It contributed evidence to and met with the Committee on the Office of the Deputy Prime Minister in producing its report on Social Cohesion.

Health of the Local Population - the Trust’s strategic aims set out the commitment to improve the health of the local population and to reduce health inequalities. People in the North East Sector of Greater Manchester suffer much higher levels of deprivation and ill health than the average for England, and there are some particularly disadvantaged groups and areas often linked to higher levels of black and minority ethnic populations.

The Trust is working closely with PCTs and local authorities to improve health, and reduce inequalities. A number of health inequality strategies were produced in 2003/04 and the Trust is working in partnership to implement these.

The Trust’s ethnic health and interpretation service has recently received national praise for its work from the Parliamentary Select Committee on Social Cohesion, who visited Oldham in September 2003.

Targets set for 2004/05 include the objective “to improve community cohesion and diversity in respect of staff employment and patient interaction”. Success in meeting this objective will be measured by the action programmes introduced to improve community representation in the workforce and to increase sensitivity to the needs of black and ethnic minority patients.

Other key targets for improving health and reducing health inequalities in the localities served by the Trust are set out in PCT Local Delivery Plans. These include trajectories showing the rate of change to achieve the targets. Those targets particularly relating to hospital services include reductions in women smoking in pregnancy, increases in breastfeeding initiation rates and reductions in death rates from Coronary Heart Disease and cancer.

Consultation and Work with Local Groups and Organisations

Partnership working arrangements with PCTs and local authorities have already been described. The Trust also works closely with and consults local and national voluntary groups and charities including those (such as Macmillan Cancer Relief, WRVS, Leagues of Friends etc) who directly provide services working alongside Trust staff or who raise funds to support services. This is in addition to hundreds of volunteers recruited by the Trust itself who assist patients and staff throughout the hospitals.

Developments in 2003/04 include posts of lymphoedema practitioner, oncology pharmacist, palliative care nurse and oncology dietitian funded by Macmillan.

A Patient and Public Involvement Strategy was produced in 2003/04 for implementation in 2004/05 to ensure that patients and the public are increasingly involved in decisions on the planning and operation of the Trust’s services.
Governance

Governance is the system of ensuring the quality of an organisation’s work, highlighting areas where improvements are needed, and making sure that action is taken. As such, it supports all of the activities of the Trust’s staff, and is of central importance in ensuring that the Trust continues to strive to constantly raise standards and minimise risks, both clinical and non-clinical.

Following a time of development, the governance structure within the Trust is now well established. Each clinical division has established its own governance committee and structure for the work that will take place over the coming year. This will ensure that the process becomes embedded within the clinical area teams and down to ward and departmental level. Governance is everyone’s responsibility, and it is only by empowering staff in this way that the results will be delivered.

Clinical governance

The Trust’s current clinical governance development plan has recently been reviewed by the Strategic Health Authority along with a review of the outstanding actions from the Commission for Health Improvement (CHI) reviews of the former Trusts of Bury and Oldham. The current development plan is now updated on a bi-monthly basis and is used as a monitoring document to ensure progress is being made. The Trust complies with the national clinical governance reporting process.

A recent addition to the development plan has been the action plans from the divisions, derived from a baseline assessment completed during 2003/04. This baseline assessment was undertaken using the CHI Self Assessment Tool primarily at clinical area team level to establish the strengths and weaknesses in clinical governance terms of the organisation.

As well as the development plan, an annual report and outcome summary were produced in relation to the Trust’s clinical governance activities. These are available to patients and members of the public through our website.

Also in 2003/04 the following key pieces of work have taken place under the remit of the clinical audit departments.

1. The development of a clinical audit framework to ensure forward planning of clinical audit projects to reflect both national, Trust and local clinical priorities.
2. Continuation of patient satisfaction surveys, both national and local initiatives along with the development of action plans where areas of improvement have been recorded.
3. The establishment of a patient information review group to ensure that the production of patient information across the organisation is standardised, of a high quality and fundamentally what the patient wants.

Over the coming year the audit function will be exploring the ways in which patient involvement can be further extended within the above processes.

North East sector governance group

The Trust has also been instrumental in the creation of a north east sector governance group which allows the acute Trust, its constituent five PCTs and Pennine Care Trust to ensure the governance processes are joined up across different health organisations. Areas of work so far have focussed on incident reporting and clinical audit.
Risk Pooling Scheme for Trusts

In March 2004 the Trust underwent an external review relating to the Risk Pooling Scheme for Trusts. This scheme looks at the organisation’s risk management strategy and policies, accident and incident reporting systems, as well as complaints and claims processes and training in relation to risk management.

The Trust received a high pass mark of 84 per cent. A number of strategies and policies were highlighted as examples of good practice and early progression to Level 2 is anticipated.

Preparation for assessment for this scheme saw the roll out of the Trust’s accident and incident reporting system which now means that all sites within the Trust report in a standardised way, highlighting the grading of the incident and the action requirement.

National Learning and Reporting Scheme

A data mapping exercise towards the end of the year paved the way for the Trust’s acceptance into the National Learning and Reporting Scheme, which is run by the National Patient Safety Agency. In doing so, the Trust became the first in Greater Manchester to be accepted, with the exception of an early pilot site.

The scheme records and analyses information anonymously, to enable the analysis of incident trends, and the development of national guidelines and policies aimed at improving patient safety.

Controls assurance

The controls assurance submission for 2003/04 has also recently been completed. This process entails the scoring of the Trust against 22 standards including the three core standards:

- risk management
- governance
- finance

The first combined assessment as a new Trust in 2002/03 saw the combined results being lower than that for the previous years in the individual Trusts. However, one year on, there has been a 16 per cent improvement across all the standards to note in the 2003/04 submission. This reflects a considerable amount of work taking place across the organisation in each of the 22 standards. For example, the establishment of a health and safety structure and the review of policies and practices.

The Statement of Internal Control which is prepared on completion of the Controls Assurance exercise is referred to later in this report (page 30). It identifies a number of the standards for further detailed work in the coming year. This includes the controls assurance standard for infection control which is recognised by the organisation as requiring a high priority.
With Trust staff seeing patients on more than 1,000,000 separate occasions a year, staff receive far more letters and cards of praise than of complaints. However, the Trust is committed to using both as a learning mechanism, to build on what is working well and address issues which still need action. The level of complaints dropped slightly over the last year, but ongoing work will be needed to ensure this continues. The introduction of the PALS service, plus developments in relation to the complaints service will continue to progress this agenda.

PALS service

The Patient Advice and Liaison Service (PALS) had its first year of operation with the Trust. The service provides a single access point for on-the-spot help, advice, support and resolution to informal complaints for patients, their relatives and carers.

There is a PALS officer on each site providing advice and support for patients and their families. They provided a prompt resolution to 1,826 contacts in 2003/04.

PALS officers have also liaised closely with senior managers, highlighting issues that occur frequently or identified trends. Their ability to do this has been enhanced by the introduction of the Safeguard Ulysses system, which enables sophisticated data analysis.

PALS officers have promoted the service internally, attending clinical area team meetings, explaining their role in induction sessions and disseminating leaflets to wards and departments.

The service is committed to the establishment of strong working links with external agencies, support groups, primary care providers, PALS officers from other NHS organisations and social services. Secretarial support for the PALS officers is pending, which will enable increased contacts with the communities the Trust serves in order to progress the patient and public involvement agenda and obtain proactive feedback on Trust services.

Accessibility is a key component to a successful PALS service. A review of the office locations and signage to each office is being undertaken in order to ensure every PALS office is easily accessible to the general public.

PALS will continue to expand and develop in response to demand. This exciting new initiative is providing the Trust with a wealth of feedback from service users and reducing the number of formal complaints by achieving prompt, effective, informal local resolution.

Complaints received on a formal or informal basis should be seen as an opportunity to view the services the Trust provides through the eyes of the people using them, in order to learn from past experiences and improve service provision.

The Trust is one of the largest in the country, and received 845 complaints this year, down from 892 the previous year.

The complaints received were recorded by the subject category of the issue raised. The chart below shows the breakdown by category.

### Complaints received 2003/04

- **Staff attitude (15%)**
- **Communication (11%)**
- **Waiting times/ Delays/Cancellations (20%)**
- **Admission/ Discharge/Transfer (4%)**
- **Admin/Housekeeping/Facilities (7%)**
- **All aspects of Clinical Treatment (41%)**
- **Other (2%)**

Total 845 - a drop from 892 in 2002/03
Despite a year of changes and challenges for the complaints department staff, they have achieved an overall rate of 97% for the target of acknowledgement to a complainant’s letter within two days of receipt.

The Trust achieved an overall 47 per cent response to the target of responding to complainants within the 20 working days. This shortfall was due to the lack of a computerised system for logging complaints, delays caused by transferring information across sites and staff sickness.

A new computer system, Safeguard Ulysses, was introduced in November 2003 to collect and store the necessary information on complaints. This simplifies the process of tracking the progress of complaints, highlights when responses are due and gives more detailed information to the managers of the service. In turn this allows analysis of trends and recurring issues with greater detail in order to develop the services in light of this information.

The centralisation of the complaints function at the Westhulme site will bring greater benefits to a small workforce in terms of cover for absence and equity of workload and will reduce the delays caused by transferring files across sites.

Of the 845 complaints received, there were 17 requests for independent review. No review panels were required as seven complaints required no further action and 10 were sent back for further action under local resolution.

The Trust continues to build on the success of local resolution and face-to-face meetings are proving to be very useful in complex complaints.

**Training**

As a result of reviewing the complaints function this year, a new training programme has been developed to educate staff on good customer care and how to achieve early resolution to the issues raised. This programme will commence late 2004 and will be initially aimed at all new starters.

Additional training on the investigation of complaints using a root cause analysis method is also being developed and will be available later this year. This training will be aimed at staff who are involved in investigating complaints. Trust staff who currently are attending a course to enable them to teach root cause analysis methods will provide the training.

Improved information technology and new systems of working are already beginning to impact positively on the service. Additional developments and further training will ensure further improvements are made in how the complaints are handled across the Trust.
Introduction
The division provides many of the ‘behind the scene’ services which enable the Trust’s frontline staff to see patients more than 1,000,000 times a year. Its teams provide pathology, radiology, critical care and anaesthesia and pain services, along with services covering a wide range of clinical professions.

Many of these areas are facing modernisation drives and are moving towards closer integration to meet the ever increasing demands for services, against the need to make best use of both highly-skilled staff and equipment.

There have been significant challenges throughout the year and some real achievements in relation to improving services to patients.

The year ahead will continue in a similar light which will see a review of capacity and demand and challenging access targets for diagnostics not previously seen. This continued modernisation drive should ensure additional improvements to patient access in all our services.

Anaesthetics
An additional consultant anaesthetist has been recruited at the Rochdale site, and £140,000 has been invested in the purchase of seven new anaesthetics machines for Rochdale.

The acquisition of ultrasound machines in theatres on all four hospital sites will assist with central venous line placements and enable compliance with best practice as indicated by the National Institute for Clinical Excellence.

Critical care services
Significant investment in critical care this year has seen an increase in patient care facilities across the Trust, including the opening of an eight-bedded combined critical care and high dependency unit at Fairfield General Hospital.

Sophisticated ultrasound scanning equipment has been introduced to all four intensive care units in Bury, Oldham, Rochdale and North Manchester, to help with care and treatment for the most seriously-ill patients.

A policy review of the use of critical care and high dependency beds has enabled the admission of a broader range of patients into the critical care beds at Oldham and Rochdale, giving a more flexible and responsive service.

The use of senior specialist nurses “outreached” from critical care to other wards has aided the recovery of patients from their critical illness by ensuring their needs are fully met following their transfer back to hospital wards.

Neurophysiology
The sites at Rochdale and North Manchester have amalgamated, enabling the provision of a much improved service for the whole Trust. The work to reconfigure the department at North Manchester to accommodate the new service was completed in March 2004.

Nutrition and dietetics
The departments on the four sites are working more closely together to ensure that high quality services are maintained in the face of increased pressure. A successful bid for funding from Macmillan Cancer Relief has enabled support of a palliative care dietitian. Oldham PCT has agreed to fund the programme after its initial three year run.

A joint service between the Trust, social services and the PCT has been developed to provide dietetic services to intermediate care. It is hoped permanent funding can be secured to continue to make improvements in this service which supports people getting back into their own homes after they have been discharged from hospital.

Pain Services
There has been significant investment in pain services over the year. A total of £90,000 has been invested in the service to support the delivery of shorter waiting times for patients with chronic pain and to ensure the Trust meets national targets. Thirty pain pumps have been purchased for Fairfield General Hospital which will revolutionise the delivery of pain relief.

Pathology
Pathology services have continued on their ambitious programme of modernisation with the development of a major business case to create a state-of-the-art network across the Trust.

Under this project, a major pathology centre would be created at The Royal Oldham Hospital, with essential service laboratories (ESLs) at each of the other sites. The ESLs would enable swift turnaround of time-sensitive samples.
The project is a response to pressures in relation to increasing demand, a national shortage of skilled staff and the need to use equipment to greatest advantage. The creation of this re-modelled service will enable staff to be moved from existing accommodation, some of which is simply not up to the job.

Partnership working continues with Rochdale PCT and has resulted in the achievement of their “Going for Gold” award which was given for outstanding service in anticoagulation services at Rochdale Infirmary. The award was given for the transfer of 800 patients from the hospital setting to primary care, enabling patients to be treated in the community. Work is continuing to further increase the number of patients who can be treated in this way.

Pharmacy
This year has seen some major improvements in pharmacy including the successful implementation of a pharmacy computer system at North Manchester General Hospital and Fairfield General Hospital. This new system supports pharmacists to ensure they can give accurate advice to clinicians and patients about the use of drugs and their costs.

Two pharmacists have received training to become supplementary prescribers supporting the anticoagulation service at The Royal Oldham Hospital and the infectious diseases service at North Manchester General Hospital.

Macmillan Cancer Relief have agreed to fund an oncology pharmacist at Oldham. This will assist the development of highly specialist medicine advice for cancer patients.

At Fairfield General Hospital in November 2003 a new pharmacy department was opened providing both patients and staff with much improved facilities. This investment of £700,000 created a working environment which helped in attracting additional staff to the service.

Physiotherapy
The physiotherapy service is working closely with PCTs to develop integrated services. In particular, funding from Oldham PCT has enabled more services under the Tier 2 project to be provided, making services more accessible to patients. There has been excellent teamwork throughout the project which has enabled patients to be triaged to the most appropriate clinic for their care ie. physiotherapist or consultant orthopaedic surgeon. This has significantly improved patient access and between 30-40 per cent of patients are now seen by a physiotherapist, rather than being seen unnecessarily by the surgeon.
Radiology

It has been a challenging year in radiology but one which has seen improvement and development towards service modernisation.

In terms of equipment there have been improvements in obstetric services with the acquisition of four new sophisticated ultrasound scanners. Work has started on the development of a magnetic resonance service at Rochdale, to accommodate a MRI scanner provided under the NHS Cancer Plan. The scanner, which costs £250,000, will be housed in a specially-built £750,000 unit, with the Trust funding £500,000 of the building costs and the Department of Health providing the rest. Local PCTs are continuing to support the on-going running costs. The new scanner will eventually increase the number of scans offered annually by the Trust from 7,800 to around 11,000. The strength of the Trust as a whole, and its strategic capabilities, have helped progress this scheme.

The number of radiologists has increased by the successful recruitment of a further two International Fellows bringing the total to five. There has been continued development of advanced practice for radiography with the appointment of a clinical specialist in radiographic reporting.

A modernisation programme focusing on improving patient waiting times commenced in February 2004 and is already showing major achievements in reducing waiting times for ultrasound at The Royal Oldham Hospital. The challenge in the next 12 months is to reduce all waiting times to all patients. A programme of overall radiology service improvement will include implementation of the national initiatives.
The Trust’s facilities department is responsible for a range of issues, including capital works, cleaning, catering and security. Improving the patient experience has been at the centre of all facilities developments during the past 12 months.

Departmental teams have focused on the patient environment throughout the year and have developed action plans to improve and modernise facilities across the Trust. Patient Environment Assessment Teams (PEAT) on each hospital site have completed self assessments of wards and other areas for patients and achieved ‘green status’ when measured against national targets. External PEAT assessors have inspected all hospital accident and emergency departments and awarded the highest green status. The PEAT teams also monitor the segregation of patient accommodation to ensure patients’ privacy and dignity needs are met.

The Trust is committed to continuing to build on these improvements. Recently there has been an upgrade of the accident and emergency department treatment area at The Royal Oldham Hospital to improve the layout and provide more space for patients and staff. This was the first phase of improvement works which will continue with remodelling of the main reception and waiting area, as part of a £250,000 project.

Throughout the year, the Trust has been developing and consulting on a strategy to harmonise all “hotel services” across the Pennine Acute Hospital sites. Harmonisation of these services, including catering, cleaning, portering, linen and security, will improve quality for both patients and staff and deliver value for money.

The Trust continues to achieve targets laid down by the Better Hospital Food Programme and in March participated in the national protected meal times day, which aims to ensure that patients have the time to make the most of their meals. This initiative, which involves ward staff working with patients, their visitors and health professionals has proven a success and is being piloted on wards across all Pennine hospitals.

In partnership with Patientline, television, telephone and information services have been provided to all beds on the North Manchester General Hospital site to meet targets set out in the NHS Plan. This facility is continuing to be rolled out and will be operational on all sites by the end of 2004.

We have invested in a number of projects to improve and modernise services across the Trust:

- in addition to the new £700,000 pharmacy at Fairfield General Hospital, a new £250,000 critical care unit, combining existing intensive care and high dependency facilities, was commissioned in 2004. The new unit, adjacent to the main operating theatre suite, delivers improvements to patient care and greater flexibility. The improvements to both these areas helped us recruit additional staff;
- £200,000 investment in the coronary care unit at Rochdale Infirmary has enabled remodelling to provide more space around each bed and improve patient observation for nurses;
- a £50,000 programme has improved the layout of the special care baby unit at North Manchester General Hospital, further increasing safety.

The innovative protected mealtimes project ensures that patients can enjoy their food in peace.

Photo courtesy of the Oldham Evening Chronicle
Philosophy and management arrangements

The Trust is committed to being a model employer and employer of choice. It is acknowledged that the success of the organisation in delivering its commitment to provide high quality and accessible patient care is dependent first and foremost on the contribution of staff. The recruitment, retention and development of staff is therefore a key ingredient in achieving the Trust’s goals to provide a patient focused service. The Trust is therefore committed to providing progressive people management based on offering fulfilment, fair reward, development, active participation and involvement in the organisation. In addition, the Trust subscribes to the concept of work life balance. In pursuit of this it encourages and is responsive to requests for flexible working and other initiatives designed to support staff in achieving the right balance between work and home. This is particularly important in the NHS given the large number of female staff employed.

The structure of the human resources (HR) department is aligned to the matrix management arrangements in the Trust based on a divisional structure. The principal function of the HR department is to provide strategic direction and operational support. However the delivery of operational HR management is the responsibility of the management community and given the labour intensive nature of the organisation and the link between staff and quality, patient care is without doubt their most important function. The Trust is committed to continuing the development of the people management skills of the managers responsible for delivering services on a daily basis.

Recruitment and retention activity

Recruitment activity for the Trust has been centralised and harmonised at North Manchester General Hospital. The Trust employs approximately 10,000 staff and therefore the activity associated with recruitment is significant, despite the organisation’s commitment to staff retention. Process management continues to be refined and the Trust is currently working with the Modernisation Agency to ensure that best practice is exercised as a matter of routine. The Trust is experimenting with new methods of recruitment including pursuing further electronic systems.

The Trust also recognises its wider responsibilities to the economic viability of the communities it serves and targets the local population wherever possible in promoting employment opportunities. In particular the Trust actively promotes NHS careers in schools and colleges and amongst minority groups. The Trust has been successful in the last year in reducing its dependency upon agency staff through the establishment of an integrated bank, offering competitive and progressive terms and conditions of employment. This initiative is also aimed at improving continuity of patient care by reducing the dependency upon ad hoc and transient staff.

Medical recruitment and reducing junior doctors’ working hours

The Trust employs in excess of 650 doctors, including approximately 370 doctors in training. The recruitment of medical staff, particularly at consultant level, is very competitive because of national shortages and also investment in services increasing demand for medical staff. The Trust has experienced particular difficulties in national shortage areas including pathology and radiology, and is pursuing all available avenues, including overseas recruitment and training and development opportunities to improve the situation.

Under the NHS Junior Doctors’ New Deal agreement no junior doctor should work more than 56 hours per week and the Trust is making progress towards this target with percentage compliance at approximately 80 per cent at the end of March 2004. In addition, under the
European Working Time Directive, further stricter controls apply to all staff and substantial investment has been identified to ameliorate the situation in respect of junior medical staff. The Trust is also experimenting with new ways of working including transferring work traditionally done by junior doctors to other competent clinicians.

Workforce information/planning
Since the merger of the Trust, work has been undertaken on establishing an integrated workforce information system reflecting the divisional management arrangements. The new system will shortly be ready to generate valuable and integrated reports to assist management in the effective and efficient utilisation of resources.

The Trust is committed to modernising roles with a clear focus on the needs and best interests of the patient. To support this initiative the Trust is investing with the support of the Strategic Health Authority, in both advanced practitioners and assistant practitioners. These developments will allow the Trust to respond to traditional workforce pressures and support our commitment to staff development and providing challenging employment.

Education, training and development
The Trust is committed to continuous professional development and lifelong learning for all its staff. A new £1.8 million education centre is being commissioned on the Fairfield General Hospital site and will open in Autumn 2004. A clinical skills training centre has been opened at The Royal Oldham Hospital and this will allow clinical staff to perfect and enhance their invasive skills.

The Trust continues to work in partnership with the Greater Manchester Strategic Health Authority and is appreciative of the support and funding provided to support various initiatives including the cadet scheme and continuous professional development for all staff. The Trust has identified training and development priorities designed to improve standards and equip staff to enhance the patient experience.

Equality and diversity
The Trust continues to work in partnership with local communities to progress initiatives, to improve the quality of service and employment opportunities for black and ethnic minorities. To this end, it has developed an equality and diversity strategy clearly outlining its commitment to various initiatives including treating all patients as individuals.

An Equality and Diversity Sub-Committee of the Board has been established and is committed to progressing initiatives associated with the race equality scheme arising from the Race Relations Amendment Act 2002. Particular equality and diversity initiatives include reviewing the patient interpreting service and providing additional training to all staff to raise awareness of equality and diversity issues, and ensure that the organisation is sensitive to all cultures, including those of an increasing number of minority groups.

Active work continues with local job centres and community organisations in recruiting and retaining people from historically disadvantaged groups including the disabled.

The Trust’s two-year cadet course gives young people a real insight into the best NHS career for them.
Occupational health services
The Trust’s occupational health service, which includes Mediscreen, has undergone a major reorganisation in the last 12 months, culminating in a new Trust-wide integrated department. The income from external contracts has been maintained and increasing funds generated from such contracts have been invested in staff services. A new stress policy has been launched and is supported by training and development opportunities. Additional counselling services have been provided and the department is ensuring that all sites enjoy the same standard of provision. Various important clinical policies have been revised and harmonised and this should improve the health and welfare of staff. An important investment has been committed to improve information technology and this will improve efficiency and also benefit staff. The Trust is planning a major review of smoking and alcohol policies in the near future.

Employee relations
The first year of the new Trust saw a huge amount of change and although much of this has been consolidated in year two, both national and local priorities have presented substantial challenges for management and staff side in attempting to work in partnership and manage change in harmony. Despite difficulties and tensions, valuable progress has been made and there is a commitment to work in partnership for the benefit of both staff and patients. Further progress has been made in harmonising policies and procedures and preparations are in place to introduce significant pay modernisation initiatives.

Improving Working Lives
The Trust was awarded Practice Status during the year and this was recognition of tangible evidence of flexible working and supporting the work life balance approach already alluded to. The Trust recognises that if it is to be successful in further improving recruitment and retention, it must promote fundamentally different ways of working, related to both patterns of work and role determination. The Trust is also committed to supporting staff experiencing unexpected difficulties and changing circumstances. The Trust is working towards IWL Practice Plus Status.

Staff effort
Implicit in this report is acknowledgement of the superb commitment and dedication of staff and it would be remiss of the Trust’s director of human resources in the Annual Report not to formally acknowledge this and to thank staff for their sterling efforts.
A range of innovative schemes developed by clinical and managerial staff are helping the thousands of emergency patients the Trust treats each year – before they reach hospital, during their time in hospital, and when it is time for them to be discharged.

The projects are helping patients avoid unnecessary admissions to hospital, ensuring that they receive expert assessment and treatment at each stage, and help them avoid unnecessary waits, which result in longer than required stays in hospital.

The division’s work includes outreach services, the Trust’s A&E services, emergency admissions, and liaison with other health and social care professionals.

Each year, more than 65,000 patients are admitted to the Trust’s hospitals as emergency cases. Around 50,000 of those are medical emergencies, the others being emergency surgical admissions.

The Healthcare Commission, which measures NHS performance, found that 92.99 per cent of patients were admitted, treated or discharged after visiting Trust A&E units and Primary Care Trust walk-in centres within the four hour target.

This figure, measured over a nine-month period, bettered the national average of 91.35 per cent, and represented around 226,000 patient attendances. The figure for last year was 71.2 per cent, and the rise to 92.99 per cent came against an increase – sometimes very sharp – at all Pennine Acute A&E units.

In comparison with the previous year, the Trust as a whole saw emergency attendances increase by 6.4 per cent, or 14,528 more patients. For individual hospitals this represented a rise of 5,127 patients at The Royal Oldham Hospital (7.9 per cent), a rise of 4,281 patients at Fairfield General Hospital (8.6 per cent), a rise of 3,917 patients at Rochdale Infirmary (7.6 per cent) and a rise of 1,203 at North Manchester General Hospital (2 per cent).

The success in meeting these targets, and beating the national average, under such challenging circumstances is a tribute to the efforts made by teams throughout the Trust, both in their own efforts, and in the partnerships they have developed successfully with primary care and ambulance staff.

Over the last year, the division’s clinical and managerial staff have been building on the success of existing schemes and devising new ways to help patients receive expert assessment and treatment at each stage of their hospital care. The shared knowledge and skills base at each hospital means that the division will continue to build on past successes and roll out good practice across all hospitals.

**Pioneering scheme cited as national example**

One of the longest-standing schemes, an emergency nurse practitioner project at North Manchester General Hospital, marked its tenth year by being praised in the NHS annual report.

NHS chief executive, Sir Nigel Crisp said that the scheme, which involves specially-trained A&E nurses taking full responsibility for specified minor injuries, had resulted in “a marked increase in patient satisfaction”.

Since its launch, the scheme has been copied throughout the country, and each Trust hospital now operates a similar scheme.

**Emergency care czar takes notes**

Trust staff were able to share their views on emergency care with the national clinical director when Professor Sir George Alberti visited in September.

Sir George toured the A&E departments at both North Manchester General Hospital and The Royal Oldham Hospital, discussing A&E access issues with staff. He also gave a presentation on emergency care to staff groups at North Manchester. In a letter to the chief executive Sir George said that he had found the whole day extremely instructive and helpful. He had been impressed by the way the Trust was handling situations and had gained a lot of valuable information for his work at the Department of Health.
Rochdale team scoop first-ever national award

Staff from Rochdale Infirmary won the first Best Practice in Cardiac Care national award for their life-saving partnership work with Greater Manchester Ambulance Service teams.

The award recognised the successful introduction of a range of schemes, including world-class performance on the administration of thrombolysis-busting drugs to heart attack patients. Rochdale Infirmary gave 100 per cent of suitable patients the drugs within an hour of their initial 999 call, compared with a national target of 48 per cent.

The pilot schemes at Rochdale have involved hospital staff having closer liaison and joint education programmes with paramedics, and have been so successful that all ambulance crews in the region now follow the same procedures.

Cardiac care at Rochdale

Rochdale Infirmary further cemented its growing reputation for cardiac care with the opening of a second room at the Silver Heart Unit. This project of more than £200,000 has increased the number of patients from across the Trust area who can be fitted with pacemakers. The Infirmary was also chosen as the base for a mobile cardiac catheter lab, which will also provide services by visiting hospitals in Tameside, Hope and Macclesfield. The mobile lab is likely to provide an additional 1,800 procedures, helping detect coronary heart disease and determine treatment. This marks a significant enhancement of the service in the region. One of the main factors for the choice of Pennine as the host Trust was the excellence of cardiology facilities and staffing.

Cutting-edge diabetes scheme

Continuing subcutaneous infusion of insulin (CSII) is now an established method of managing people with insulin requiring diabetes (predominantly people with type 1 diabetes) and has been included in the National Institute for Clinical Excellence (NICE) guidelines. Currently, the expertise in this service lies at North Manchester General Hospital with diabetes specialist nurse Kath West, providing the main patient link and referrals can be made to Professor Wiles. The service has been extended to The Royal Oldham Hospital. At present there are 14 patients currently on CSII with another patient going through the assessment programme. This service will continue to develop further in the future and is becoming one of the major changes within the diabetes service.
Cancer services
The NHS Plan identified the importance of reducing waiting times for urgent treatment. The NHS cancer plan therefore set a two week waiting time target, from the point of GP referral, to an appointment with a hospital consultant, for those patients who were assessed as requiring urgent treatment.

The modernisation team has led a restructure of the teams responsible for managing these referrals, and redesigned the processes involved, to ensure that this target is consistently met across the Trust.

Working collaboratively with the local cancer network has enabled the funding of five new posts. These staff will work towards improving the experience and outcomes for patients with suspected or diagnosed cancer. The key targets are as follows:

- reduce the time from initial GP referral (for suspected cancer) to first definitive treatment to 62 days;
- increase the number of “booked” appointments to improve patient certainty and choice;
- increase the number of patients who are cared for by a full cancer services team (multi-disciplinary team).

This modernisation programme encourages local clinical teams to review their services and supports them in making improvements by redesigning the way that care is delivered.

National Service Frameworks
The team also worked with local PCTs in submitting a £220,000 bid to the Department of Health to improve hospital care for older people. The bid was successful and the funding will be used to further develop the skills of staff in caring for older people. The work will also involve patients and carers in the design and delivery of a teaching programme.

Pre-operative assessment and scheduling
The team is working closely with the division of surgery to develop and expand existing pre-operative assessment services. This assessment is an important part of the surgical patient’s pathway.

The aim is to ensure that patients are fully informed about their operation. The assessment confirms that they wish to undergo surgery and are as fit as possible for this to take place on the agreed date. It minimises the risk of late cancellation by ensuring that all essential resources and discharge requirements are met.

Implementing pre operative planning and assessment before admission is a key component in improving the patient’s experience of surgery. To achieve these benefits and provide a co-ordinated patient focused service, pre operative assessment services involving all healthcare professionals, are being developed across the Trust.

In addition to the expansion of pre operative assessment, theatre scheduling is being developed which will improve the booking process for patients, and will assist in ensuring the necessary resources at each stage of the patient journey are available, thereby reducing the unnecessary delays in patient treatment plans.

Medical records
The medical records department provides essential administrative support to clinical services. Often behind the scenes and unseen by the public, 398 whole time equivalent staff work to provide clinic reception, case note library facilities, outpatient booking systems, clinical coding and other administrative functions.

Great emphasis is placed on ensuring the systems are accurate and that patient records are ready and available for when the patient attends. The service regularly monitors its performance and a recent three month long audit of case note availability showed that in over 99.9 percent of occasions, case notes are made available prior to the patient’s appointment or treatment.

The medical records staff have had to embrace considerable change since the creation of the Trust. They have played an essential role in the redesign of the Trust’s booking processes, and have assisted in the implementation of a single Patient Administration System (PAS). A health records strategy has been published that will guide the department to further improvement over the coming 12 to 18 months.

Accessing national funding
Bids for funding from various sources within the NHS have been developed and submitted by the modernisation team on behalf of the Trust. This has resulted in an additional £287,000 being allocated to the Trust in order to improve services to patients. This funding will directly impact on patient care and will involve seeking the views of patients and carers on the services that the Trust provides.
The division of surgery met its performance targets for the year 2003/04. This meant that the longest wait for an operation at the end of this period was nine months, although almost all patients were actually operated on within six months of being listed.

For patients awaiting an outpatient consultation, by the end of this year, no patient waited more than seventeen weeks, and in practice very few wait more than thirteen weeks for an outpatient consultation.

This excellent progress moves the Trust towards the NHS Plan targets for 2005, which aim for a maximum inpatient waiting time of six months and a maximum outpatient waiting time of thirteen weeks.

This very high priority for the division was achieved through the upstanding and sustained efforts from the medical, nursing and support staff, in collaboration with the other divisions.

**Choice initiative**

Some of the additional activity required to meet these targets was obtained through the patient Choice initiative, whereby patients were offered the opportunity of shortening their wait for surgery by being referred to another hospital of their choice. Experience has shown that more than 50 per cent of patients elect to take this opportunity. This pattern can help inform general vision for the future direction of service development, as most patients undergoing surgery say that short access times and high quality service are at least as important as local service.

**Additional medical staff**

In anticipation of the European Working Time Directive, which reduces the maximum time medical staff and others are allowed to work, funding has been found to strengthen the “junior” rotas in surgery so that during 2004 the duty rotas and shift patterns of doctors will enable us to have improved cover arrangements for patients.

The division is now looking towards creating better on call arrangements for the consultant surgeons so that their on call arrangements are less onerous and increasingly they are freed from routine work to manage emergencies when they are on duty during the day.

In addition, a seventh consultant urologist post has been funded to help reduce urology waiting lists.

**Developments and service improvements**

During 2003/4 the clinical area teams supported the achievement of corporate objectives with a range of developments across specialties.

A lead nurse was appointed in urology to co-ordinate, develop and improve services to patients. This has included the establishment of the erectile dysfunction service. Within gastroenterology, a nurse endoscopist was appointed, as was a trainee nurse colonoscopist.

At North Manchester General Hospital, the colorectal multidisciplinary team (MDT) was established to further improve services to patients with cancer. Head and neck MDTs have also been established at North Manchester and Fairfield General Hospitals.

Funding from the Strategic Health Authority enabled a nurse-led discharge project and pilot projects commenced in ophthalmology, orthopaedics and in endoscopy, in relation to
patients going home after endoscopic retrograde cholangio-pancreatography.

The division remains committed to developing the entire workforce through its support of the trainee assistant practitioner programme in orthopaedics, gastroenterology and theatres; advanced practitioners begin training in 2005.

Rochdale Infirmary theatres have been successful in a proposal to work in a national context with regard to the development of a surgical assistant role.

The division also supported the introduction of an orthopaedic discharge liaison nurse to accelerate the post-operative discharge of patients and improve patient access to the orthopaedic inpatient service. This scheme was positively evaluated and demonstrated a significant reduction in orthopaedic length of stay for the duration of the pilot. The success of this pilot has allowed an extension of funding to support the scheme in 2004/05. In addition, processes and systems to support the physical pre-operative assessment and telephone pre-procedure screening of patients have been consolidated.

The division, through the clinical area teams structure, continues to work with patients and colleagues in primary care. The ophthalmology project group for the capital development on the Rochdale site underscores the division’s commitment to patient public involvement, with patient representation on the group. The services across Rochdale, Oldham, Bury and Heywood for diabetic retinopathy and glaucoma has expanded and a nurse practitioner for the Tier 2 ENT/aural care project was appointed. The direct access dyspepsia service has continued to be a significant part of the primary care/secondary care portfolio with Bury PCT and agreement has been reached to develop a nurse triage system for gastroenterology patients at North Manchester. A percutaneous endoscopic gastrostomy service for patients requiring enteral feeding has been established at Fairfield.
In addition to the provision of obstetric, gynaecology and paediatric services, divisional teams have been heavily involved in a range of projects involving local, regional and national issues. Much of this has involved testing the views of patients, whether adults or children, and representative organisations, to ensure that a wide range of stakeholders are shaping the work of the division.

**Child protection**

One part of this work involved a local response to the recommendations of the Laming Report (Victoria Climbie Inquiry) and the Kennedy Inquiry, which investigated the above-average death rate of children undergoing heart surgery in Bristol. As a result, a north east sector multi-agency safeguarding board has been established, bringing together hospital and community-based health professionals who have responsibility for child protection issues.

The board is chaired by Dr Ruth Jameson, the division’s associate medical director, and has made steady progress towards introducing and harmonising best practice to safeguard vulnerable children. This work has included the appointment of Lesley Ingoe as Trust lead nurse for child protection. Lesley will be heavily involved in raising the awareness of all staff, across all divisions, on how best to protect children. This is not an issue simply for the women and children’s division because many staff from other divisions will become involved with caring for or treating children as part of more general work.

---

**Breast-feeding**

The division is also firmly committed to the promotion of breast-feeding, and this work has continued this year. Val Finigan, the Trust’s infant feeding co-ordinator, in collaboration with public health colleagues in primary care and midwives, is working to increase breast-feeding rates in line with Department of Health targets. A key aim of the division is to be recognised by UNICEF as a UK Baby Friendly Trust. As a consequence of these efforts, The Royal Oldham Hospital was re-awarded baby-friendly status by UNICEF this year.

**Children’s services**

There is widespread clinical recognition of the need to modernise Greater Manchester’s children’s services. Divisional staff were heavily involved in the service review carried out over the last year by the regional Children and Young People’s Network. Their work influenced the report of the Network Board that will go to formal public consultation later this year. (Copies of the report are now available from www.gmsha.nhs.uk/childrens).

While the review primarily had a paediatric focus, the Trust recognised that the recommendations would have implications for obstetrics, gynaecology and other services, so a range of working parties was set up, bringing together divisional staff from across the organisation.

These sub-groups looked at:

- children’s services (led by Dr Yemi Oluwole, consultant paediatrician, Rochdale Infirmary, and Chris Fallon, senior children’s nurse, Fairfield General Hospital);
- community and care at home (led by Dr Bratati Bose-Haider, consultant paediatrician, Fairfield General Hospital, and Yvonne Tunstall, senior children’s nurse, The Royal Oldham Hospital);
- gynaecology (led by Dr Janet Patrick, The Royal Oldham Hospital, and Mr Alan Russell, Fairfield General Hospital, consultant obstetricians and gynaecologists);
- midwifery-led units (led by Cathy Trinick, clinical midwifery manager and Viv Twomey, senior midwife, Fairfield General Hospital);
• neo-natal services (led by Dr Tony Tan, consultant paediatrician, North Manchester General Hospital and Jackie Blease, neo-natal intensive care unit Manager, Fairfield General Hospital);
• obstetrics (led by Miss Caroline Rice, North Manchester General Hospital and Miss Brigid Hayden, Fairfield General Hospital, consultant obstetricians and gynaecologists);
• divisional re-design (led by John Lindars, divisional director).

A key part of this work was to review services across all four sites, sharing best practice and making the delivery of services more effective. This work will continue through the coming year.

The division has had demonstrable success in engaging patients and the public in its work. User and carer views have been gathered via patient forums, satisfaction surveys and focus groups. Children’s views have been sought to help improve the clinical environment and to make their stay in hospital a better experience.

The National Commission for Health Improvement Young Persons’ Survey fed into this work, but also had broader implications. More than 400 questionnaires were returned from young people or parents of children who had been patients in the Trust’s hospitals.

National targets and staff effort

In addition, the division has met all its targets relating to activity and waiting times. There are now no patients waiting more than 17 weeks for their first outpatient appointment, and the division also performed well in relation to national cancer targets, with 100 per cent of patients referred with suspected gynaecological cancer being seen within two weeks.

The division’s highly-skilled staff remain its greatest asset. For example, the Trust has an accredited gynaecological oncologist, one of only two in Greater Manchester and Cheshire. This means that patients from Oldham and Tameside who require complex surgery and some chemotherapy can be treated locally.

This year also saw the formation of a governance team, consisting of two maternity risk managers and two practice development/governance facilitators, to help the division with its continual drive to increase standards. The maternity standards action plan and an audit programme are well developed, giving a firm foundation on which to build future work.
Financial overview

The following summary financial statements set out the performance of The Pennine Acute Hospitals NHS Trust for the financial year 2003/04.

The Trust has met all its financial duties:

- breakeven at the year-end;
- keep within our borrowing limit;
- stay within our capital allocations;
- make a 3.5% return on our assets.

The Trust was required, in 2003/04, to increase its efficiency and provide for cash savings as part of its annual uplift in income from local Primary Care Trusts (PCTs). Value for money reviews, eg procurement of goods and services, contributed to savings targets in the year.

In balancing its books, the Trust, with the approval of the Greater Manchester Strategic Health Authority, used capital budgets to the value of £7.0m to support revenue budgets.

The Trust will continue to pursue financial balance in the coming financial year and is currently drawing up plans to resolve its underlying recurrent deficit with local PCTs.

Better payments practice code

The non-NHS Trade Creditor Payment Policy of the Trust complies with both the CBI Prompt Payment Code and with Government Accounting Rules.

The Trust’s measure of compliance in 2003/04 was:

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total bills paid 2003/04</td>
<td>146,985</td>
<td>106,541</td>
</tr>
<tr>
<td>Total bills paid within target*</td>
<td>132,565</td>
<td>96,452</td>
</tr>
<tr>
<td>Percentage of bills paid within target*</td>
<td>90.19%</td>
<td>90.53%</td>
</tr>
</tbody>
</table>

* The target is to pay 100% of non-NHS trade creditors within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier.

There were no claims made by small businesses under the Late Payment of Commercial Debts (Interest) Act 1998.

Management and administration costs

The management costs for 2003/04 were £14,029,000 which equates to 3.6% of total income.

Income and expenditure

Operating Income

Operating income in 2003/04 amounted to £387,225,000. Income from activities was £346,840,000 with other operating income of £40,385,000.

Operating Expenditure

Operating expenses amounted to £376,831,000 and the largest element of this is the pay bill for our staff of £254,675,000. In 2003/04 the Trust employed 8,999 wte staff.
## Capital expenditure

In 2003/04 the Trust spent £10,957,000 on buildings, equipment and information technology, the main items being:

<table>
<thead>
<tr>
<th>Item</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stonehill Wards at Rochdale Infirmary</td>
<td>600</td>
</tr>
<tr>
<td>(Ventilation &amp; Clinical areas)</td>
<td></td>
</tr>
<tr>
<td>Education Dept - Fairfield</td>
<td>700</td>
</tr>
<tr>
<td>High Dependency Unit (HDU) - Fairfield</td>
<td>300</td>
</tr>
<tr>
<td>Pharmacy - Fairfield</td>
<td>600</td>
</tr>
<tr>
<td>Information Technology</td>
<td>2,000</td>
</tr>
<tr>
<td>Medical &amp; Scientific Equipment</td>
<td>3,600</td>
</tr>
</tbody>
</table>

Future capital investment will continue to be directed towards medical equipment, streamlining services delivered by the Trust, and improving the information technology infrastructure.

## Codes of conduct and accountability

Full details of Directors’ remuneration is given on page 36.

## Remuneration and terms of reference committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Steven Price</td>
<td>Chairman</td>
</tr>
<tr>
<td>Mr John Battye</td>
<td>Non-executive director</td>
</tr>
<tr>
<td>Dr Ruth Boaden</td>
<td>Non-executive director</td>
</tr>
<tr>
<td>Mrs Carol Brooks</td>
<td>Non-executive director</td>
</tr>
<tr>
<td>Councillor Tim Pickstone</td>
<td>Non-executive director</td>
</tr>
<tr>
<td>Professor Anne Rogers</td>
<td>Non-executive director</td>
</tr>
<tr>
<td>Mrs Razia Shamim</td>
<td>Non-executive director</td>
</tr>
<tr>
<td>Mrs Anne Unwin</td>
<td>Non-executive director</td>
</tr>
</tbody>
</table>

## Register of declared interests

A register of declared interests is maintained by the Trust and is available for inspection on application to Mr C Appleby, chief executive. There are no company directorships held by directors of the Trust with companies who are likely to, or are seeking to, conduct business directly with the Trust.

## External auditors

The Trust’s Auditors are KPMG LLP. The cost of work performed by the auditor in respect of the 2003/04 reporting period was £220,000 relating to audit services and the requirements of the Audit Commission’s Code of Practice, ie the statutory audit and services carried out in relation to the statutory audit eg reports to the Department of Health.

## Statement on internal control

The Trust Board is accountable for internal control. As accountable officer, the chief executive of the Board, has responsibility for maintaining a sound system of internal control that supports the achievements of the organisation’s policies, aims and objectives. The chief executive also has responsibility for safeguarding the public funds and the organisation’s assets for which he is personally responsible, as set out in the Accountable Officer Memorandum.

As a large acute Trust with a number of constituent stakeholder organisations, various arrangements and agreements are in place through which the Trust’s performance is monitored. These are set out in the full Statement of Internal Control along with an explanation of the purpose of the system of internal control, information on the capacity to handle risk, the risk and control framework and review of effectiveness.

The full statement is available on the Trust’s website (www.pat.nhs.uk). Alternatively, more information is available from the governance director at Trust Headquarters (address on back cover).
Summary of financial statements
A summary of the Trust’s Annual Accounts for 2003/04 is set out on pages 32 to 36. A full set of accounts is available on request from my office. In addition it should be noted that to comply with legislation governing charities, a separate set of Annual Accounts is maintained for funds held on trust. A summary of the Trust’s Charity Accounts for 2003/04 is set out on pages 37. A full set of these accounts is also available on request from my office.

Mr R Chadwick, director of finance and IM&T
The Pennine Acute Hospitals NHS Trust, Headquarters, Westhulme Avenue, Oldham OL1 2PN

Independent Auditors’ Report to the Directors of The Pennine Acute Hospitals NHS Trust on the Summary Financial Statements
We have examined the summary financial statements set out on pages 32 to 36. This report is made solely to the Board of The Pennine Acute Hospitals NHS Trust in accordance with Section 2 of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to The Pennine Acute Hospitals NHS Trust’s Board 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 Pennine Acute Hospitals NHS Trust and The Pennine Acute Hospitals NHS Trust’s Board, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors and Auditors
The directors are responsible for preparing the Annual Report. Our responsibility is to report to you our opinion on the consistency of the summary financial statements with the statutory financial statements. We also read the other information contained in the Annual Report and consider the implications for our report if we become aware of any misstatements or material inconsistencies with the summary financial statements.

Basis of opinion
We conducted our work in accordance with Bulletin 1999/6 ‘The auditor’s statement on the summary financial statements’ issued by the Auditing Practices Board for use in the United Kingdom.

Opinion
In our opinion the summary financial statements are consistent with the statutory financial statements of the Trust for the year ended 31 March 2004 on which we have issued an unqualified opinion.

Date: 16 August 2004
KPMG LLP
St James Square, Manchester, M2 6DS, United Kingdom

Notes
1 The maintenance and integrity of The Pennine Acute Hospitals NHS Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements or audit report since they were initially presented on the web site.

2 Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.
# Income and Expenditure Account for the Year Ended 31 March 2004

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income from activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuing operations</td>
<td>346,840</td>
<td>333,573</td>
</tr>
<tr>
<td><strong>Other operating income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuing operations</td>
<td>40,385</td>
<td>42,137</td>
</tr>
<tr>
<td><strong>Operating expenses:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuing operations</td>
<td>(376,831)</td>
<td>(358,942)</td>
</tr>
<tr>
<td><strong>Operating Surplus (Deficit)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuing operations</td>
<td>10,394</td>
<td>16,768</td>
</tr>
<tr>
<td>Cost of fundamental reorganisation/restructuring</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Profit/(loss) on disposal of fixed assets</td>
<td>1,713</td>
<td>(59)</td>
</tr>
<tr>
<td><strong>Surplus (Deficit) before Interest</strong></td>
<td>12,107</td>
<td>16,709</td>
</tr>
<tr>
<td>Interest receivable</td>
<td>728</td>
<td>428</td>
</tr>
<tr>
<td>Interest payable</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other finance costs – unwinding of discount</td>
<td>(296)</td>
<td>(24)</td>
</tr>
<tr>
<td>Other finance costs – change in discount rate on provisions</td>
<td>(1,482)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Surplus (Deficit) for the Financial Year</strong></td>
<td>11,057</td>
<td>17,113</td>
</tr>
<tr>
<td>Public Dividend Capital dividends payable</td>
<td>(10,831)</td>
<td>(17,103)</td>
</tr>
<tr>
<td><strong>Retained Surplus (Deficit) for the Year</strong></td>
<td>226</td>
<td>10</td>
</tr>
</tbody>
</table>
## Balance Sheet as at 31 March 2004

<table>
<thead>
<tr>
<th></th>
<th>31 March 2004 £000</th>
<th>31 March 2003 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fixed Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intangible assets</td>
<td>1,269</td>
<td>283</td>
</tr>
<tr>
<td>Tangible assets</td>
<td>325,255</td>
<td>311,515</td>
</tr>
<tr>
<td>Investments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>326,524</td>
<td>311,798</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stocks and work in progress</td>
<td>6,973</td>
<td>4,339</td>
</tr>
<tr>
<td>Debtors</td>
<td>19,378</td>
<td>20,477</td>
</tr>
<tr>
<td>Investments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>1,088</td>
<td>1,112</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>27,439</td>
<td>25,928</td>
</tr>
<tr>
<td><strong>Creditors:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amounts falling due within one year</td>
<td>(25,488)</td>
<td>(30,822)</td>
</tr>
<tr>
<td><strong>Net Current Assets (Liabilities)</strong></td>
<td>1,951</td>
<td>(4,894)</td>
</tr>
<tr>
<td><strong>Total Assets Less Current Liabilities</strong></td>
<td>328,475</td>
<td>306,904</td>
</tr>
<tr>
<td><strong>Creditors:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amounts falling due after more than one year</td>
<td>0</td>
<td>(129)</td>
</tr>
<tr>
<td><strong>Provisions for Liabilities and Charges</strong></td>
<td>(12,294)</td>
<td>(8,723)</td>
</tr>
<tr>
<td><strong>Total Assets Employed</strong></td>
<td>316,181</td>
<td>298,052</td>
</tr>
<tr>
<td><strong>Financed by:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Taxpayers Equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital</td>
<td>253,376</td>
<td>260,202</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>60,896</td>
<td>37,985</td>
</tr>
<tr>
<td>Donated Asset reserve</td>
<td>3,597</td>
<td>3,613</td>
</tr>
<tr>
<td>Government grant reserve</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other reserves</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Income and expenditure reserves</td>
<td>(688)</td>
<td>(3,748)</td>
</tr>
<tr>
<td><strong>Total Taxpayers Equity</strong></td>
<td>316,181</td>
<td>298,052</td>
</tr>
<tr>
<td>Description</td>
<td>2003 / 2004 £000</td>
<td>2002 / 2003 £000</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Surplus (deficit) for the financial year before dividend payments</td>
<td>11,057</td>
<td>17,113</td>
</tr>
<tr>
<td>Fixed asset impairment losses</td>
<td>(927)</td>
<td>0</td>
</tr>
<tr>
<td>Unrealised surplus (deficit) on fixed asset revaluations/indexation</td>
<td>26,899</td>
<td>38,684</td>
</tr>
<tr>
<td>Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed assets</td>
<td>133</td>
<td>188</td>
</tr>
<tr>
<td>Reductions in the donated asset and government grant reserve due to the depreciation, impairment and disposal of donated and government grant financed assets</td>
<td>(376)</td>
<td>(354)</td>
</tr>
<tr>
<td>Additions (reductions) in ‘other reserves’</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total recognised gains and losses for the financial year</td>
<td>36,786</td>
<td>55,631</td>
</tr>
<tr>
<td>Prior period adjustment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pre 1995 early retirement</td>
<td>0</td>
<td>(4,087)</td>
</tr>
<tr>
<td>- Other</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total gains and losses recognised in the financial year</td>
<td>36,786</td>
<td>51,544</td>
</tr>
</tbody>
</table>
## Cash Flow Statement for the Year Ended 31 March 2004

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Operating Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net cash inflow (outflow) from operating activities</td>
<td>24,092</td>
<td>37,740</td>
</tr>
<tr>
<td><strong>Returns on Investments and servicing of Finance:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest received</td>
<td>686</td>
<td>433</td>
</tr>
<tr>
<td>Interest paid</td>
<td>0</td>
<td>(24)</td>
</tr>
<tr>
<td>Interest element of finance leases</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net cash inflow (outflow) from returns on investments and servicing of finance</td>
<td>686</td>
<td>409</td>
</tr>
<tr>
<td><strong>Capital Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payments to acquire tangible fixed assets</td>
<td>(8,974)</td>
<td>(15,686)</td>
</tr>
<tr>
<td>Receipts from sale of tangible fixed assets</td>
<td>4,787</td>
<td>265</td>
</tr>
<tr>
<td>(Payments to acquire)/receipts from sale of intangible assets</td>
<td>(900)</td>
<td>0</td>
</tr>
<tr>
<td>(Payments to acquire)/receipts from sale of fixed asset investments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net cash inflow (outflow) from capital expenditure</td>
<td>(4,907)</td>
<td>(15,421)</td>
</tr>
<tr>
<td><strong>Dividends Paid</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Payments to acquire)/receipts from sale of liquid resources</td>
<td>(10,831)</td>
<td>(17,103)</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) before management of liquid resources and financing</td>
<td>9,040</td>
<td>5,625</td>
</tr>
<tr>
<td><strong>Management of Liquid Resources</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchase of investments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sale of investments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net cash inflow (outflow)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>from management of liquid resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net cash inflow (outflow) before financing</td>
<td>9,040</td>
<td>5,625</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital received</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Public dividend capital repaid (not previously accrued)</td>
<td>(5,843)</td>
<td>(4,111)</td>
</tr>
<tr>
<td>Public dividend capital repaid (accrued in prior period)</td>
<td>(3,221)</td>
<td>(1,453)</td>
</tr>
<tr>
<td>Loans received</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loans repaid</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other capital receipts</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Capital element of finance lease rental payments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cash transferred from/to other NHS bodies</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net cash inflow (outflow) from financing</td>
<td>(9,064)</td>
<td>(5,564)</td>
</tr>
<tr>
<td>Increase (decrease) in cash</td>
<td>(24)</td>
<td>61</td>
</tr>
</tbody>
</table>
Salary and Pension entitlements of senior managers

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Commenced</th>
<th>Age</th>
<th>Salary</th>
<th>Other remuneration</th>
<th>Golden hello/compensation for loss of office</th>
<th>Benefits in kind</th>
<th>Real increase in pension at age 60</th>
<th>Total accrued pension at age 60 as at 31.03.03</th>
</tr>
</thead>
<tbody>
<tr>
<td>C Appleby</td>
<td>Chief Executive</td>
<td></td>
<td>48</td>
<td>135 - 140</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>45 - 50</td>
</tr>
<tr>
<td>R Chadwick</td>
<td>Director of Finance and IM&amp;T</td>
<td></td>
<td>46</td>
<td>100 - 105</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>35 - 40</td>
</tr>
<tr>
<td>R Glew</td>
<td>Medical Director</td>
<td>ceased 15.02.04</td>
<td>57</td>
<td>115 - 120</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2.5 - 5</td>
<td>45 - 50</td>
</tr>
<tr>
<td>D Houghton</td>
<td>Director of Nursing</td>
<td></td>
<td>46</td>
<td>90 - 95</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>35 - 40</td>
</tr>
<tr>
<td>A Moran</td>
<td>Director of Planning &amp; Performance</td>
<td>ceased 01.06.03</td>
<td>52</td>
<td>15 - 20</td>
<td>0</td>
<td>cw</td>
<td>0</td>
<td>0</td>
<td>35 - 40</td>
</tr>
<tr>
<td>R Tyndall</td>
<td>Director of Human Resources</td>
<td></td>
<td>45</td>
<td>100 - 105</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5 - 7.5</td>
<td>35 - 40</td>
</tr>
<tr>
<td>J Wilkes</td>
<td>Director of Facilities</td>
<td></td>
<td>46</td>
<td>90 - 95</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.25</td>
<td>15 - 20</td>
</tr>
<tr>
<td>K James</td>
<td>Director of Modernisation &amp; Performance</td>
<td>comm 12.06.03</td>
<td>42</td>
<td>70 - 75</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5 - 7.5</td>
<td>20 - 25</td>
</tr>
<tr>
<td>S Price</td>
<td>Chairman</td>
<td></td>
<td>52</td>
<td>20 - 25</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>J Battye</td>
<td>Non Executive Director</td>
<td></td>
<td>58</td>
<td>5 - 10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>R Boaden</td>
<td>Non Executive Director</td>
<td></td>
<td>43</td>
<td>5 - 10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C Brooks</td>
<td>Non Executive Director</td>
<td></td>
<td>39</td>
<td>5 - 10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>T Pickstone</td>
<td>Non Executive Director</td>
<td></td>
<td>35</td>
<td>5 - 10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>R Shamim</td>
<td>Non Executive Director</td>
<td></td>
<td>60</td>
<td>5 - 10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>A Unwin</td>
<td>Non Executive Director</td>
<td></td>
<td>49</td>
<td>5 - 10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Prof A Rogers</td>
<td>Non Executive Director</td>
<td></td>
<td>46</td>
<td>5 - 10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

‘cw’ indicates that consent to disclose information was withheld.

During the year a director has left the Trust. The director has withheld consent to disclose any details.

Appointment of executive directors - All directors are appointed by the Board. Contracts are permanent and can be terminated by either party giving three months’ notice. Directors receive basic salaries only and no other benefits are payable. An inflation adjustment was paid in year on the recommendation of the Department of Health. The remuneration committee determines the remuneration for the directors.

Payments are made for professional indemnity insurance for officers and directors.
Charitable Funds

The Trust operates a registered charity called The Pennine Acute Hospitals NHS Trust General Charity (Charity Commission registration no 1050197).

People and organisations make donations to the Trust’s charity funds for many different reasons. Sometimes it is to mark gratitude for treatment, sometimes it is to support the service generally and sometimes it is to help remember a family member who worked for the Trust.

These donations range from donations of a few pounds up to six figure sums, but they are all equally welcome – and they are all put to good use. Last year the charity spent £801,000 during the year, mainly on patients or staff welfare and amenities.

The charity has the Trust Board as the corporate trustee and covers all of our hospitals - Fairfield General, Birch Hill, Rochdale Infirmary, North Manchester General and The Royal Oldham for any charitable purpose relating to the NHS.

The charity received income of £691,000 in the year 2003/04 comprising:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donations</td>
<td>£395,000</td>
</tr>
<tr>
<td>Legacies</td>
<td>£123,000</td>
</tr>
<tr>
<td>Investment Income</td>
<td>£173,000</td>
</tr>
</tbody>
</table>

Significant donations/legacies received were as follows:

Legacies from the estates of:

<table>
<thead>
<tr>
<th>Name</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nora Mellor Wallwork</td>
<td>£6,007</td>
</tr>
<tr>
<td>Sheila Douglas</td>
<td>£11,227</td>
</tr>
<tr>
<td>Henry F Wakeham</td>
<td>£59,083</td>
</tr>
<tr>
<td>Ethel Dransfield</td>
<td>£9,960</td>
</tr>
<tr>
<td>J Fitzpatrick</td>
<td>£10,000</td>
</tr>
<tr>
<td>Charles Mellveny</td>
<td>£7,199</td>
</tr>
</tbody>
</table>

Donations:

<table>
<thead>
<tr>
<th>Name</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>M Shepherd</td>
<td>£12,500</td>
</tr>
<tr>
<td>Hill Dickinson</td>
<td>£7,000</td>
</tr>
<tr>
<td>Hospital Saturday Fund</td>
<td>£5,300</td>
</tr>
<tr>
<td>AST Hempson</td>
<td>£10,000</td>
</tr>
<tr>
<td>Nottingham Clinic</td>
<td>£9,750</td>
</tr>
<tr>
<td>Pfizer Ltd</td>
<td>£5,000</td>
</tr>
<tr>
<td>Oldham Mayor’s Appeal</td>
<td>£7,500</td>
</tr>
</tbody>
</table>

Expenditure:

Major individual items of expenditure were:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upgrade SONOS Fusion Imaging Transducer</td>
<td>£8,720</td>
</tr>
<tr>
<td>Flow Sensor &amp; volumetric pump</td>
<td>£14,073</td>
</tr>
<tr>
<td>Cooler scalp PSC-2</td>
<td>£9,998</td>
</tr>
<tr>
<td>Mammography Viewer</td>
<td>£18,900</td>
</tr>
<tr>
<td>15 Electric Profiling Beds</td>
<td>£18,388</td>
</tr>
<tr>
<td>LIME Arts in hospitals project</td>
<td>£23,695</td>
</tr>
<tr>
<td>12 Lead Interpretative ECG Monitor Recorder and accessories</td>
<td>£8,567</td>
</tr>
<tr>
<td>Digital Imaging System CCU</td>
<td>£120,279</td>
</tr>
</tbody>
</table>

A full copy of the charity’s annual report and accounts is on the Trust’s website: www.pat.nhs.uk

Donations to The Pennine Acute Hospitals NHS Trust General Charity can be received at any of the hospitals’ cashiers’ offices, or more information is available by contacting our endowment accounting department on 0161 921 4986.
Trust Board Members

Mr Steven Price
Chairman

Mr Chris Appleby
Chief Executive

Mr Bob Chadwick
Director of Finance and IM&T

Dr Roger Glew
Medical Director

Ms Karen James
Director of Modernisation and Performance *

Mr Tom Wilders
Director of Strategic Planning *

Mr Roy Tyndall
Director of Human Resources

Mr John Wilkes
Director of Facilities

Mrs Marion Carroll
Director of Nursing ‡

Mrs Carol Brooks
Non-executive Director

Councillor Tim Pickstone
Non-executive Director

Mr John Battye
Non-executive Director

Dr Ruth Boaden
Non-executive Director

Professor Anne Rogers
Non-executive Director

Mrs Razia Shamim
Non-executive Director

Mrs Anne Unwin
Non-executive Director

* Mr Alan Moran, Director of Planning & Performance left 01.06.03
‡ Mrs Marion Carroll, Director of Nursing appointed 21.01.04, commenced 12.04.04

Associate directors: Mr Peter Conway, Mrs Jean Frankell, Mrs Jean Jones, Mrs Meg Langton
Pennine Acute is committed to continually improving its communications with patients and their families, staff, residents and stakeholder groups, whether these organisations are NHS, other statutory organisations or voluntary organisations.

The Trust formally adopted its communications strategy in February. This commits the Trust to continuing to develop two-way communication processes. A copy of this strategy is available on www.pat.nhs.uk or by contacting the communications team.

**PALS**

If you have a specific query about your treatment then you should initially discuss this with either your medical team or, if you prefer, you can contact the Patient Advice and Liaison Service officer at the hospital. These staff have a role in supporting patients to ensure that they get the information they need, and to help sort out any problems quickly. You can read more about their work on page 13 of this report.

The PALS team can also help if you have suggestions about how to improve services, or if you wish to pass on thanks to staff.

Their numbers are:

- Rochdale Infirmary/Birch Hill Hospital: ....................................01706 517354
- Fairfield General Hospital: ..................................................... 0161 778 2455
- North Manchester General Hospital: ......................................0161 720 2707
- The Royal Oldham Hospital: ...................................................0161 627 8678

**Patient and Public Involvement Forum**

Ten local people have been appointed to The Pennine Acute Hospitals NHS Trust Patient and Public Involvement Forum. It will be a key vehicle for raising awareness of the needs and views of patients and the public on health in the community. For more information contact Bev De Vere on telephone 0161 214 3900 or email: Gaddum@btconnect.com

**Key brief**

As part of its communications strategy, the Trust now produces a one-page external bulletin, which is issued after each Board meeting. This ‘key brief’ is a summary of the internal core brief, which is included in all team briefings. It gives information and updates on major issues involving the Trust. If you wish to receive free copies of the key brief then please contact Nicola Berry, communications administrator, on 0161 627 8707 or email: nicola.berry@pat.nhs.uk

**Annual report**

If you have thoughts, suggestions or comments about this report, and how we could improve it in future years, then please contact Lesley Holland, communications manager, on tel: 0161 627 8737 or email: lesley.holland@pat.nhs.uk

**Chief Executive**

Chris Appleby is the chief executive of the Trust. If you wish to contact him then please telephone 0161 627 8708 or write to The Pennine Acute Hospitals NHS Trust, Westhulme Avenue, Oldham OL1 2PN or email: chris.appleby@pat.nhs.uk.

**Website**

The Trust’s website is available at www.pat.nhs.uk and offers a wide range of information about the Trust and its work.