Central Manchester University Hospitals
NHS Foundation Trust

Annual Report and Accounts 2010/11

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Annual Report and Accounts – 2010/11.

Presented to parliament pursuant to Schedule 7,
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Contents

Mission Statement

The Trust aims to become the leading integrated health, teaching, research and innovation campus in the NHS and to position itself on an international basis alongside the major biomedical research centres, as part of the thriving city region of Manchester – with its strong emphasis on economic regeneration, science and enterprise.

We have three main organisational objectives, all of which we are committed to and working to improve:

1) Patient safety and clinical quality.
2) Patient and staff experience.
3) Productivity and efficiency.

Message from the Chairman and Chief Executive

Welcome to our third annual report as a Foundation Trust. We would like to begin this report by thanking our staff for all their hard work and dedication over the year.

One major event for our organisation was the transfer of around 1,400 staff members working in community services. The transfer took place on 1st April 2011 as part of the Government's Transforming Community Services (TCS) programme.

The aim of the national TCS programme is to secure greater effectiveness and efficiencies in community services so that they can provide modern personalised and responsive care of a consistently high standard.

In Manchester, community health services transferred from NHS Manchester (Manchester Primary Care Trust) and split across and merged into four main NHS organisations including our own.

The community services transferred to us included Adult Services (eg District Nursing) for the central Manchester area, along with Children's Services, Contraception and Sexual Health, Community Dentistry, and Learning Disabilities services for the whole of the city.

Our Quality Campaign, which was launched on 12th May 2009, goes from strength to strength with each of our divisions working hard to improve quality for patients within their wards and departments. The campaign focuses on many areas such as implementing, measuring, recognising and rewarding high quality standards thereby supporting one of our key objectives of improving patient safety and patient experience.

Following an inspection by the Care Quality Commission, we were pleased with their report which confirmed we are meeting all essential standards. Their report highlighted each standard and how we are performing against it. The following quote was detailed in the report: "Every person we spoke to said that they felt involved in their care and that they had no

complaints at all about any of the staff. People used words like "excellent" and "brilliant" to describe the staff and people were particularly complimentary about the nursing staff. One patient said that "nothing was too much trouble".

We are proud to be a member of the Manchester Academic Health Science Centre (MAHSC), which together with our Biomedical Research Centre status means that we are one of the leaders of medical research. Our vision is to be a leading global centre for the delivery of innovative applied health research and education into healthcare.

On 5th May 2011 the new £19 million Manchester Health Academy building was officially opened by Olympian Jonathan Edwards. This was the first NHS sponsored Health Academy. We are also pleased to report that a recent OFSTED assessment categorised this Academy School as 'good', an amazing achievement in such a short space of time.

Together with our co-sponsors Manchester City Council and The Manchester College, the Health Academy provides 600 places for 11-16 year olds with an additional 120 post 16 places. The Academy is also supported by the Manchester United Foundation who provide on site coaching for pupils.

The Trust, in partnership with Manchester City Council, The University of Manchester and Manchester Metropolitan University, are founders of 'The Corridor, Manchester'. The Corridor partnership based around Oxford Road has been formed to drive future economic growth and investment. The former Royal Eye Hospital is now under development to establish a state-of-the-art facility providing research, laboratory and business space.

Work continues in relation to our Carbon Reduction Management Plan. As a large organisation we are committed to reducing our emissions and ensuring that we use energy appropriately and efficiently thereby reducing our carbon footprint.

In the first part of 2011 our second series of 'Children's Hospital' was broadcast for 12 weeks on ITV1. This is a prime-time series, which achieves over 3 million viewers each week and features the work and staff of Royal Manchester Children's Hospital.

In these current challenging times with the impact of the financial and economic climate it is more important than ever to ensure that staff are engaged and informed about the organisation. Staff engagement sessions are held regularly whereby the Chief Executive and his Executive Director colleagues hold open briefings in each division providing up-dates on the national, regional and organisational direction. Additional sessions are also held with our consultant colleagues to ensure that the doctors at the forefront of our patient services are fully briefed and informed. It is not only an opportunity for staff to be up-dated but also a forum where they can raise any matters of concerns directly with the directors.

There have been many more developments and achievements which are highlighted throughout the report.

News and up-dates throughout the year can be found on our website (www.cmft.nhs.uk) and we are excited that we have just launched a new improved version of our website which is easier to navigate and provides more information for our patients and visitors.

We are indebted to our staff, without whom our achievements would not have been possible.

Peter W Mount CBE
Chairman

Mike Deegan
Chief Executive

Message from the Medical Director

Following the move into our new hospitals during 2009, the opening of the boulevard in 2010, running through the middle of the site has brought into sharp focus the real vision that went into the design and planning of the whole site. We have spent this last year concentrating on settling in and delivering high quality, safe care to all our patients.

Almost by definition, healthcare is a high risk area. Despite best efforts things do not always go as well as patients and staff would hope. Maintaining and improving patient safety is a primary concern for the organisation. As every hospital does, we are constantly seeking to reduce harm from patient safety incidents.

At the beginning of this year we set some ambitious targets for improvement in some specific areas, and I'm pleased to report we were able to achieve almost everything we set out to do. The Trust Quality Accounts set out all of these achievements in detail but some of the headlines include a marked reduction in the number of serious incidents even from the small number we had previously recorded; achieving the national standard of 90% of all patients being assessed for the risk of developing thrombosis whilst in hospital; significant reduction in problems with medication; greatly improved performance in the national stroke audit with our score better than the national average. We also learned that over an earlier period, we were the best performing hospital nationally in outcomes following bowel cancer surgery. All of these improvements are a reflection of the care and attention that staff pay to safety and to ensuring that they offer every patient their best effort every time.

We also set out to improve organ donation rates and with the support of our Organ Donation team, many more families felt able to discuss donation this year at a time of great sadness for themselves. As a result, more patients have benefited nationally from organ transplants. For our own transplant unit, over 200 transplant operations were carried out, more than in any previous year.

Our Undergraduate Medical Students have had an outstanding year, with our highest ever pass rate in finals. A number of students have won awards in presenting their work in national and international meetings. These results are a credit to them, to our Undergraduate Education staff and to all those who enthusiastically take on the teaching of the next generation of doctors. Feedback on our Postgraduate training programmes has again improved. The Foundation School at the Trust has received excellent feedback, and in most other areas, trainees report being very busy, but learning a lot. As ever there are always areas where we can improve, and the Education teams will continue to work with the University and the Deanery to meet emerging challenges.

We've continued to develop our research activities. The Manchester Biomedical Research Centre (BRC), a partnership between ourselves and The University of Manchester, has consistently been one of the better performing nationally funded BRCs, with better outputs per pound invested than most of the historically more generously funded Trusts in London and the Southeast. The numbers of high quality research publications, the grants won by our researchers, the numbers of patients who have entered into research trials, the numbers of young researchers gaining national recognition are all testament to the huge steps we've made over the last few years. We've attracted some impressive colleagues to further strengthen our research capability, and opened CADET, the Centre for Advanced Discovery and Experimental Therapeutics. The work that comes out of CADET will put us at the forefront of the discovery of new ways of treating common and uncommon diseases. We were also delighted to welcome ICON on site. ICON are an international trials company with whom we have worked for a number of years, ensuring high quality early trials in a safe environment within a hospital site.

Teams from the Trust have won national recognition for innovative developments in patient care. Dr Sandip Mitra and his team on the Renal Unit have been named overall winner in the Department of Health Innovation Challenge for their programme increasing the numbers of patients who need haemodialysis who can receive that in their own home. A number of other colleagues have gained recognition and funding to develop a range of exciting and innovative new ways of delivering treatment across a wide spectrum of areas.

I am sure 2011/12 will continue to present many challenges and I look forward to working with all our staff to again deliver improvements in standards across all areas. In the current challenging financial times, the safety of our patients and the quality of care we provide remains paramount.

I would like to take this opportunity to thank our staff and all of our partners involved in the delivery of care for their hard work and very much look forward to another successful year ahead.

Mr R C Pearson,
Medical Director

All about the organisation

Central Manchester University Hospitals NHS Foundation Trust came into being on 1st January 2009 following a successful application to become a Foundation Trust. We were previously known as Central Manchester and Manchester Children's University Hospitals NHS Trust which was established on1st April 2001 following the merger of Central Manchester Healthcare NHS Trust and Manchester Children's Hospitals NHS Trust.

Our Trust is located in Manchester, just two miles outside the city centre. It is the leading Trust for teaching, research and specialist services in the North West of England. We provide an extensive range of district general hospital services to the local population of 166,000 residents within central Manchester and tertiary and specialist services to patients from across the North West and beyond.

We are a centre of excellence for healthcare research with a long standing and extremely successful academic partnership with The University of Manchester. The success of this partnership now sees the Trust as one of a small number of organisations in England who have attained Biomedical Research Centre (BRC) status. We collaborate closely with other NHS organisations in Greater Manchester and have strong links with institutions within Manchester such as the City Council and across the North West and beyond.

The Trust is a large and very complex organisation. Cutting through all of this however is our continued focused attention on three themes, namely:

- Patient safety and clinical quality
- Patient and staff experience
- Productivity and efficiency

We are made up of five hospitals:

Manchester Royal Eye Hospital (MREH) provides secondary and tertiary care to residents of Greater Manchester and beyond. It provides an extensive range of services and facilities for both adults and children. These include the Emergency Eye Centre, Acute Referral Centre, Ophthalmic Imaging, Ultrasound Unit, Electrodiagnosis, Laser Unit, Optometry, Orthoptics, the state-of-the-art Manchester Eye Bank and Ocular Prosthetics.

Manchester Royal Infirmary (MRI) was formed in 1752. It had 12 beds and began in a small house in the city centre. We are now a large teaching hospital for Manchester University's Medical School, and a specialist regional centre for kidney and pancreas transplants, haematology and sickle cell disease. Our Heart Centre is a major provider of cardiac services in the region, specialising in cardiothoracic surgery and cardiology.

Royal Manchester Children's Hospital (RMCH) provides specialist healthcare services for children and young people throughout the North West, as well as nationally and internationally. The hospital sees 135,000 patient visits each year across a range of specialties including oncology, haematology, bone marrow transplant, burns, genetics, and orthopaedics.

Saint Mary's Hospital (SMH) was founded in 1790 and, over the years, has successfully developed a wide range of world class medical services for women, babies and children as well as a comprehensive Genetics Centre and an internationally recognised teaching and research portfolio. Our leading edge services are tailored both to meet the needs of the local population in Central Manchester and patients with complex medical conditions referred from other areas in the Greater Manchester conurbation, the North West and beyond.

University Dental Hospital of Manchester (UDH) is one of the major teaching hospitals in the UK, undertaking the training of postgraduate and undergraduate dental students, student dental nurses and hygienist therapists. In all, a dental team of around 300 staff work in the hospital.

Due to the large size of the organisation, the Trust is managed by grouping together those departments who work closely. These are called Divisions and are as follows:

- Children's (RMCH)
- Clinical and Scientific Services
- Ophthalmic (MREH)
- Dental
- Medicine and Community Services
- Saint Mary's Hospital
- Specialist Medicine
- Surgical
- Research & Innovation
- Corporate.

Quality Accounts

Statement on quality

from **Mike Deegan**, Chief Executive

I am pleased to confirm that the Board of Directors has reviewed this report and confirmed that it is a true and accurate reflection of our performance. Each month the Board reviews progress against quality standards and the information contained within the report draws from these. We remain firmly committed to ensuring the highest levels of patient safety and clinical quality and this is reflected in our three operational priorities which are:

- Patient safety and clinical quality
- Patient and staff experience
- Productivity and efficiency

Being able to set targets and monitor the impact of what we do is a fundamental part of our quality strategy. In addition to the national clinical targets on which we have reported for some time, we have a range of indicators covering the three domains of patient safety, clinical effectiveness and patient experience.

As reported last year we partake in the Strategic Health Authority Northwest Advancing Quality programme which routinely measures performance for a range of five clinical conditions:

- Acute myocardial infarction
- Coronary artery bypass grafting
- Hip and knee replacements
- Heart failure
- Community acquired pneumonia

In addition for this year Stroke has been added to this programme.

We have presented some of our results on this programme later in this report.

Last year we reported on the opening of the new healthcare and research facilities in June 2009. This year we are pleased to report the completion of the central boulevard which concluded the New Hospitals Development project in summer 2010.

Our Quality Campaign which was launched in 2009 continues to deliver improvements to the patient experience across the organisation. A number of these have been recognised in our 'We're Proud of You' staff awards scheme.

QUALITY CAMPAIGN
IMPROVING PATIENT EXPERIENCE

We are encouraging a culture in our hospitals where staff feel recognised and supported but also where poor performance is challenged and managed appropriately. We have introduced a visible celebration of success as local areas of priority are now being identified via our 'Change One Thing' initiative which encourages all staff to contribute to the quality agenda by raising issues which will improve the patient and staff experience within the Trust.

This annual report contains more information on quality and safety than ever before and I believe the information to be accurate to the best of my knowledge.

A Year of Quality
~ Focus on the Year 2010/11

We have delivered a number of key achievements through a series of Quality Improvement programmes

Key Achievements

- We have been registered to provide health care services by the Care Quality Commission
- Our Hospital Standardised Mortality Rate is 91.5, a reduction from 94.4 last year
- Cardiac arrests outside of critical care units reduced by 20%
- 95% of patients surveyed during Senior Leadership Walk Rounds said that they would be happy for a friend or relative to be treated at our Trust
- In 2008 we successfully maintained our Level 2 compliance against the NHS Litigation Authority Risk Management Standards. Since then we have been working towards our further assessment in November 2011 for Level 3 and have been further strengthening our systems and processes for the management of risk and delivery of safe care to our patients. Our Maternity services have maintained their Level 3 accreditation
- Serious harm from falls reduction of 80%
- The Board of Directors has revised its agenda to ensure that as a priority a significant part of its meetings are dedicated to reviewing Clinical Effectiveness and Quality issues. In 2009 we established a Quality Forum which has met monthly and has had a dedicated agenda to Quality Improvement in order to focus on the range of Quality Initiatives within the organisation
- We began Senior Leadership Walk Rounds in 2009 and have so far visited 83% of wards and departments.

Summary of Progress

Our focus on a range of priority areas has delivered significant improvements. These are summarised below and explained further under section 2 of this report.

	Achieved	*Almost Achieved*	*Behind Schedule*
Safety			
VTE (Venous Thromboembolism)	✓		
Risk Assessment	✓		
Acutely Unwell Adult	✓		
Falls	✓		
Preventable Harm	✓		
High Risk Medication			✗
Pressure Ulcers	✓		
Clinical Effectiveness			
Hospital Mortality	✓		
Infection Prevention	✓		
Stroke	✓		
Reliable Care		⊖	
Urgent Care	✓		
Patient Experience			
Improving Quality Programme (IQP)	✓		
Leadership Walk Rounds	✓		
Gathering Real Time Patient Feedback	✓		
National Priorities (CQUINS)		⊖	
Locally Set Priorities (CQUINS)		⊖	
Organ Donation	✓		
End of Life Care	✓		
Single Sex Accommodation	✓		

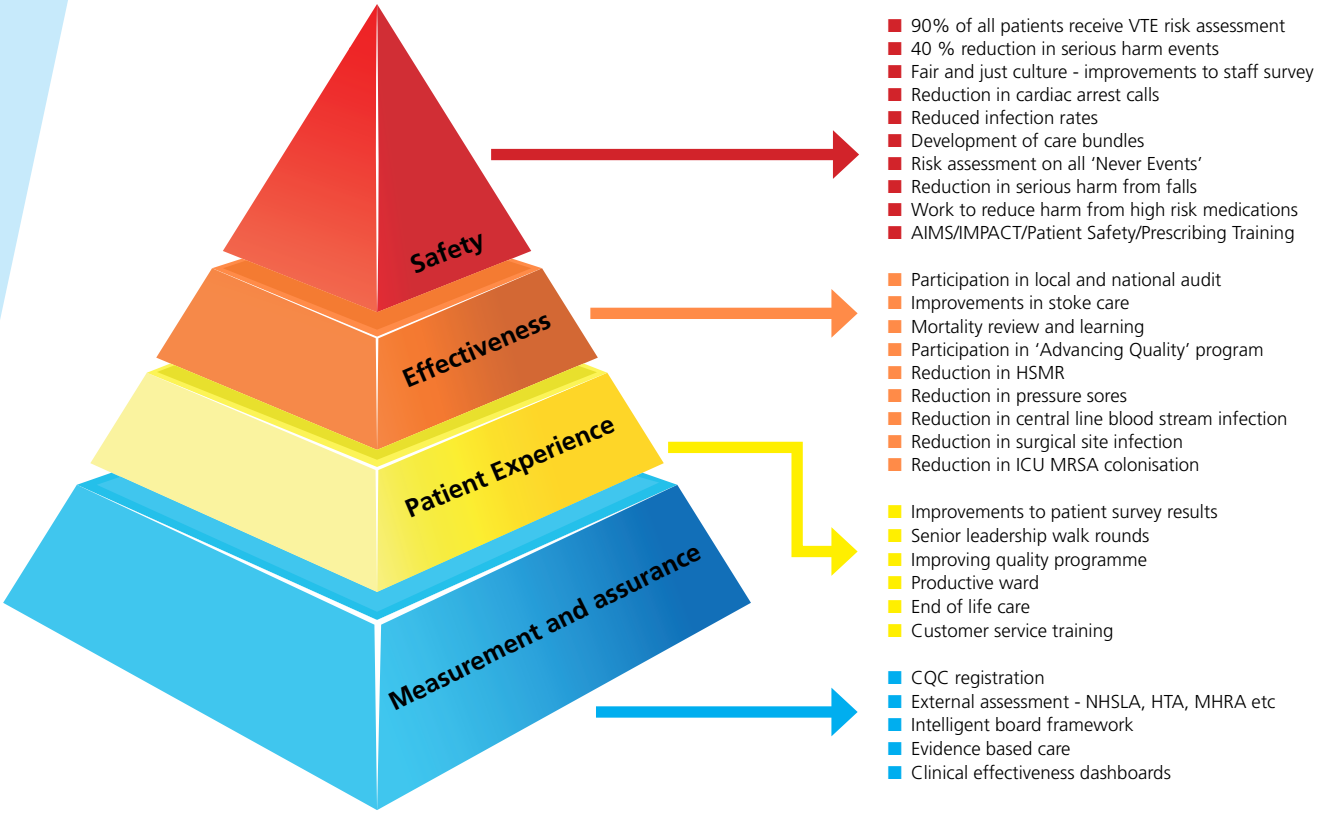
Priorities for Improvement and Statements of Assurance from the Board

Priorities for improvement ~ what do we want to improve?

We have a focused aim of improving the patient experience. A number of areas for improvement over a three year period have been identified and these have been grouped into three absolute priorities – care will be **Safe, Clinically and Cost Effective** and the **Patient Experience** will be a positive one. All of this will be underpinned by accurate systems of measurement and assurance which we will communicate to patients, staff and external stakeholders.

The programme of work is being delivered through a number of focused projects. The programme is designed to contribute to our overall success in the key areas.

The diagram below presents those key areas against some of the streams of work aimed to support them.



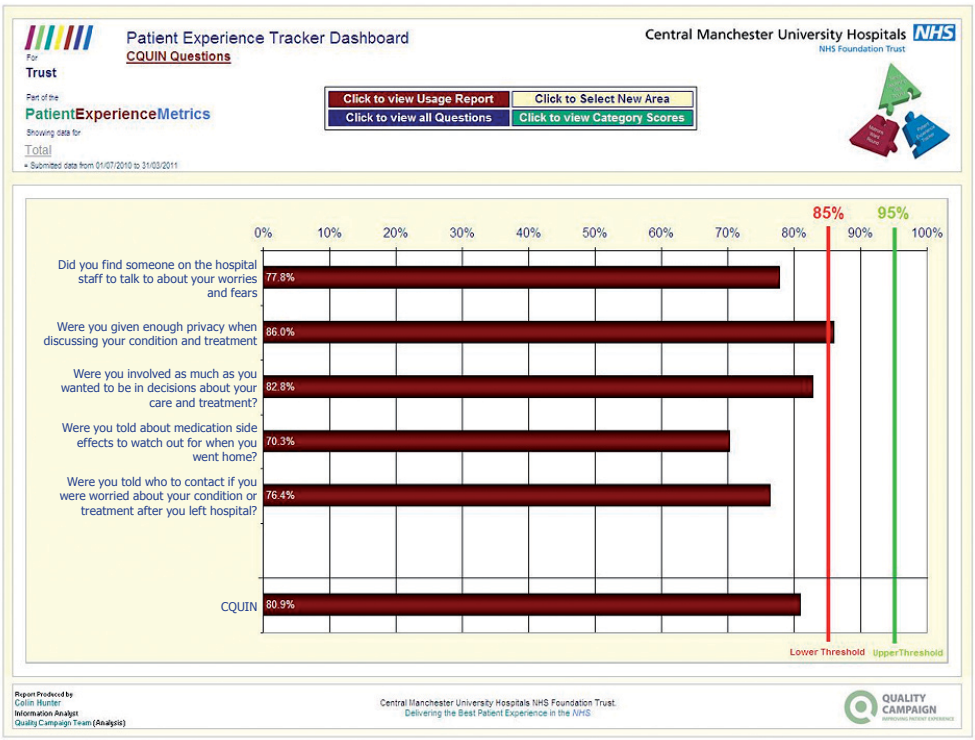
We use a range of quality improvement and measurement tools to measure and monitor our progress.

Patient experience - In the five areas focused on last year – nutrition, cleanliness, pain, communication, privacy and dignity - we have demonstrated improvements in all areas but one. The exception being nutrition where we have seen a slight deterioration in our overall performance based on the views of our patients and staff self assessment. The five areas will continue to be a focus for 2011/12 with particular attention applied to cleaning and nutrition. We will shortly launch our Cleaning Matters project which will highlight the importance of maintaining a clean environment and how this is everyone's responsibility.

As in 2010/11 we aim to further improve the experience of our patients by focusing on five key areas in line with the national CQUIN (Commissioning for Quality and Innovation) requirements. These are assessed annually as part of the National In-patient Survey Programme. The questions used and our results are as follows:

- Were you involved as much as you wanted to be in decisions about your care and treatment? (score moved from 86% in 2009/10 to 89% in 2010/11)
- Did you find someone on the hospital staff to talk to about your worries and fears? (score stayed at 80% for both years)
- Were you given enough privacy when discussing your condition and treatment? (score moved from 90% in 2009/10 to 89% in 2010/11)
- Did a member of staff tell you about medication side effects and what to watch for when you went home? (score moved from 52% in 2009/10 to 63% in 2010/11)
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? (score moved from 71% in 2009/10 to 75% in 2010/11).

These questions are measured together and given one total score. Overall the scores from the 2010/11 survey indicated a significant improvement. Work will continue this year to improve scores further.



The questions are incorporated into the patient feedback devices to ensure that the wards receive monthly data from patients to enable action to be taken to bring about improvements where required. Local targets have been set to drive improvements aiming to achieve a threshold of 85 – 95%.

Integration of community services - We aim to integrate a number of services from Manchester Community Health into the Trust and provide high quality safe care for the patients using those services.

A total of 45 community services have transferred to the organisation as of the 1st April 2011. These now form part of the Division of Medicine and Community Services and there are two specific Community Directorates within the Division – the Directorate of Adult and Specialist Community Services and the Directorate of Children's Community Services. Each of these Directorates has a senior leadership team comprising a Directorate Manager, Clinical Director, and Lead Nurse.

There is now a proposed one year development plan for all these services based on four main foundations, these being:

- **Function** – To clarify the function of services to deliver high quality care that meets the needs of patients, carers and practitioners in the future.
- **Integration** – To understand the integration of services, not only with other teams within the Trust but also primary care, social services, children's services at the council and other partners who provide care to Manchester people.

- **Transformation** – To transform services so that the workforce can ensure the care model is one that delivers care in the most appropriate and effective way for the future.
- **Form** – To ensure the form of services reflect the most appropriate organisational model for the future.

How have we prioritised our Quality Improvement Programme?

Our overall aim to improve the patient experience has involved improving quality across a wide range of areas in 2011/12. A number of these, and the reasons for their inclusion, are set out here. Some work streams will continue from 2010/11 and others are new for 2011/12.

The ability to bring about focused and sustained improvement is through the provision of strong executive leadership working to support and engage with staff at every level. Clinical champions work with teams to identify areas of improvement and implement changes to bring about sustainable improvement.

Through our Improving Quality Programme, ward teams are supported to take ownership of the changes that are required to be made to improve the quality of care for patients.

The patient healthcare journey does not end when they leave the doors of our hospitals and we are seeking to improve communication with our patients, their GPs and other healthcare staff on discharge. We want to ensure all patients have good information about their treatment and further support available and that any health care professionals know everything they need to continue to support the patients at home or in another care environment. This work is being led by senior clinicians from across the healthcare continuum.

We are also seeking to develop a number of 'care bundles', evidence based pathways for patients with specific conditions giving guidance to staff on the best treatment within set timescales. These bundles can be measured and have been proven to improve outcomes.

Supporting our Staff to Improve Quality

Our staff are key to the delivery of our quality plans. They have been supported in a variety of ways to become more skilled in quality improvement methodology. Some examples of training and support given are:

- Improving Quality Programme (IQP) - almost 500 individuals from ward teams trained in improvement methodology
- Three cohorts of staff have participated in the Quality, Innovation, Productivity and Prevention Programme (QIPP) of education gaining quality improvement skills and taking forward quality projects supported by the NHS Institute for Innovation and Improvement (NHSI)
- 1:1 consultation and support via Improvement Clinics
- Patient Safety Training (Human Factors Training)
- Senior managers engaged with NHSI leaders to develop own awareness and skills of improvement
- Acute Illness Management (AIMs) training provided for nursing and medical staff
- Prescribing compliance programme for junior medical staff
- Customer training programme.

Statements of assurance from the Board

The Board of Directors is assured that the priorities for quality improvement agreed by the Board are closely monitored through robust reporting mechanisms in each clinical division. Action plans are developed where performance becomes unsatisfactory and regular reports are received at the Board meetings and through the Board sub committees, for example the Clinical Effectiveness Committee and the Risk Management Committee. During 2010/11 we provided and/or sub-contracted the provision of all services set out as Mandatory Services under the Terms of Authorisation.

The Central Manchester University Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these NHS services. The information presented in the Intelligent Board Report covers a wide range of performance indicators for safety, clinical effectiveness, patient experience, performance and productivity and covers all services provided. This process enables all Board members to drill down and interrogate data to a local level when the need arises. Therefore all the services fundamentally involved in the generation of NHS service income in 2010/11 were subject to a review of quality data.

Quality Improvement Projects - What we set out to do in 2010/11 and what we achieved

Patient Safety Week 2010
15 - 21 November 2010

In November the Trust participated in National Patient Safety Week during which a number of initiatives were undertaken thanks to the support and hard work of the Divisional Governance and the Corporate Risk teams.

Patient Safety

Improving assessment and prevention of Venous Thromboembolism (blood clots which form within a vein):

What	To improve risk assessments for appropriate patients
How much	90% of patients to be risk assessed on admission to hospital
By When	End of March 2011
Outcome	90% of patients assessed
Progress	✓

Improvements Achieved

We aimed to improve our risk assessments for patients who were at risk of developing a blood clot in a vein and to ensure that at least 90% of those patients needing it had a full risk assessment recorded on admission to hospital. We are delighted to report that following a comprehensive programme of work across all areas this was achieved by the end of the year.

Further Improvements Identified

In 2011/12 we aim to reduce the incidence of thrombosis by a minimum of 20%.

- All clinical teams will continue their efforts in risk assessment
- Incidence of hospital acquired thrombosis (blood clots) will be investigated to understand what happened and how they can be avoided in the future
- Better patient information will be developed to make patients more aware of the risks and what they can do to protect themselves and work with staff.

Improving care for the Acutely Unwell Adult

What	To reduce potentially avoidable incidents and avoidable cardiac arrest calls
How much	By 20%
By When	By December 2010
Outcome	Reduction of 20%
Progress	✓

Improvements Achieved

The recognition and early appropriate response to the deteriorating patient is a nationally recognised safety issue.

- We continued with our programme of implementation of an electronic alert system of patient monitoring which now alerts doctors and nurses when there is a problem
- Use of the system reduced length of stay, cardiac arrests and Critical Care bed days
- The decision has been made to roll out this type of system across the entire organisation
- We are also using a number of tools including mortality review and an analysis of every emergency bleep call to understand what further improvements can be made in this area. These review processes are overseen by the Medical Director and themes are reported to the Board of Directors.

Further Improvements Identified

This has informed our programme of work for 2011/12 which will include work to improve the standard of clinical records and Patient Safety Training for all groups of staff.

In 2010 we won a Health Service Journal Patient Safety Award for this work and also the e-health insider award for best use of IT to promote patient safety.

Reduction in harm from falls

What	To reduce the serious harm caused to patients as a result of falls
How much	Year on year percentage reduction
By When	March 2011
Outcome	80% reduction in falls resulting in serious harm in 2010/2011 compared to 2009/2010
Progress	✓

The focus of this programme of work is to improve patient safety by ensuring that all in-patients have a risk assessment recorded on admission to hospital, actions are taken to prevent patients falling, and there is a reduction in the severity of harm if a patient falls.

Improvements Achieved

- Wards own their data in the form of quality dashboards which are refreshed monthly and displayed in each clinical area
- Falls risk assessment tool in place – audit of compliance for completion takes place
- Regular monitoring of patients identified as being at high risk of falling
- Increased involvement of relatives in managing the risk of falls including education on environment and appropriate footwear
- Reassessment after any change in condition of patient
- Action plan after a fall to prevent recurrence.

Further Improvements Identified

- To reduce overall the number of falls by 10% by March 2012
- Introduction of simplified risk assessment tool
- Patient and relative information leaflet to inform about risk reduction
- Review of the pilot areas who have introduced 'Intentional Rounding'*, seeking to spread learning and success across the organisation
- Identification of priority ward areas to enable targeted support and training
- All personal possessions within easy reach
- Bathroom needs are being addressed
- That the patient is comfortable and is not in any pain.

**Intentional Rounding encourages ward teams to check on all patients at least hourly. In doing this the aim is to decrease the need for patients who may be unstable to move unaided thereby reducing their risk of falls and improving the overall experience of our patients.*

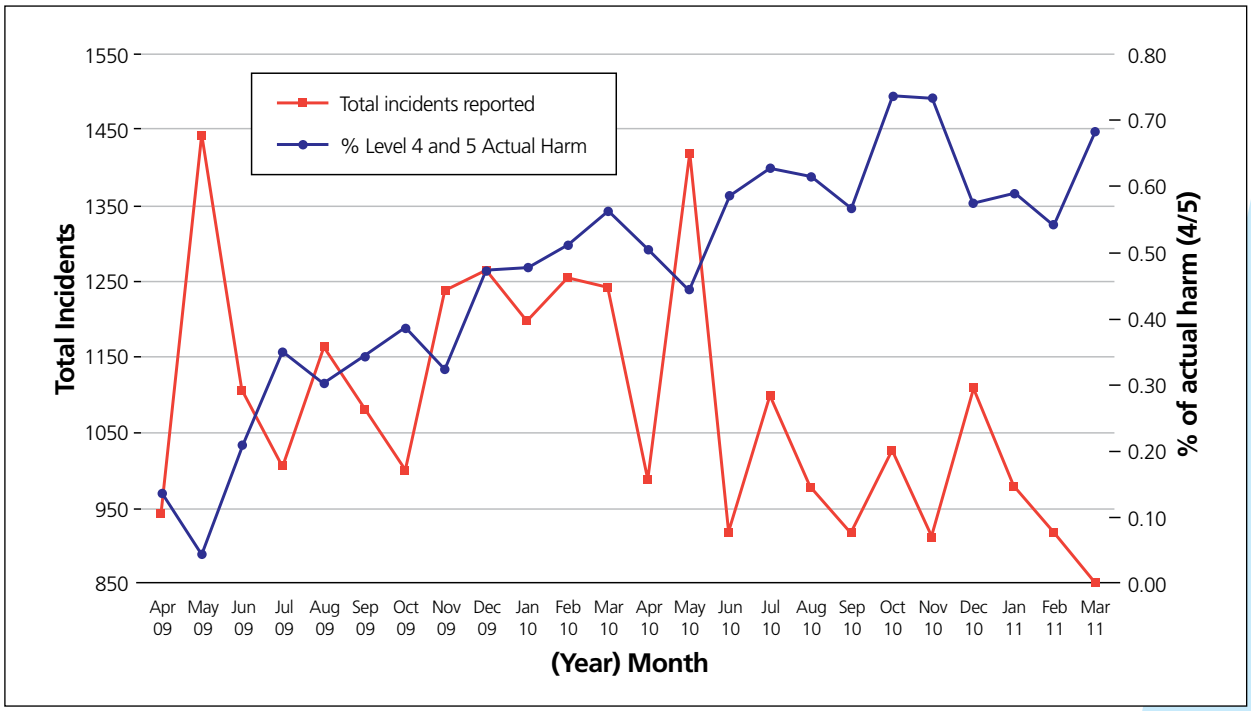
A reduction in the number of 'serious harm' patient safety incidents

What	Reduce the number of serious harm (those graded at level 4 or 5) incidents occurring
How much	Minimum of 20%
By When	During 2010/11
Outcome	41% reduction
Progress	✓

A number of patient safety initiatives have been taking place during the year and the combined effort of these indicate a 41% reduction in those incidents reported as serious harm.

Further Improvements Identified

We will continue this work through 2011/12 aiming to reduce these incidents year on year by a minimum of 10%.



High Risk Medication Safety

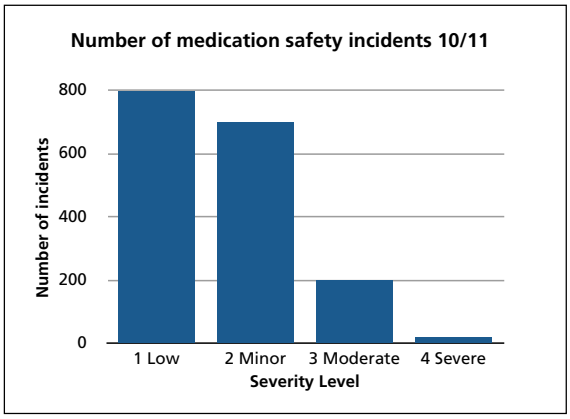
What	To reduce the number of serious errors relating to medication
How much	50% reduction in serious errors
By When	March 2011
Outcome	35% reduction in serious errors
Progress	✗

Improvements Achieved

- Medication errors account for 11% of all patient safety incidents reported nationally. Serious errors involving medication are a rare event but one that the Trust seeks to reduce substantially. In 2009/10 there were 14 serious medication related events and this reduced to 10 in 2010/11
- Whilst we have not fully achieved the desired 50% improvement against numbers of incidents reported in respect of high risk medications such as Insulin, there has been an improvement in the percentage of serious harm incidents. It is clear that more incidents are being reported and that the percentage of those resulting in serious harm is reducing
- A reduction in the number of incidents reported in relation to oxygen and antibiotic prophylaxis
- Improved systems for identifying and managing patients on Warfarin
- Junior doctors all now undertake a prescribing test as part of their induction. This needs to be passed before they can prescribe medications
- Implementation of protected medication rounds with administrative staff answering the phone during medication rounds
- Implementation of new medication trolleys that have drawers for each patient
- Pre medication pain rounds to ensure patients receive analgesia in a timely fashion
- Increased numbers of ward-based pharmacists to support clinical teams and patients
- Increased knowledge of nursing and medical staff through training and assessment
- A 10% increase in the numbers of medication safety incidents reported overall against a picture of a reduction in serious harm incidents indicates an improving reporting culture. The vast majority of these incidents were of low or minor harm as illustrated.

Further Improvements Identified

- To continue to improve reporting rates and reduce serious harm from medication errors by 10% each year
- A review of intravenous medications administration in the operating theatre
- Purchase of online monitoring system for prescribing assessment
- Safe medication projects in wards and departments
- Improved compliance process for medicines safety guidance and alerts
- Review of Children's in-patient medication chart
- Medication Safety programme for 2011/12 has been developed by the Medicines Safety Steering Group. Key work areas include:
  - Improving prescribing
  - Assessing prescribing error reviews
  - Improving Medicines Reconciliation on admission performance
  - Reducing frequency of delayed and omitted doses of time 'critical' medicines
  - Reducing dispensing errors



Pressure Ulcer Reduction

What	To reduce the number of grade 3 and 4 pressure ulcers
How much	25% reduction
By when	March 2011
Outcome	41% reduction achieved
Progress	✓

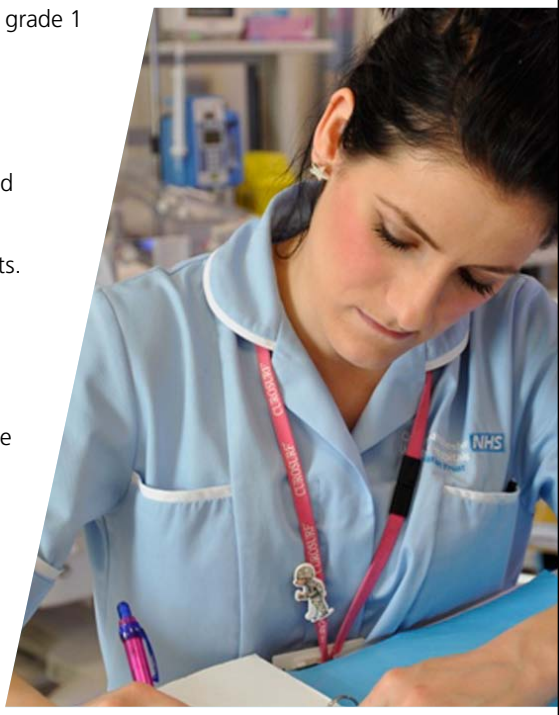
The acquisition of a pressure sore is a serious complication for any patient and is reported as a clinical incident. We aimed to have a zero tolerance approach to pressure sores and work closely with our Community partners in their prevention.

Improvements Achieved

- Prevalence of hospital acquired pressure ulcers reduced to 3%.
- Increased number of pressure area risk assessment completed within 6 hours of admission from 68% (May 2010) to 87% (March 2011).
- Pressure Ulcer Integrated Care Pathway implemented to ensure adequate assessment of patients at risk.
- Root Cause Analysis (RCA) tool developed to investigate all grade 3 and 4 pressure ulcers and to provide a framework for learning and focus resources.

Improvements Planned

- Promote earlier identification of grade 1 pressure ulcers, reducing the occurrence of grade 1 and 2 pressure ulcers.
- To achieve 95% of all patients pressure areas to be risk assessed within 6 hours of admission.
- Integration of community Tissue Viability Service promoting partnership working and reducing the number of community acquired pressure ulcers.
- Develop pressure ulcer policy including framework for safeguarding vulnerable adults.



Patient Safety Training

We have continued to implement a programme of patient safety training with over 450 staff attending in 2010/11. This training focuses on human factors in error and the prevention of harm. The course has proved extremely valuable and is well evaluated. The central message is:

"Error is inevitable, harm is not."

Over 700 staff have now had training in investigation and being open techniques which helps the organisation learn lessons when things go wrong. This enables us to share learning and provide explanation to patients and families who raise concerns.

Patient Safety Alerts

A new policy and procedure for managing National Patient Safety Alerts was implemented during the year which has resulted in improvements to the compliance within deadlines with none outstanding at the end of the year.

Information on patient safety and clinical quality is shared monthly throughout the organisation in our 'Lessons Learned' bulletin to which many staff contribute.

Clinical Effectiveness

Hospital Standardised Mortality Ratio (HSMR)

What	To reduce HSMR and have less than the expected number of deaths.
How much	HSMR total of less than 100
By When	March 2011
Outcome	91.5
Progress	✓

HSMR is a widely used national measurement which compares a hospital's actual number of deaths with its predicted number of deaths for certain conditions. The reduction calculation takes account of factors such as the age and sex of patients, their diagnosis, whether the admission was planned or an emergency.

The standard is 100, if the Trust has an HSMR of 100. This means that the number of patients who died is exactly as predicted. If the HSMR is above 100 this may mean that more people have died than would be expected, a HSMR below 100 may mean that fewer people than expected died. Every year in October this figure is adjusted based on the standardised benchmark so that the NHS expected figure is 100 - this may mean that the Trust figure will alter accordingly.

Improvements Achieved

- All areas review a proportion of deaths to ensure that the care and treatment given has been of the highest standard.
- We have, this year, developed a tool for review to ensure consistency of that process going forward.
- We have a Mortality Review Group chaired by an Associate Medical Director where good practice and lessons learned are shared.

Further Improvements Identified

We aim to end every year with less than the expected number of deaths = HSMR of less than 100.

Reducing MRSA bacteraemias (bloodstream infections)

What	To reduce the number of MRSA bacteraemias
How much	Year on year reduction
By when	March 2011
Outcome	12.5% reduction of cases from 2009/10
Progress	✓

Healthcare associated infection presents a significant problem to hospitals and contributes to patient morbidity and mortality (BMA 2006). The focus of the work was to reduce the harm caused to patients as a result of developing MRSA bacteraemia and a target was set to achieve the Vital Signs trajectory of 6 or less MRSA bacteraemias. Preventative measures were implemented for all hospital in-patients who screened MRSA positive.

The Trust has shown year upon year a reduction in cases of MRSA bacteraemias (MRSA in the blood). This year the actual number of bacteraemias was 7, which demonstrates a 12.5% reduction in cases from last year.

Improvements achieved

- Extended MRSA screening of all elective and emergency admissions.
- Investigation of all cases of MRSA bacteraemia jointly by the Division and Infection Prevention & Control Team.
- Identification of any gaps in practice and the creation of an action plan to address these.
- Provision of MRSA education to all disciplines of staff.
- Audit of the use of MRSA care pathways.

Further Improvements

- Continue to review practice to maintain the downward trend in MRSA bacteraemias.
- Focus on specific patient groups and teams to provide additional support and training.

Reducing Surgical Site Infection in patients undergoing Coronary Artery Bypass Surgery (CABG)

Developing a surgical site wound infection after surgery can have a significant effect on quality of life for a patient (NICE 2008).

What	To reduce surgical site wound infections
How much	To achieve an infection rate lower than the national benchmark
By When	March 2011
Outcome	A reduction from 10.5% in 2009/10 to 3.3% in 2010/11
Progress	

The focus of this programme was to reduce the numbers of patients developing a surgical site wound infection following Coronary Artery By-Pass Surgery. Voluntary surveillance of surgical site infections (CABG) began in January 2009. This involved collecting information which was then submitted to the Health Protection Agency who formulates reports allowing our infection rates to be compared to the national benchmark.

Improvements Achieved

- Appointment of a dedicated surveillance nurse for identifying infections.
- Additional patient and staff education.
- Regular microbiologist ward rounds.
- Monthly multi-disciplinary team meetings with ward medical and nursing staff, theatre staff and the Infection Prevention and Control Team.
- Introduction of a new wound integrated care pathway.
- Improved communication with GPs and district nurses.

Further Improvements

- To continue to review practice and instigate changes as necessary in line with the most up to date national guidance.
- Development of a website for community staff.

Clostridium difficile infection (CDI)

CDI causes serious illness and outbreaks can occur among hospital patients. Normally it affects the elderly, the debilitated and patients who have had antibiotic treatment (DH 2010).

What	To reduce the incidence of Clostridium Difficile infection
How much	Not to exceed 231 cases of Clostridium difficile infection (CDI) in all patients over the age of two years
By When	Full year 2010/11
Outcome	106 cases (54% below the maximum)
Progress	✓

Improvements achieved

- Improved compliance with antibiotic prescribing guidance.
- Each division within the Trust monitors antibiotic usage.
- Increased uptake of antibiotic e-learning teaching package.
- Joint microbiology and pharmacy ward round.

Further Improvements

- Trust wide audit of adherence to care pathway.

Stroke

What - The National Sentinel Stroke Audit is conducted by The Royal College of Physicians on behalf of the Intercollegiate Stroke Working Party and is centrally funded by the Healthcare Quality Improvement Partnership (HQIP). It monitors the rate of progress in stroke care services in England, Wales and Northern Ireland in a two year cycle.

In 2008 we received a score of 60% in the audit. This was a disappointing result and we have since embarked on a series of projects within stroke services to improve the overall quality of stroke services.

By When - The 2010 National Sentinel Stroke Audit was carried out between May and August 2010 with results available in March 2011.

Outcome - Stroke services received a score of 87% in the 2010 National Sentinel Stroke Audit. This was a marked improvement on the 2008 score and was above the national median score of 82%.

Improvements Achieved

There have been improvements in many areas of stroke care, including:

- The number of patients screened for swallowing disorders within the first 24 hours of admission.
- The number of patients receiving a brain scan within 24 hours of having a stroke.
- The number of patients being assessed by an Occupational Therapist within 4 working days of admission.
- The number of patients being assessed by a Physiotherapist within their first 72 hours of admission.
- The number of patients commenced on aspirin within 48 hours of having a stroke.
- The number of stroke patients treated in a Stroke Unit for at least 90% of their overall stay in hospital.

Progress ✓

Further Improvements Identified

We aim to continue this work and also improve care for patients in the community by having a minimum of 50% of stroke patients assessed by an Early Supported Discharge Service.

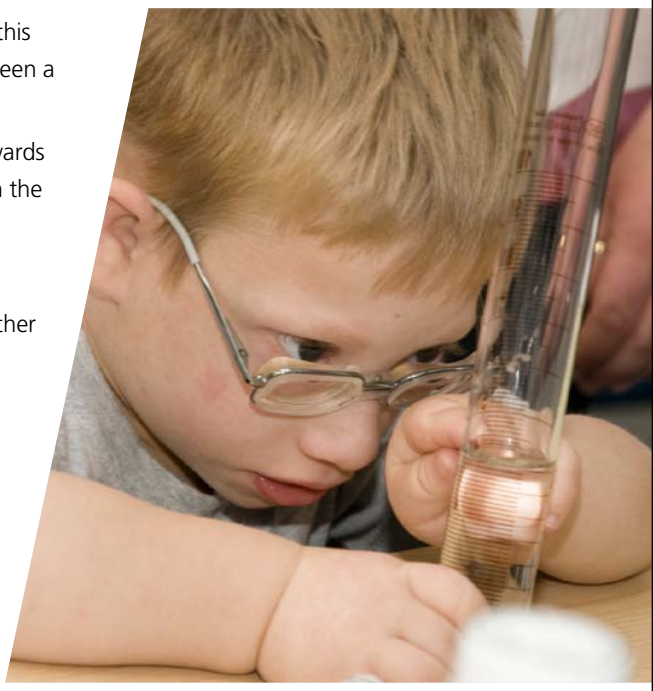
Reliable Care

We are participating in a region wide programme known as Advancing Quality (AQ). The aim is to record and report the level of compliance to a set of evidence based measures that experts have agreed all patients should receive.

What	To improve the quality of care received by patients with:
	Acute Myocardial Infarction ✓
	Coronary Artery Bypass Grafting (CABG) ✓
	Heart Failure ✗
	Community Acquired Pneumonia ⛔
	Hip and Knee Replacement ✓
	Stroke ✓
How much	To demonstrate year on year improvement
By When	By end of March 2011
Outcome	Improvements achieved in all but two indicators
Progress	⛔

Improvements Achieved

- Performance in CABG has been consistently high.
- A mandatory field has now been added to the Discharge summary letter; this encourages staff to give and record smoking cessation advice. There has been a notable improvement in this area.
- An AQ nurse has been appointed, who supports staff and patients in all wards involved in AQ and ensures the documentation for measures is recorded in the patients health records.



Further Improvements Identified

- To achieve scores which are in the top 25% when benchmarked against other organisations across all Advancing Quality categories for 2011/12.
- To improve the data collection for patient experience.
- Improving information for patients with Heart Failure on discharge, aiming to reduce the readmission rates for this group of patients.
- Work programme in A&E to improve the support of patients with pneumonia to ensure provision and documentation of antibiotics within 6 hours of admission.

Urgent Care

What	To ensure that patients wait less than 4 hours to be seen, discharged or treated within the Accident and Emergency Department
How much	98% of patients to achieve this standard from 1st April 2010 to 1st June 2010 and then subsequently at 95% for the remainder of 2010/11
Outcome	96.32% against this standard as of 31st March 2011
Progress	✓

Improvements Achieved

System and process improvements identified across the following areas:

- Emergency Department
- Medical Assessment Units
- Medical Wards
- Complex Discharge
- Bed Management

Further Improvements Identified

For 2011/12 there are 5 new Clinical Quality Indicators for Urgent Care. These are:

- Time to Initial Assessment
- Time to Treatment Decision
- Total Time in the Emergency Department
- Unplanned re-attendance to the Emergency Department within 7 days
- Left the Emergency Department without being seen

In order to facilitate an improved patient experience through the urgent care system, we will be continuing to make improvements across all areas but specifically focusing on the following three key priorities:

- The development of a rapid assessment and treatment model for the Emergency Department at Manchester Royal Infirmary.
- The development of an emergency acute medicine strategy and implementation plan.
- The implementation of new internal professional standards that support patient flow.

Patient Experience

Improving Quality Programme/Productive Ward

What To roll out sustainable quality improvements across wards

How much 100% of all ward areas

By When End March 2011

Outcome Project delivered across all ward areas

Progress ✓

The Improving Quality Programme (IQP) was developed and implemented across all in-patient wards across the Trust within 2010/11 in order to:

- **Standardise** ward environments and communication about patients, in particular around the time of shift handover.
- **Embed knowledge** within ward teams to review data, identify areas of concern and to use improvement methodology to achieve a better patient experience.
- **Align the Productive Ward methodology to normal business** thus ensuring a culture of continuous improvement.

Improvements Achieved

n% of In-patient wards (n=50) that:	Results	Progress
Completed IQP programme (approx 500 ward staff involved)	100%	✓
Implemented colour code standards in non-patient clinical areas	96%	✓
Implemented multi-disciplinary patient status at a glance communication boards as part of daily work	98%	✓
Implemented standardised shift handover	100%	✓
Completed programme with bronze, silver or gold awarded	90%	✓
Currently report greater than 50% of registered nurse time as being for direct patient care	86%	✓

- All wards have had an initial assessment and some have received reassessment.

Further improvements identified

- To continue to develop in-patient ward areas to enable all wards to work to achieving Gold Ward status.
- To roll out IQP programme to day case and other patient areas.
- To develop the assessment framework so that it incorporates a level of assurance along with Matrons' Ward Rounds and becomes a formal nursing accreditation process when awarding bronze, silver or gold.

Senior Leadership Walk Rounds

Leadership Walk Rounds commenced in 2009. These are led by members of the Executive along with a senior nursing lead. They aim to focus on the environment of care and patient and staff experience. All Executive Directors and Non-executive Directors take part in the Walk Rounds and around eight are completed each month.

Progress ✓

The aims of the Walk Rounds are:

- ASSURANCE - that there are continuous improvements to the quality and safety of service given.
- APPRECIATION - to demonstrate Senior Leaders' interest in valuing staff and patients.
- ACTION - to set the tone through role modelling and to support front line staff in delivering an excellent patient experience.

Improvements Achieved

- 146 Walk Rounds have been conducted since 2009.
- 83% of all wards/departments have been visited.
- Results of Walk Rounds profiled onto ward dashboards to give direct feedback.
- Governors involved in Walk Round process.
- Rapid action taken to address areas of concern identified.

Further Improvements Identified

- Modification of ward round rotas to ensure wider coverage of areas.
- Improved information to senior leaders to improve action planning.

Key Themes Identified

- Menu choice and provision.
- Design/maintenance of environment.

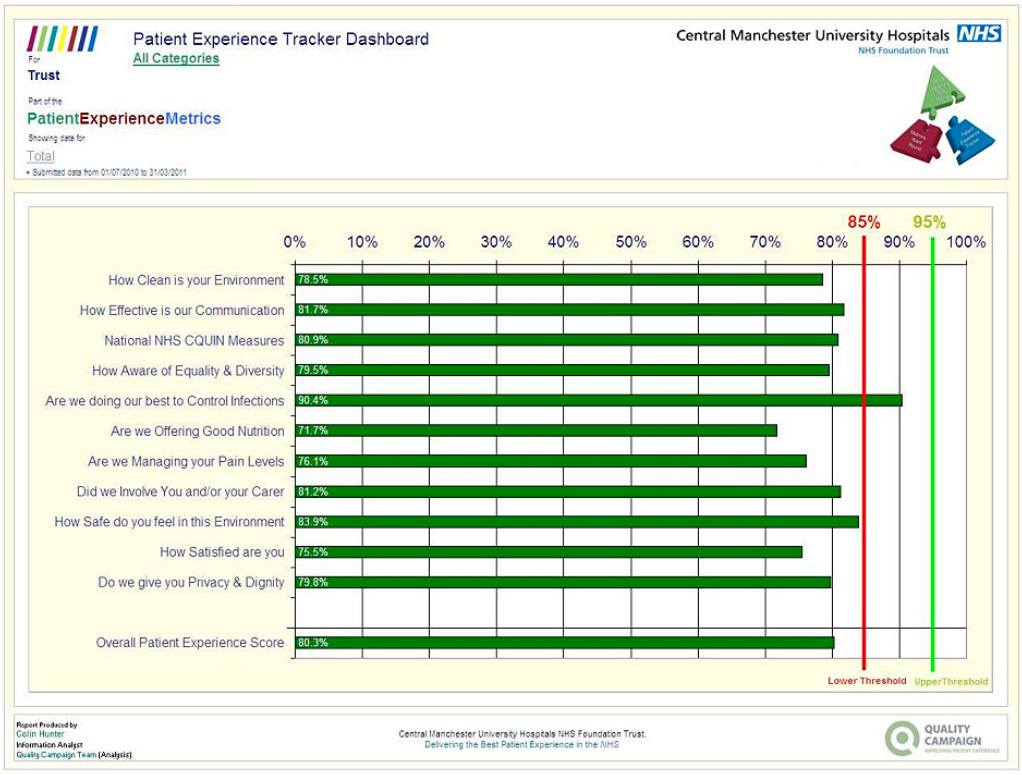
Local action plans are developed for each area assessed and fed back to the management teams.

Gathering Real Time Patient Feedback

What	To enable patients to give feedback on services at the point of their experience
How much	To have system available in all wards by end March 2011
Outcome	100% achieved
Progress	✓

Patient feedback devices have been introduced across every clinical area within the Trust. They are used to collect data at the time of the patient's experience and feedback is provided to the individual wards and areas, and this is profiled into the local area dashboard to enable review and performance management.

The feedback from patients is being used by Matrons alongside local teams to bring about change in the area where it is required and is an integral part of our Improving Quality Programme. Local targets have been set to drive improvements aiming to achieve a threshold of 85 – 95%.



Further Improvements Identified

- Work will continue to ensure that overall patient satisfaction scores are improved.
- Devices are being introduced into out-patient areas and departments to capture feedback from patients using these services.

Matrons' Ward Rounds

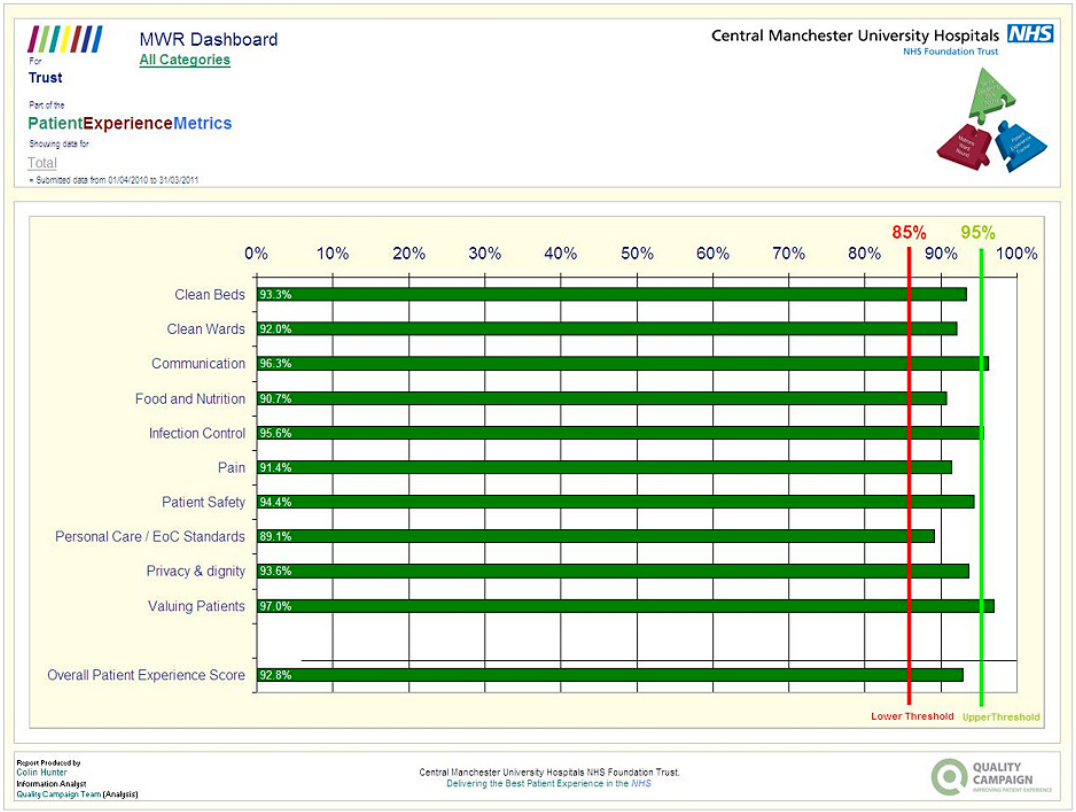
The Matrons' Ward Rounds have been in progress since January 2009 and are undertaken weekly in all clinical wards and departments. They aim to make clinical leaders more visible and enable them to engage actively in improving the environment of care and the experience of our patients. They focus on five main areas:

- Cleanliness
- Pain
- Nutrition
- Communication
- Privacy and Dignity

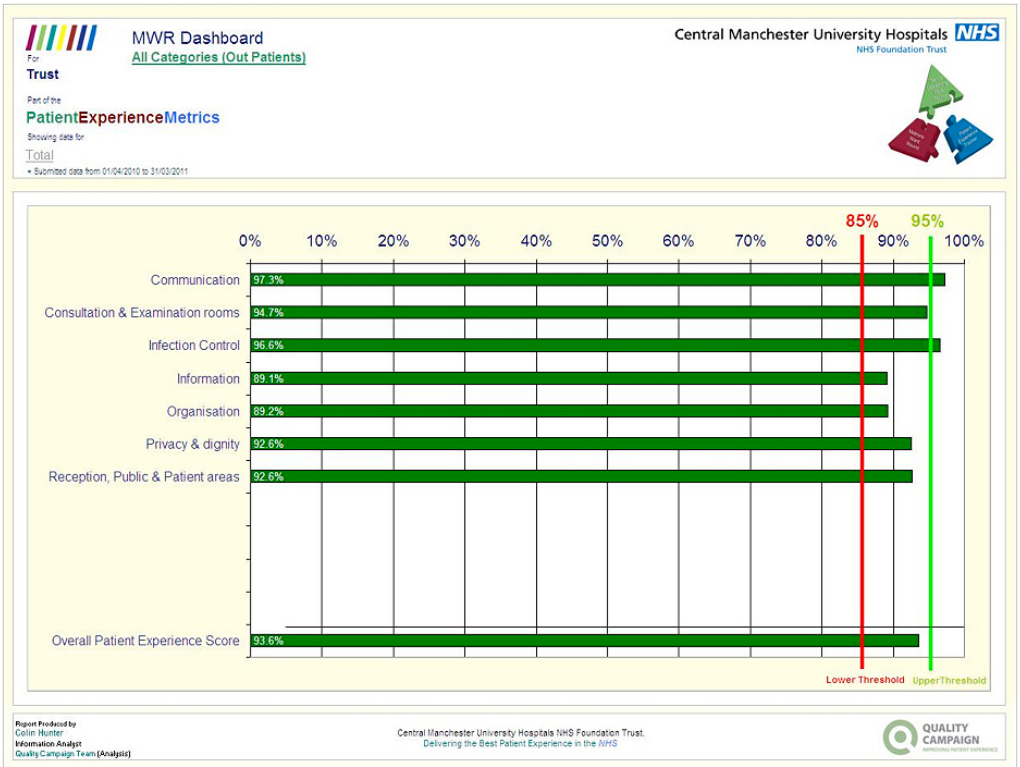
Improvements Achieved

- Across all in-patient and out-patient areas consistent improvement has been achieved in all areas assessed under the matrons ward rounds; however this year has seen a very slight deterioration in the scores for nutrition.
- Overall patient experience has been assessed at almost 93% and over 93% for out-patient services.

In-patients Matron Ward Round results



Out-patient Matron Ward Round results



Further Improvements Identified

- The matron ward round process has been completely redesigned for 2011/12. Ward managers will focus each month on a new 'Quality of Care Round' and will be supported by matrons to deliver on their action plans.
- Under the Improving Quality Programme, ward staff have been trained to use their own data to bring about changes which will improve the patient experience.

Organ Donation

What Increase in the numbers of referrals for Organ Donation

How much 50%

By When March 2011

Outcome 100% increase in referrals

Progress ✓

This work has been steered by a multi-disciplinary group which is chaired by one of the Governors and has benefitted 18 patients nationwide who have received transplanted organs from patients who have been admitted.

Further Improvements Identified

To continue to raise awareness, raise referral rates and ensure that all patients and families have the opportunity to discuss organ donation should they wish.

End of Life Care

What To increase compliance with usage of the Liverpool Care of the Dying Pathway (LCP)

How much To 40% of all in-patient deaths

By When August 2010-March 2011

Outcome Achieved 42.5% by the end of the year

Progress 

During 2010/11 efforts have been focused to improve end of life care ensuring that the use of the Liverpool End of Life Care Pathway is implemented in all adult in-patient areas. The End of Life Steering Group has led the revision and implementation of Version 12 of the Liverpool End of Life Care Pathway which provides staff with a framework for evidence based standards of care to improve the experience at end of life for patients and relatives.

We aimed to improve the use of the End of Life Care Pathway for patients identified as 'expected to die' and achieved the target of 40% of all in patient deaths having their care managed using the End of Life Care Pathway.

Improvements Achieved

- Implementation of Version 12 Liverpool Care of Dying Pathway.
- Increase in the use of End of Life Pathway by 12% in 6 months.
- 43% of patients being cared for on End of Life Pathway had preferred place of care identified.

Further Improvements Identified

- Revision of end of life pathway to reflect feedback from users.
- Project began with renal patients to improve discussions with patients in terms of end of life/limitations of treatment providing patients and families with informed choice.
- Communication project commenced to develop skills and knowledge of staff in relation to beginning discussions about end of life options and choice.

Providing Same Sex Accommodation

What Elimination of mixed sex accommodation

How much Provide 100% single sex compliant accommodation for patients.

By When March 2011

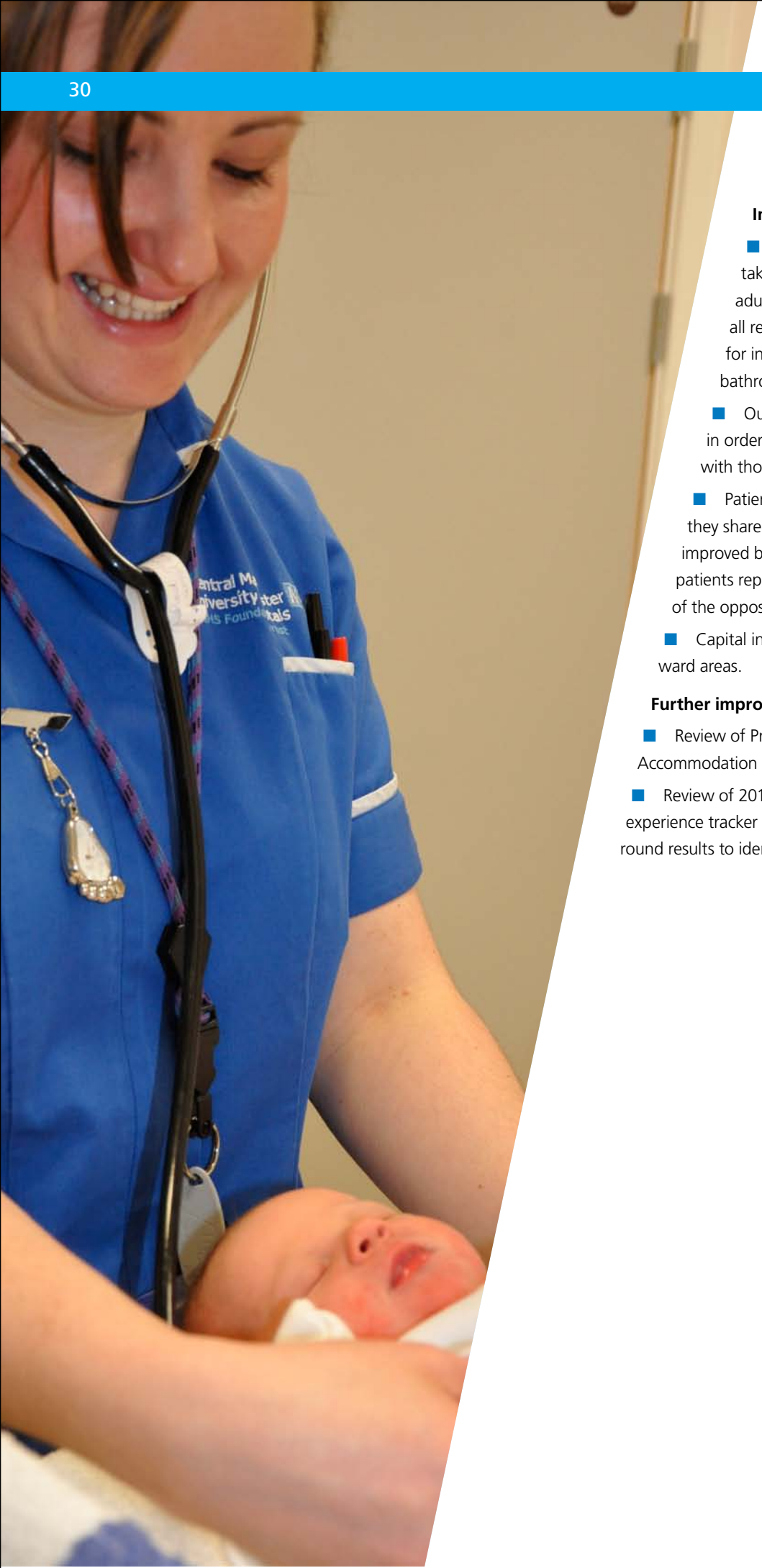
Outcome All adult in-patient wards are compliant.

Progress 

During 2010/11 we continued work on the provision of same sex accommodation and has declared compliance with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice.

We have the facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area.

Sharing with members of the opposite sex only happens when clinically necessary, for example where patients need specialist equipment such as in intensive care, coronary care unit, and recovery areas for immediate post operative period; or when patients actively choose to share for instance the renal units or Children's clinical areas where age appropriate care provision may override gender requirements.



Improvements Achieved

- Service reconfigurations have taken place to ensure 56% of our adult in-patient wards are single sex. In all remaining wards patients are cared for in single sex bays with dedicated bathroom facilities.
- Our endoscopy unit has single sex lists in order that patients do not have to wait with those of the opposite sex.
- Patient perception in relation to whether they shared mixed sex accommodation has improved by 1.4% in 2010/11 to 99% of patients report they did not share with patients of the opposite sex.
- Capital investment to refurbish identified ward areas.

Further improvements identified

- Review of Provision of Same Sex Accommodation policy.
- Review of 2010 in-patient survey results, patient experience tracker results and ward manager ward round results to identify areas for focus for 2011/12.

Learning from Clinical Audit to improve care

National Clinical Audit

During 2010/11 the Trust elected to participate in a number of the national clinical audits identified by the Healthcare Quality Improvement Partnership [HQIP].

National clinical audit is designed to improve patient outcomes across a wide range of conditions. Its purpose is to engage all healthcare professionals across England and Wales in systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care.

National clinical audit is divided into two main categories: snapshot audits [including patient data over a short, pre-determined period e.g. Sentinel Stroke Audit, Paediatric Asthma Audit] and those audits where data on every patient with a particular condition or undergoing specific treatment is included [e.g. Cancer audits and the National Hip Fracture Database].

A total of 55 audits are listed on the HQIP database. There are a number in which the Trust does not participate as the service is not provided in the Trust. Examples of these are adult mental health disorders, liver transplantation and chronic pain services.

During 2010/11 45 national clinical audits covered NHS services that we provide. In 2010/11 the Trust participated in 93% of national clinical audits.

The national clinical audits that we participated in during 2010/11 are as follows:

Ongoing Data Collection	Participated ✓ / ✗	Data Collection
Perinatal mortality (CEMACE - Centre for Maternal and Child Enquiries)	✓	In progress
Neonatal intensive and special care (NNAP - National Neonatal Audit Programme)	✓	In progress
Childhood epilepsy (Royal College of Paediatricians and Child Health National Childhood Epilepsy Audit)	✓	In progress
Paediatric intensive care (PICANet - Paediatric Intensive Care Audit Network)	✓	In progress
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	✓	In progress
Cardiac arrest (National Cardiac Arrest Audit)	✓	In progress
Adult critical care (Case Mix Programme)	✓	In progress
Potential donor audit (NHS Blood & Transplant)	✓	In progress
Hip, knee and ankle replacements (National Joint Registry)	✓	In progress
Elective surgery (National Patient Reported Outcome Measures Programme)	✓	In progress
Cardiothoracic transplantation (NHSBT UK Transplant Registry)	✓	In progress
Coronary angioplasty (National Institute of Cardiovascular Outcomes Research - Adult cardiac interventions audit)	✓	In progress
Peripheral vascular surgery (Vascular Society of Great Britain and Ireland - Vascular Surgery Database)	✓	In progress
Carotid interventions (Carotid Intervention Audit)	✓	In progress
Coronary Artery Bypass Graft and valvular surgery (Adult cardiac surgery audit)	✓	In progress
Acute Myocardial Infarction & other ACS (MINAP - Myocardial Ischaemic National Audit Project)	✓	In progress
Heart failure (Heart Failure Audit)	✓	In progress
Acute stroke (SINAP - Stroke Improvement National Audit Programme)	✓	In progress
Renal replacement therapy (Renal Registry)	✓	In progress

Ongoing Data Collection	Participated ✓ / ✗	Data Collection
Renal transplantation (NHSBT UK Transplant Registry)	✓	In progress
Patient transport (National Kidney Care Audit)	✓	In progress
Lung cancer (National Lung Cancer Audit)	✓	In progress
Bowel cancer (National Bowel Cancer Audit Programme)	✓	In progress
Head & neck cancer (DAHNO - Data for Head and Neck Oncology)	✓	In progress
Hip fracture (National Hip Fracture Database)	✓	In progress
Severe trauma (Trauma Audit & Research Network)	✓	In progress

The national clinical audits that we participated in and for which data collection was completed during 2010/11 are listed below alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the teams of that audit.

Snapshot Audits Completed During April 2010 - March 2011	Participated ✓ / ✗	Type of Audit	Target	N	%
Paediatric pneumonia (British Thoracic Society)	✓	Snapshot	All cases	47	100%
Paediatric asthma (British Thoracic Society)	✓	Snapshot	All cases	18	100%
Emergency use of oxygen (British Thoracic Society)	✓	Snapshot	All cases	8	100%
Pleural procedures (British Thoracic Society)	✓	Snapshot	All cases	12	100%
Adult asthma (British Thoracic Society)	✓	Snapshot	All cases	34	100%
Bronchiectasis Paediatrics (British Thoracic Society)	✓	Snapshot	All cases	7	100%
Paediatric fever (College of Emergency Medicine)	✓	Snapshot	50	50	100%
Renal colic (College of Emergency Medicine)	✗*	Snapshot			
Vital signs in majors (College of Emergency Medicine)	✗*	Snapshot			
Diabetes (RCPH National Paediatric Diabetes Audit)	✗*	Snapshot			
Diabetes (National Adult Diabetes Audit)	✓	Snapshot	All cases	570	100%
Heavy menstrual bleeding (RCOG National Audit of HMB) – Organisational (no patient data required)	✓	Snapshot	-	-	100%
Ulcerative colitis & Crohn's disease (National IBD Audit) – Organisational (no patient data required)	✓	Snapshot	-	-	100%
Familial hypercholesterolaemia (National Clinical Audit of Mgt of FH)	✓	Snapshot	40	103	100%
Stroke care (National Sentinel Stroke Audit) *Unable to meet target of 60, all relevant patients entered*	✓	Snapshot	49	49	100%
Falls and non-hip fractures (National Falls & Bone Health Audit) *Unable to meet target of 60, all relevant patients entered*	✓	Snapshot	41	41	100%
National Audit of Dementia	✓	Snapshot	40	40	100%

Snapshot Audits Completed During April 2010 - March 2011	Participated ✓ / ✗	Type of Audit	Target	N	%
O neg blood use (National Comparative Audit of Blood Transfusion)	✓	Snapshot	32	32	100%
Platelet use (National Comparative Audit of Blood Transfusion)	✓	Snapshot	40	40	100%

There were six National Confidential Enquiries taking place throughout the year and the Trust participated in all of the relevant studies. The details are set out below. In 2011/12 we will seek to improve data completeness for these studies and have implemented a revised continuous monitoring system to ensure improved data submission rates in 2011/12.

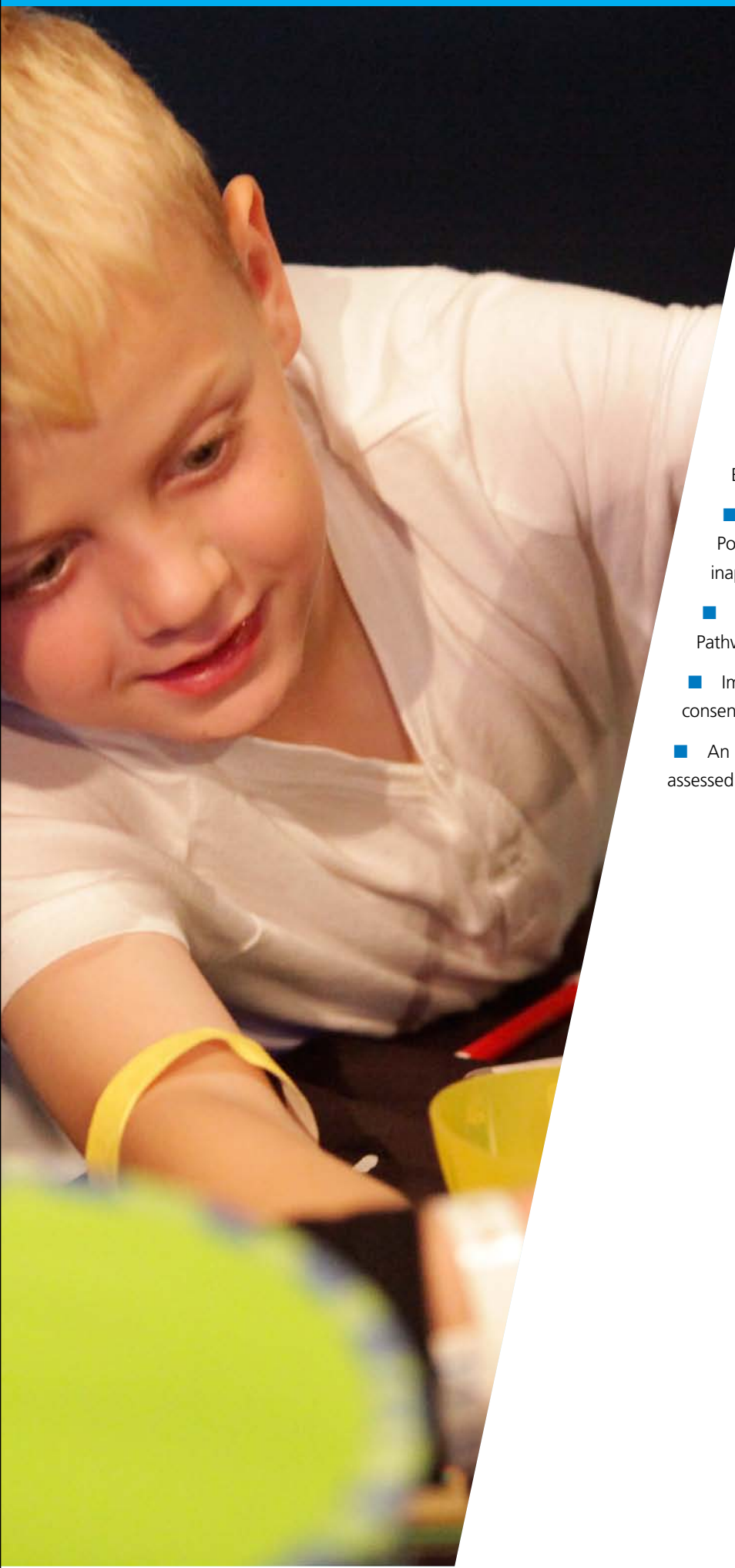
NCEPOD study	Eligible	Participated	%submission	Status
Parenteral Nutrition	✓	✓	44%	Complete
Surgery in the Elderly	✓	✓	60%	Complete
Perioperative care	✓	✓	Ongoing	Ongoing
Surgery in Children	✓	✓	Ongoing	Ongoing
Cardiac Arrest procedures	✓	✓	Ongoing	Ongoing
Cosmetic Surgery	NA	NA	NA	Complete

We received and reviewed the reports of four national clinical audits in 2010/11 and we intend to take the following actions to improve the quality of healthcare provided:

- A review of treatment provided to patients with Acute Kidney Injury has been undertaken in response to the National Confidential Enquiry into Patient Outcome and Death [NCEPOD] 'Adding Insult to Injury' and a comprehensive action plan for improvement has been developed. This work is being led by senior Renal Physicians.
- Our performance against other Trusts regarding Stroke care, measured by the Sentinel Stroke Audit showed that our overall score was 87%, above the national median of 82%. This was an excellent result however there is still more work to be done in terms of reducing the time from arrival of the patient to admission to the stroke unit, and we intend to pursue this further in 2011/12. We also aim to improve care for patients in the community by having a minimum of 50% of stroke patients assessed by an Early Supported Discharge Service.
- Familial hypercholesterolaemia audit results for the Trust on the whole showed good compliance with NICE Guidelines but it was noted that further work was required to develop patient and service user groups and this will be undertaken in 2011/12.
- Results from the National Audit of Dementia showed many areas of good practice but did identify that improvement was required in some areas of record keeping and discharge planning. The Trust is establishing a detailed work programme in respect of dementia and aims to demonstrably improve outcomes for this group of patients in the coming years. Record keeping and discharge planning will remain a focus for all patient groups.

Local Audit

We undertake a comprehensive programme of clinical audit across the organisation. Each specialty is required to produce an annual audit calendar which is based on national, local and speciality priorities for the year. Performance against this plan is monitored on a quarterly basis and reports provided for review at the Trust Clinical Audit Committee. We have over 600 local Clinical Audits ongoing or completed for 2010/11.



All audits are deemed incomplete until an action plan in response to audit findings has been detailed. This year a number of audits have required the development of individual action plans for each area. Examples of this are the Divisional action plans in response to the Patient Falls Risk Assessment and Adherence to Antibiotic Prescribing Policy audits. Thus all audits are reviewed and actions completed to ensure improvement based on the audit outcome.

Examples of those improvements include:

- An increase in adherence to the Antibiotic Policy and a reduction in the prescribing of inappropriate antibiotics.
- The production of a revised MRSA Care Pathway.
- Implementation of new condition specific consent to treatment forms.
- An increase in the number of patients being risk assessed for falls.

Research and Innovation

Research and innovation is a key focus within each of our five hospitals.

Along with our main academic partner The University of Manchester, we are one of 12 Biomedical Research Centres in the country, designated by the National Institute for Health Research (NIHR). Biomedical Research Centres are acknowledged as outstanding centres of research excellence and leaders in turning university science into hospital care. Our NIHR Manchester Biomedical Research Centre is specialist in genetics and developmental medicine.

We are also proud to be a founding partner of the Manchester Academic Health Science Centre.

Improving our research figures

During 2010/11:

9729	patients receiving NHS services, provided or sub-contracted by the Trust in 2010/11, were recruited to participate in research approved by a research ethics committee.
£29m	of external research funding was awarded to researchers working within the Trust
723	clinical research studies were underway, of which
108	were in the follow-up stages
262	new studies were approved, of which
229	were approved within 30 working days (87%)
160	of our new studies were supported by the National Institute for Health Research through its research networks
100%	of all appropriate studies were established and managed under national model agreements
81	Research Passports were processed, allowing external researchers access to our facilities

Investing in unique facilities

We have built on the success of previous years in significantly strengthening our research infrastructure during 2010/11.

Our Biomedical Research Centre opened the new £3 million Centre for Advanced Discovery and Experimental Therapeutics (CADET), which is dedicated to developing new drugs to prevent and treat major diseases such as diabetes, dementia and heart failure. Our work in this area will improve the quality of life for people around the world, as well as delivering efficiencies to the NHS in terms of how these long-term conditions are diagnosed, treated and managed.

ICON Development Solutions, a large contract research organisation, opened a 34-bed research unit on the hospital campus next to Manchester Royal Infirmary. The unit works with pharmaceutical, biotechnology and medical device companies to speed up putting new treatments and innovations into the NHS.

Over £1 million was invested in new technologies so that our researchers can undertake highly complex investigations into the genetic causes of diseases. New mutations responsible for a range of disorders have already been identified, which will lead to improved diagnosis and treatment for patients.

Attracting and developing outstanding researchers

Several high-profile research appointments were attracted to Manchester during 2010/11, including Professor Garth Cooper who joined us from the University of Auckland, New Zealand.

Professor Cooper leads our new CADET facility, and is a world-leading expert in drug discovery. He has published over 200 articles in leading journals, been listed as inventor on more than 40 patents and discovered several new drugs to treat diabetes. In the last year alone, these drugs were used to treat more than 700,000 patients in the United States.

We are also continuing to invest in our young, promising researchers. In February 2011 the Biomedical Research Centre awarded a total of £93,000 to six researchers, allowing them to accept placements at leading US and Canadian universities. The scholarships will allow our researchers to work with world-leading professors in their chosen fields to learn the latest research techniques, and then bring these skills back to Manchester.

Delivering world-class research

3	Manchester patients have regained some of their sight as part of a revolutionary worldwide retinal implant trial
9p	is the chromosome on which our researchers have found a genetic risk factor for frontotemporal dementia, the most common cause of dementia after Alzheimer's disease
400	children in Manchester may benefit from our research to find new treatments for mucopolysaccharide diseases, genetic disorders which affect 1 in 26,000 people
500+	examinations into high risk pregnancies have been performed in our Placenta Clinic since it opened in 2009
250,000	individuals from South Asian communities in the North West can now benefit from genetic testing to identify hereditary conditions

Driving healthcare innovation

Our work in healthcare innovation continues to thrive. In 2010 we were awarded both the Health Service Journal 'Improving Care with Technology' award and the E-Health Insider award for 'Best Use of IT to Promote Patient Safety' for the use of Patientrack. The IT based alert system has been trialled and shown to reduce mortality and length of stay for patients.

We are also a partner in the MedTECH Centre, which aims to provide support and facilities for companies looking to trial new medical devices that will improve outcomes for our patients.

Commissioning for Quality and Innovation (CQUIN)

A proportion of Central Manchester University Hospitals NHS Foundation Trust income in 2010/11 was conditional upon achieving quality improvements and innovation goals agreed between Central Manchester University Hospital NHS Foundation Trust and the bodies entered into a contract agreement for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2010/11 and for the following 12 month period are available online at www.cmft.nhs.uk.

In 2010/11 we received a total of £6.1 million (from a total of £6.5 million) in income from the achievement of our CQUIN goals. This has been a huge success and was accomplished by the delivery of measurable improvements to areas such as:

- In-patient and Out-patient Survey responses
- VTE risk assessment
- Discharge documentation
- Stroke care
- Diabetes care
- End of life care
- Paediatric asthma care
- Management of patient safety

We look forward to achieving similar successes working in partnership with all stakeholders and commissioning bodies in future years.

Information Relating to Registration with the Care Quality Commission (CQC) and Periodic/Special Reviews

The Trust is required to register with the Care Quality Commission and its current registration status is fully registered without conditions applied.

The Care Quality Commission has not taken any enforcement action against the Trust during 2010/11.

Central Manchester University Hospitals NHS Foundation Trust has participated in a special review by the CQC during the reporting period. This review examined our Child and Adolescent Mental Health Services and found that:

> *"The children and young people were found to be in receipt of a high standard of child-centered care. An increase in Occupational Therapy and Psychology provision was noted. From talking with patients it was clear they were as involved as they could be in the planning, implementation and reviewing of their care, with the majority feeling they had a voice and could influence decisions. A review of care planning documentation reflected this. The interpersonal environment between staff and patients was observed to be positive, respectful and pro-social, and all patients interviewed commented positively about the staff, who were described as "bubbly…..nice", "upbeat", "inclusive…..friendly", & "caring".*

The CQC also undertook a planned review of adult services during the period from which the findings overall were very positive. The following is an extract from that report:

> *"The feedback we had from people using the service during our visit was extremely positive. Every person we spoke to said that they felt involved in their care and that they had no complaints at all about any of the staff. People used words like "excellent" and "brilliant" to describe the staff and people were particularly complimentary about the nursing staff. One patient said that "nothing was too much trouble" for the nurses and another said he felt that he could tell the nurses "anything at all". Everyone said that it was easy to get a nurse's attention when they needed it.*
>
> *Everyone we spoke to said that they felt that their individual needs were being met. They were all aware of why they were still in hospital and said that staff were good at keeping them informed. They all said that the staff asked their permission before performing any procedures or providing care. They all felt that staff listened to them, although one patient commented that "some staff listen better than others". One person was not happy about how long they had to wait to be transferred from the emergency department to the Medical Assessment Unit but they had no complaints about their care on the ward.*
>
> *Everyone we spoke to said that they had seen a doctor regularly during their hospital stay. Although we did not specifically ask people about the cleanliness of the hospital, three people volunteered that they thought their ward was very clean.*
>
> *The only negative feedback we received from people related to the food. Two of the three people we spoke to on one ward said they did not like the taste of the food and they did not think the quality was good. The other person on this ward, when we asked for their views on the food, said "it's hospital food, but it's OK". One person on this ward also said that the food was often cold.*
>
> *However, the patients on the other ward we visited were much more positive about the food. One person commented that her lunch that day tasted good. We were told by staff that the catering system used on this ward is being rolled out to the rest of the hospital later this year. All the people we spoke to said that they had plenty of choice at mealtimes and they always got the meal they ordered. Everyone also said that they could get snacks and drinks between meals if they wanted them."*

The full report can be viewed on the Care Quality Commission website at www.cqc.org.uk.

We have taken the comments and the minor recommendations in relation to nutrition and training on board and have included them as areas of focus in the work plan for 2011/12.

Information on the Quality of Data

Central Manchester University Hospital NHS Foundation Trust submitted records during 2010/11 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data:

- the patients valid NHS Number was 97.3% for admitted patient care; 97.9% for out-patient care; and for accident and emergency care. 86.2%.
- the patient's valid General Practitioner registration code was 100% for admitted care 100% for out-patient care and 100% for accident and emergency care.

The Trust Information Governance (IG) Assessment Report overall score for 2010/11 was 80% and was graded Green. Further Work is being carried out on patient experience and also risk reviews and safeguarding so that we can improve our score for the IG toolkit in 2011/12.

Central Manchester University Hospital NHS Foundation Trust was subject to the Information Governance Clinical Coding Audit during the period and the error rates reported in the latest published audit period for diagnoses and treatment coding (clinical coding) was: non-coder diagnostic error 1.7%, coder diagnostic error 5.5%, and non-coder procedure error 1.5% and coder procedure error 6.4%.

The Trust was not subject to the Payment by Results clinical coding audit during the period by the Audit Commission.

Other Information

Achievements against key national priorities and National Core Standards

Achievements against National Requirements

We applied for registration with the Care Quality Commission in January 2011 in line with the Health and Social Care Act 2008 and has been 'Registered without Conditions' beginning 1st April 2011.

Informing and Involving

- Foundation Trust members are invited to take part in a range of involvement and improvement events. We encourage feedback from members, Governors and the public.
- Foundation Trust members are regularly updated through the newsletter 'Foundation Focus'.
- Quality Improvement awareness is raised to the public through hospital open days and events.
- Patient groups took part in the Trust annual Clinical Audit and Risk Management Fair providing valuable information to inform the ongoing development of our services.

Performance of Trust against Selected Metrics

Patient Safety Outcome	2009/10	2010/11	Status
Improvement in VTE Risk Assessment's carried out	15.5% (assessed at June 2010)	90.1% (assessed at March 2011)	✓
Reduction in hospital acquired grade 3 or 4 pressure ulcers	30 Sept – Feb	17 Sept - Feb	✓
Reduction in serious patient safety incidents resulting in actual harm (those graded at Level 4/5)	49	29	✓

Clinical Outcome Measures			
Reduce Hospital Standardised Mortality Ratio (HSMR)	94.3	91.5	✓
Reduce the number of potentially avoidable cardiac arrests outside of critical care areas	N/A	135	N/A
Improve Stroke Care (Sentinel Audit Composite Score)	May 2008 – 60%	March 2011 – 87%	✓
Patient Experience Measures			
Increase overall satisfaction expressed with pain management*	N/A	76.14%	N/A
Increase overall satisfaction expressed with fluids and nutrition provided*	N/A	71.73%	N/A
Increased overall satisfaction with the cleanliness of the ward or department*	N/A	77.60%	N/A

** Data captured from feedback devices July 2010 – End March 2011*

National Targets and Regulatory Requirements

Definition	Indicator	2008/09	2009/10	2010/11	Target 2011/12
Intelligent Board Report	C Difficile (number of cases)	242	179	106	96
Intelligent Board Report	MRSA (number of cases)	17	8	7	6
2008/09 Q4 2009/10 Full Year 2010/11 Apr-Dec	Maximum waiting time of two weeks from urgent GP referral to first out-patient appointment for all urgent suspect cancer referrals	99.0%	94.1%	92.6%	93.0%
2008/09 Q4 2009/10 Full Year 2010/11 Apr-Dec	Maximum 31 days from decision to treat to start of treatment extended to cover all cancer treatments	100.0%	99.9%	99.0%	96.0%
2008/09 Q4 2009/10 Full Year 2010/11 Apr-Dec	Maximum 31 days from decision to treat to start of subsequent treatment	n/a	100.0%	98.1%	96.0%
2008/09 Q4 2009/10 Full Year 2010/11 Apr-Dec	Maximum waiting time of 62 days from urgent referral to treatment for all cancers	88.0%	88.1%	82.0%	85.0%
2008/09 Q4 2009/10 Full Year 2010/11 Apr-Dec	Maximum waiting time of 62 days from screening programme	n/a	n/a	74.7%	90.0%
Intelligent Board Report	18 weeks maximum wait from point of referral to treatment (non admitted patients)	98%	98%	97%	*95%
Intelligent Board Report	18 weeks maximum wait from point of referral to treatment (admitted patients)	91%	92%	88%	**95%
QMAE - reported	Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	97%	98%	96%	90%

** Now 18.3 week target* *** Now 23 week target*

Please note the C Difficile and MRSA figures for 2010/11 are hospital attributable figures only, previous years are a combination of hospital and community attributable. C. Difficile community attributable 10/11 = 68 MRSA community attributable 10/11 = 4.

Feedback from Stakeholders

Feedback from the Governors

An important role of the Governors is to challenge and support the Trust's ability to provide safe and effective care for its patients. This is facilitated through the Governor Patient Experience Group. Meetings of the Group are attended by one or more Non-executive Directors, thereby providing a link to the Board of Directors. Governors are invited to take part and contribute to Senior Management Ward Rounds.

Governors have been encouraged to participate in work streams that will positively impact on patient experience. They have also received a wide range of presentations from front line clinicians outlining service developments and provision as requested. The high calibre of these and the openness to constructive enquiry and feedback has been commended.

The Group is supportive of the processes the Trust has in place to progressively improve the patient experience across a broad front. The Trust's performance in meeting national and internally set standards is discussed in an open way and the Trust is responsive to concerns that are raised by the Group.

Commissioners' Statement

NHS Manchester (NHSM) and Central Manchester GP Commissioning Consortium welcome the opportunity to provide a statement for Central Manchester University Hospitals NHS Foundation Trust's (CMFT) Quality Account. For this purpose, we have reviewed the information available to us and can confirm the accuracy. We have been heartened by the collaborative nature of our discussions relating to the quality of care delivered to patients at CMFT and we congratulate them on the continued achievements for quality indicators.

As Commissioners we have worked closely with CMFT over the course of 2010/11; meeting regularly to review the Trust's progress in implementing its quality improvement initiatives. CMFT and NHSM agreed 2 national, 7 regional and 17 local CQUIN (Commissioning for Quality and Innovation) goals for 2010/11. CMFT have achieved all their CQUIN targets. They will receive a partial payment for the national Patient Experience indicator where performance did greatly improve but did not quite meet the final threshold.

There are two particular areas in which we can see progress however; we look forward to working with CMFT on making continuous improvements in:

1. Care for patients who have had a stroke and their ongoing care in the community. We would anticipate that CMFT's actions will lead to an improvement when compared to other Trusts nationally.
2. Discharge planning and experience for patients when going home, and communication with their General Practitioners.

We acknowledge the hard work that has occurred supporting the Integration of Community Services into the Trust, these 45 community services each have a development plan and this will provide the opportunity to improve the quality of care.

In light of the current Care Quality Commissioners findings in other national hospitals we would wish to see evidence in future reports of quality outcomes specifically for the care of older people. We will explore these measures with CMFT in due time.

We note the reference to National Clinical Audit programme and that there are an on going number still in progress, we look forward to receiving the outcomes of those audits.

Manchester Local Involvement Network (LINk)

1. The Quality Account of Healthcare Providers must be sent to the LINk in the local authority area in which the provider has its registered office, inviting comments on the report from the LINk prior to its publication, and publish any statement (limited to 1000 words) as part of the Quality Account.
2. The QA for the year 2010/11 has been received from Central Manchester University Hospitals NHS Foundation Trust (CMFT), and this is the LINk's statement for inclusion.
3. Providers are asked to consider three chief aspects of quality in the Account:
   - Patient experience
   - Patient safety
   - Clinical effectiveness
4. This consideration should enable patients and public to be assured that the provider is scrutinising all their services, and concentrating on the aspects that need most attention.
5. In the case of CMFT, the LINk is satisfied that the Quality Account properly focuses upon the required issues above, and is generally in accord with our local knowledge of its healthcare quality -
   - outlining what it has been successful at, and where it sees improvements are required
   - identifying its priorities for improvement in service quality for the coming year
   - and showing how it has involved service users, staff, and others with a legitimate interest to help them check the quality of the services, and determine priorities for improvement.
6. This satisfaction on the part of the Manchester LINk has been possible to report chiefly because of the arrangements which we have been able to negotiate with the Trust: Following some delay, we have eventually been able to make the appropriate contacts with the executive directorate staff who were preparing the Quality Account. Though this happened somewhat later in the year than had been hoped, it has now been formatted into a regular programme, with arrangements to meet regularly throughout the next 12 months, every couple of months or so, to talk through issues and representations brought to the meetings by the Chair and Team Leader of the LINk. This should allow an effective exchange of views, including positive and negative events and feedback, so that problematic issues can be handled quickly and effectively, and the appropriate focuses of the QA can be considered and discussed in detail.

Michael Kelly, Chair, on behalf of the Manchester LINk Steering Group

Feedback from Stakeholders

Health and Wellbeing Overview and Scrutiny Committee

Manchester City Council's Health and Wellbeing Overview and Scrutiny Committee welcomes the opportunity to comment on the Central Manchester Foundation Trust Accounts for 2010/11. At its meeting on 26th May 2011, the Committee reviewed your draft Quality Accounts and we are pleased to note that the Trust has demonstrated a commitment to improving services and we are satisfied with the accuracy of the information contained within the report.

The Committee notes that Quality Accounts are aimed at members of the public and we were particularly impressed with the reader friendly format of the report which made it easy to identify where significant improvements have been made and also where further work was required. We would like to recommend that Central Manchester Foundation Trust considers including more detailed background information and benchmarking data to explain the context for each of your aims and what you have done to achieve them.

We have noted that the Trust has not yet achieved the target to reduce the number of serious errors relating to medication by 50%. We acknowledge that significant progress has been made to reduce these errors by 35% and that there are fewer occurrences of the most serious cases. We also acknowledge that this is a very ambitious target but we do feel that it was difficult to make a judgment about how well the Trust is doing in this area as no baseline figure or benchmark data (for example the national average) was provided. We would like to recommend that the Trust include this information in their Quality Accounts in 2011/12.

In terms of patient experience, we understand that patient and staff feedback has demonstrated that the Trust has shown improvements in cleanliness, pain, communication, and privacy and dignity and we commend the Trust for these improvements. We also note however that patient feedback has fallen for nutrition. We sought assurance from the Trust that it was able to identify and protect vulnerable older people with specific nutritional needs. We were reassured that patients undergo an individual assessment to consider their nutritional needs.

The Committee has monitored the implementation of the Transforming Community Services programme over the past year and we note that the Trust has taken over 45 community services as of April 2011. We understand that it will be a challenge for hospitals to integrate community services and to provide high quality safe care for patients using those services. We do think that this is a priority for the next year and we look forward to reviewing how the Trust measures the quality of these services in their Quality Accounts next year.

The Committee felt that the timescale and deadline for commenting on Quality Accounts is not sufficient for us to provide a full report on all of the elements that we would like as it does not take account of local elections and purdah periods. In the forthcoming year, the Committee is looking at ways that we can provide a detailed response through a continuous piece of work on how commissioners and providers ensure that they provide the best quality of services for Manchester residents. We hope that Central Manchester Foundation Trust will support us in carrying out this work.

Councillor Eddy Newman
Chair of the Health and Wellbeing Overview and Scrutiny Committee

Statement of directors' responsibilities in respect of the Quality Report

Statement of directors' responsibilities in respect of the quality report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

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

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010/11;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2010 to June 2011
  - Papers relating to Quality reported to the Board over the period April 2010 to June 2011
  - Feedback from the commissioners dated 28/05/10, 24/08/10, 15/11/10 and 17/02/11
  - Feedback from Governors dated 02/02/11
  - Feedback from LINks dated 28/04/2011
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2010
  - The National Patient Survey March 2011
  - The National Staff Survey March 2011
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated June 2011
  - CQC Quality and Risk Profiles dates 22/09/10, 21/10/10, 18/11/10, 16/12/10, 17/02/11 and 16/03/11.
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance, which incorporates the Quality Accounts regulations (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

2nd June 2011 **Peter W Mount**, Chairman

2nd June 2011 **Mike Deegan**, Chief Executive

Independent Assurance Report to the Council of Governors of Central Manchester University Hospitals NHS Foundation Trust on the Annual Quality Report

I have been engaged by the Council of Central Manchester University Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Central Manchester University Hospitals NHS Foundation Trust's Quality Report for the year ended 31st March 2011 (the 'Quality Report').

Scope and subject matter

I read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for my report if I become aware of any material omissions.

Respective responsibilities of the Directors and auditor

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

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

- Board minutes for the period April 2010 to March 2011;
- papers relating to Quality reported to the Board over the period April 2010 to March 2011;
- the Trust's annual complaints data;
- the 2011 national patient survey;
- the 2011 national staff survey;
- the draft Head of Internal Audit's annual opinion over the trust's control environment dated 2011; and
- Care Quality Commission quality and risk profiles dated March 2011.

I considered the implications for my report if I became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). My responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Council of Governors of Central Manchester University Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Central Manchester University Hospitals NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31st March 2011 to enable the Council of Governors to demonstrate it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Council of Governors as a body and Central Manchester University Hospitals NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

Assurance work performed

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

- making enquiries of management;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents listed previously.

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

Limitations

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31st March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

Jackie Bellard
Officer of the Audit Commission

The Audit Commission
Second Floor
Aspinall House
Aspinall Close
Middlebrook
Bolton, BL6 6QQ

2nd June 2011

Carbon Reduction

We remain committed to reducing energy consumption and carbon emissions in line with NHS and national targets.

Carbon Saving Schemes

The two key interventions to reducing energy consumption are:

- Investment in energy saving equipment and plant.
- Investment in people - staff training. Effective housekeeping will generate energy savings of 5 - 10 %.

We have previously identified a number of 'engineering-related' projects which demonstrate rapid pay back. A number of these schemes will be implemented over the coming months.

A major staff awareness campaign is also planned for September 2011. Staff engagement is crucial to the success of the energy saving initiative.

Successes so far

To complement the commitment at corporate level there are now over 80 appointed Green Champions within the Trust. These members of staff are taking an active role in driving down consumption. A number of energy audits have been undertaken and the results have been used to change behaviours.

We are currently trialling a new integrated printer/photo-copier in four areas. If successful the system will be rolled out to other areas within the organisation, therefore greatly reducing the need to procure individual printers. The new printers are energy efficient, economical and sustainable.

A new Hybrid Bus has been introduced to our 147 route operated by Bullocks and supported by our Trust and several partner organisations along Oxford Road. These vehicles offer a 35% reduction in CO2 compared to a conventional bus. This is seen as a significant step towards working in a 'greener city'.

Here are some of the Green Champions.

We have also undertaken a pilot at the Dental Hospital since 1st November 2010. Awareness around energy savings has included:

- Lunch and Learn Sessions
- Learner Greener Times - dedicated newsletters
- Energy Audits – Two undertaken to date.
- Publicity and posters

We continue to work with our neighbours on a number of 'macro' energy saving initiates. Through the offices of Corridor Manchester we are looking to develop a range of major carbon reduction measures including the potential of operating 'green vehicles' and the installation of electric plug-in points around the site.

The Challenge

As a participant of the Carbon Reduction Commitment (CRC) we will be looking to minimise our carbon emissions over the next financial year, aware of the Carbon Tax levy due April 2012 through the CRC scheme. The Trust will be charged for every tonne of CO2 it produces over the next 12 months.

It is also forecast that the cost of energy (gas and electricity) will rise sharply over the next few months. To mitigate these costs we will introduce a variety of counter-measures which are cost effective, practical and sustainable.

Equality, Diversity & Human Rights

Governance and Mainstreaming of Equalities

The year 2010/11 has seen investment by the Trust to mainstream equalities within the Clinical effectiveness and Governance agenda. We have set out to ensure that Equality, Diversity and Human Rights has become the enabler providing advice and support with helping to reduce equalities risks within the organisation, improving patient experience and quality, reducing complaints whilst adding to clinical effectiveness.

The Equality, Diversity and Human Rights Objectives Framework will support us to implement and deliver the following key strategic objectives:

- Ensure that our internal practices and performance are surpassing compliance with equality legislative requirements, Human Rights legislation and regulatory guidance.
- Ensure all policies, procedures and services are free from direct and indirect discrimination.
- Continue to embed equality and diversity in everything that we do.
- Be an exemplar employer, with equality of opportunity central to the recruitment and development of staff.
- Adapt our services to meet the identified needs of our patients, service users and the wider community.
- Work with our main contractors and suppliers to ensure the ethos and values of the Trust regarding equality and diversity are embedded within their workforce.
- Provide opportunities for all service users to participate in the decisions which affect the delivery of services they use.

Project Search

We are a beacon site for 'Project Search' which is a programme to provide diverse and sustainable opportunities that support young people with disabilities through skills training and potential employment. The scheme is very popular with line managers and it

is clear that both the organisation and the students have taken great benefit from this initiative.

Patient Profiling

We continue to review our arrangements in relation to Equality, Diversity and Human Rights and the Single Equalities Legislation (October 2010). We also support the submission of qualitative evidence to the Regional Equalities Performance Information Toolkit (EPIT) and proposed national equalities performance monitoring tool, the Equality Delivery System (EDS), from April 2011. In particular the organisation is able to provide evidence about how it is performing and responding to local needs.

We have also been able to demonstrate activity to sustain compliance with the requirements of the Equality Act 2010 and this includes evidence that Equality Data is used so that all outcomes for staff and patients are measurable and evaluated for all groups. Data monitoring incorporates gender, age, race and religious belief collected by our patient administration system and monitored via the Patient Profiling Group. The Patient Profiling information enables us to build up a comprehensive and accurate picture of the users of our services and informs future service arrangements.

Equalities Impact Assessment Process

Work has included reviewing the Equalities Impact Assessment (EQIA) framework to ensure that our key strategic policies and functions are subjected to a simplified process which is uniform and rigorous and that action plans include recommendations to improve services.

Diversity Training for Staff

We are well aware that if we want our workforce to implement and promote the equality and diversity agenda, we need to equip the workforce with the right skills and knowledge to do so.

Equality & Diversity training is provided as part of the Corporate Induction Programme and the annual Mandatory Training Scheme. In addition to this there is a monthly EQIA training programme provided for staff and a monthly Patient Experience training programme which includes Cultural Diversity and Cultural Health risks

CIRIS

SET have also recently put in place a new compliance tool called CIRIS so we can monitor and review Equality Impact Assessments through the Governance and Audit structure and framework. Delivered as a service over the internet, CIRIS is the solution for continuous improvement providing a single business management system for governance, risk and compliance in which all staff can engage to deliver our quality objectives.

Access Working Group

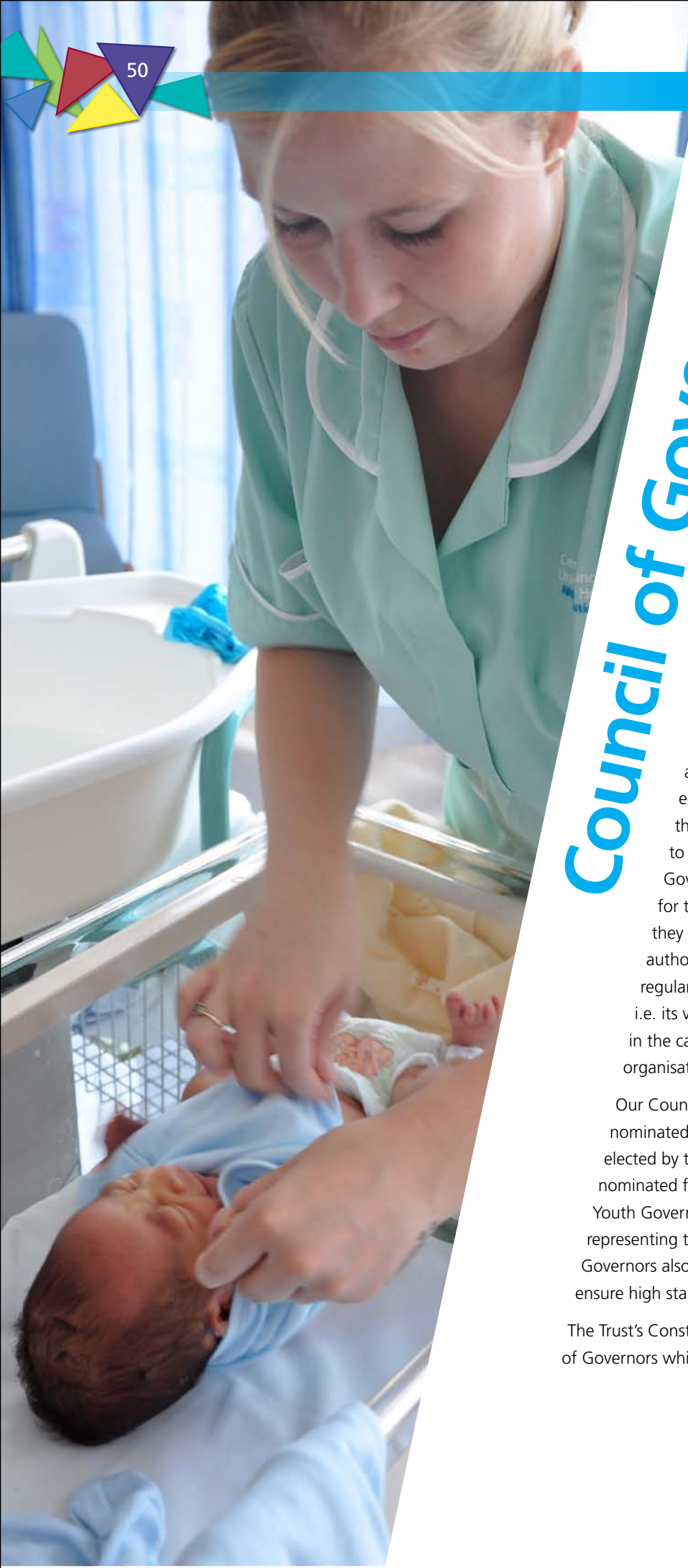
The Access Working Group will provide a focus and oversee the procurement and completion of an Access Audit on all healthcare facilities and Trust sites. The purpose of the group is to actively support the implementation process across the organisation including outcomes and key recommendations that are to be escalated to senior forums for approval and potential funding. The Group is committed to the development and implementation of an effective Access Strategy and an investment programme which mitigates risk.

QIPP Programme

The purpose of the QIPP project under the Improvement Leaders Programme is to develop an innovative and enterprising, quality based and productive Equalities and Procurement service that can make a difference to patient experience and safety, clinical outcomes and financial planning. This will enable us to deliver fit for purpose goods and services to its service users with Equality, and Patient Experience at the heart of the procurement process.

In summary, the team has supported the organisation with regard to:

- Eliminating unlawful discrimination, harassment and victimisation for patients and carers.
- Advancing equality of opportunity between patients and carers to be included in service partnerships and service improvements.
- Fostering an inclusive relationship between patients, carers and our local communities.



Council of Governors

The Council of Governors was established following the Trust's authorisation in January 2009 to become Central Manchester University Hospitals NHS Foundation Trust and has met three times during the course of 2010/11.

The Council of Governors is responsible for representing the interests of our members and partner organisations in the local health economy. Governors are encouraged to act in the best interests of the Trust and are bound to adhere to its values and code of conduct. Governors hold our Board of Directors to account for the performance of our Trust by ensuring that they act so that we do not breach the terms of our authorisation. Governors are also responsible for regularly feeding back information about the Trust i.e. its vision and its performance to members and, in the case of Nominated Governors, the stakeholder organisations that nominated them.

Our Council of Governors has 31 elected and nominated Governors. 17 of these Governors are elected by the public, 6 by our staff and 8 have been nominated from partner organisations (2 of which include Youth Governors). In addition to being responsible for representing the interests and views of our Members, Governors also monitor the performance of our Trust to ensure high standards are maintained.

The Trust's Constitution dictates the composition of the Council of Governors which is detailed in the table opposite.

Composition of the Trust's Council of Governors		
Constituency	**Area/Category/Partner Organisation**	**No. of allocated seats**
Public	Manchester	9
	Greater Manchester	2
	Rest of England & Wales	2
		Remaining 4 seats filled by the candidates that poll the next highest number of votes (after those elected)
Staff	Medical & Dental	1
	Nursing & Midwifery	1
	Other Clinical	1
	Non-Clinical & Support	1
		Remaining 2 seats filled by the candidates that poll the next highest number of votes (after those elected)
Nominated	PCT (one of which includes NHS Manchester)	2
	Local Authority (Manchester City Council)	2
	University (University of Manchester)	2
	Youth Partnership (Youth Forum)	2

Governors serve a term of office for up to three years at the end of which time they are able to offer themselves for re-election/re-nomination (serving for a maximum of nine years in total). However, Governors cease to hold office if they no longer live in the area of their constituency (Public Governors), no longer work for our Trust or hold a position in the constituency that they represent (Staff Governors) or are no longer supported in office by the organisation that they represent (Nominated Governors).

Governor Development

The Trust provides many opportunities for Governors to be actively involved, which we feel helps us to make a real difference to our patients and the wider community.

- Governors regularly attend Development Sessions to discuss and agree with our Board of Directors how they will pursue opportunities and undertake other additional roles to meet the needs of our local community and develop best practice methods.
- Governors work closely with the Board of Directors and are involved in the Trust's Annual Plan priority decision-making process. Governors are formally presented with the final Annual Report/Accounts and Annual Plan and are consulted on the development of forward plans for the Trust and any significant changes to the delivery of the Trust's Business Plan.
- Governors are involved in recruiting new members and ensuring our member communication is effective.
- Governors also cast a critical eye over the experience that our patients have, in areas such as accessibility, cleanliness and the environment, and overall 'customer care'.
- Governors ensure that the Trust meets its responsibilities to the wider community and plays a key role in regeneration, employment, education and environmental initiatives.
- Governors have active involvement in the appointment of Non-executive Directors.

- A Governors' Appraisal Panel programme has been successfully established to facilitate the 360° appraisal process for the Trust's Chairman and Non-executive Directors.
- Governors also cast a critical eye over the health and wellbeing of our staff in areas such as sickness absence, appraisals etc.

In addition to the above, the Trust also encourages Governor Development in a number of areas with training/support being provided namely:

- Equality and Diversity Training – including patient case-studies.
- Induction Training for all new Governors.
- Governor mentor/buddy assigned to our Nominated Youth Governors – support provided in preparation for Council of Governors' Meetings.
- Governor attendance at External Governor Development Events – Foundation Trust Governors' Association.
- Governor Role 'One Year On' Training Sessions – Governor role evolution and areas for further development.
- The establishment of an annual Governor Development Programme informed via Governor questionnaire findings and Governor Working Group assessments.
- Lead Governor succession planning – includes Lead Governor role description and nomination process.
- Dedicated Lead Governor/Governor meetings – promotes free discussion/debate.

Future priorities to continue to facilitate Governor Development during the course of this forthcoming year include:

- The continual development and implementation of a detailed Governor Development Programme informed via Governor questionnaire and Governor Working Group reviews – highlighting areas of particular strength and those requiring further support.
- Quarterly Key Performance Indicator Meetings focusing on patient safety, patient experience and productivity and efficiency.

Governor development is monitored in a number of ways. An annual questionnaire is completed by Governors which identifies development needs. Governors meet with the Chairman on a regular basis outside the Council of Governors and Working Group Meetings to highlight any development needs.

Elections

Our Board of Directors can confirm that the elections for Public and Staff Governors were held in accordance with the election rules as stated in the constitution approved by Monitor.

Public and Staff Governor elections were concluded in September 2010 for those initial Governors who had been elected for a two year term of office.

The Trust's Governor Election Turnout Data - 2010

Date of Election	Constituencies Involved	Number of Members in Constituencies	Number of Seats Contested	Number of Contestants	Election Turnout
September 2010	Public – Manchester	5,229	6	14	19.3%
	Public – Greater Manchester	4,380	1	5	24%
	Public – Rest of England & Wales	1,005	1	3	22.9%
	Staff – Medical & Dental	n/a	Uncontested	1	n/a
	Staff – Other Clinical	n/a	Uncontested	1	n/a

Public Governors

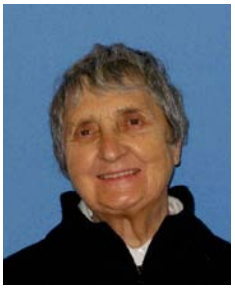
Jayne Bessant - *Manchester Constituency* - After training as a nurse, Jayne has worked in the NHS and charitable healthcare sector for over 25 years. Since 2002 she has worked in senior management within the hospice environment. She hopes to make a positive contribution to ensuring equitable and high standards of care for patients.

Abu Chowdhury - *Manchester Constituency* - As a councillor, magistrate and ex-strategic race adviser to the Police Authority, Abu has significant experience of tackling a wide range of issues. He is used to acting as a 'critical friend' to organisations. Abu aims to represent the views of local people and address their concerns about improving services, cost savings and future investment.

Peter Dodd – *Manchester Constituency* - Aged 56, Peter is now semi-retired, having survived a major stroke in 2006. Peter's first hand experience of the MRI and NHS, both as an in and out-patient, makes him ideally placed to be an advocate of good quality healthcare for the entire community. His experience enables him to communicate the views of ordinary people to health professionals. As a life long Trade Unionist, Peter also believes strongly in the importance of staff morale and welfare. As a Governor and a member of the Patient Experience Working Group, Peter has been able to raise important issues such as the dignity of patients and the quality of hospital food. As Chair of the Membership Working Group, Peter has assisted the Trust with the strategy for recruiting members and for engaging with the wider community. Peter is a lay member of the National Institute for Health Research Stroke Research Network and a lay member of the Manchester Employment Tribunal Service.

Richard Jenkins – *Rest of England & Wales Constituency* - Richard, a retired metallurgist and company director, has considerable experience of the NHS over 20 years as a patient with diabetes, liver and kidney failure. He represents fellow patients on the North West Kidney Patients Association and has been chair of governors at a Glossop Primary School for several years.

Alexena Morrison - *Manchester Constituency* - Before her retirement, Alexena worked in the public sector, in the Social Work department as a personal secretary for 18 years at Withington hospital. She supports an NHS which is free to people who require treatment and wants to maintain the unrivalled care proved by the NHS since 1948.



Margaret Parkes – *Manchester Constituency* - A founding member of the city's Valuing Older People Board, Margaret is active in their Positive Images of Ageing campaign. Throughout her career in the NHS and at The University of Manchester, she has been aware of the importance of gaining the views of service users and engaging the wider community.

Keith Paver – *Manchester Constituency* - Having retired in 2008 as a clinical scientist working for the Health Protection Agency, Keith has found that his experience, both as an NHS employee and in the field of public health, has been invaluable in his role as a Governor. For many years he provided expert advice to Trusts on hospital acquired infections and other public health issues, and he is still an honorary lecturer on virology and public health at Manchester University. Since becoming a Governor, Keith has been able

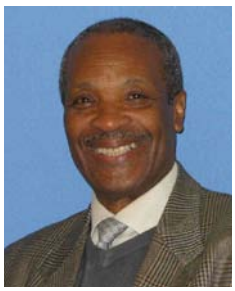
to bring his knowledge and expertise to areas such as staff health and wellbeing, in understanding the key indicators of performance of the Trust and in working with young people on the Youth Forum and as a mentor to the Youth Governors. As a member of the Membership subcommittee he is also helping to explore new ways in which the Trust can communicate with the wider community.

Martin Rathfelder – *Manchester Constituency* - Martin worked for ten years as welfare rights officer at Manchester Royal Infirmary, campaigning for the rights of disabled people and sorting out the benefit problems of patients. He writes and lectures about health and social security and campaigns on health inequality and accountability in the NHS through the Socialist Health Association of which he is the Director and only employee. Martin is a lay member of the Advisory Committee on Clinical Excellence Awards and is an election agent. Martin lives in Fallowfield and also works part time for South Manchester Law Centre. Martin was Chair of the South Manchester Community Health Council and Vice Chair of the Manchester Patients' Forum.

Bernice Reid – *Manchester Constituency* - Improving the health and wellbeing of people in Fallowfield and the wider community was Bernice's key aim during her nine years as a Manchester City Councillor. She also has a keen interest in education, as a school and university governor. Both Bernice and members of her family have been patients at the MRI. Since becoming a Trust Governor, Bernice has a keen interest and involvement in the promotion of the Trust's public health agenda. Bernice has also been involved in the Foundation Trust Network, representing views, shaping policies and sharing learning.

Lynne Richmond – *Manchester Constituency* - Lynne has worked in the nursing/care sector for 40 years training as a S.R.N and for 30 years working for a charity for learning disabled young adults, of which Lynne is now executive director. Lynne has a keen interest in working along with others to help the Trust become the best in England, enabling all those who need it receive the best possible service. Lynne feels sure that her years of experience and expertise in this field along with her business management/care management degree can bring benefits to share with other governors. Lynne is an associate member of the Royal Society of Medicine and, at the current stage of her career, is able to devote the time needed carry out the duties required as a governor. Lynne's relationship with the Trust has been as a patient, a visitor, and liaising with PALS.

Susan Rowlands – *Manchester Constituency* - Having worked for over 30 years in local government as a social worker and manager, Sue played a key role in establishing a multi-agency service for disabled children in Manchester. She believes strongly in the importance of providing speedy, efficient and cost-effective services, free at the point of delivery, and of patient consultation. Sue would also like to see an increase in the membership of the Trust.



Roy Walters – *Manchester Constituency* - Promoting better health is Roy's aim as a Governor, through better health information and a strategic approach to reducing inequalities. Previously a non-executive director of Central Manchester Healthcare Trust, he brings experience in equal opportunities, regeneration, recruitment and budgeting to the role. Roy is also interested in promoting careers in the NHS to young people.

Sue Webster – *Manchester Constituency* - Through her employer, BT, Sue is involved with the City Council and other public and private bodies on a range of strategic and local community initiatives linked to health and education. Sue supports improvements to patient care by assisting the Regional Innovation Hub, which encourages North West NHS staff to develop new products, technology and services.

Ivy Ashworth-Crees - *Greater Manchester Constituency* – Since being appointed, Ivy's priority has been training and preparation to become an effective Governor with Ivy building on her experience to add real value to the development of the organisation. Ivy takes a keen interest in Patient Services and accompanied staff to a London hospital to examine the different kinds of food preparation and service available for patients. Ivy welcomes being involved with further service improvements, as she believes that customer focus is essential to effective patient care. As a renal transplant patient Ivy has first-hand knowledge of the outstanding commitment and capability of the medical teams at the MRI stating that "this Foundation Trust deserves recognition for striving constantly for medical excellence in the North West".

Malcolm Chiswick – *Greater Manchester Constituency* - Malcolm spent 30 years as a Consultant caring for newborn babies at Saint Mary's Hospital, and four years as the Trust's Medical Director, retiring in 2006. Malcolm has practical experience of the key healthcare issues facing parents and families and believes Foundation Trusts have a great opportunity to serve patients, respond to wider community needs and shape the future. Malcolm is also the elected Lead Governor.

Brian Donaldson – *Rest of England & Wales Constituency* - Brian was a teacher for 26 years before becoming Vice Principal of the College in which he had taught for most of his career. On his retirement, Brian became Clerk to the Board of Governors of the same College and left that post at the end of 2008. Brian's interest in the Central Manchester Hospitals stemmed from experience of the Renal Unit at the Manchester Royal Infirmary, where he received two renal transplants in 1992 and 2007, the second from his wife. Brian felt keen as a result to make some contribution to the service from which he had benefited.

Gordon Cairns – *Manchester Constituency*
Deceased (June 2010)

Peter Dungey – *Manchester Constituency*
Resigned (March 2011)

Lynne Richmond – *Manchester Constituency*
Resigned (February 2011) - Currently in the role of public ambassador

Neelam Zaka – *Manchester Constituency*
Resigned (June 2010)

Staff Governors

Lawrence Cotter - *Medical & Dental Constituency* - Following qualification at Manchester University in 1971, Dr Cotter's first year as a doctor was spent in Manchester Royal Infirmary. He then spent the following thirteen years training in Medicine and Cardiology in Hammersmith Hospital, the Brompton Hospital and Edinburgh Royal Infirmary before spending three years as Lecturer in Cardiovascular Medicine at Oxford University. He was appointed as one of three Consultant Cardiologists at MRI in 1984.

As well as being a Consultant Cardiologist, Dr Cotter is Hospital Dean in charge of the training of 450 medical students in the Trust.

From 2003 to 2011, Dr Cotter was Chairman of the Trust Medical Staff Committee and Local Negotiating Committee.

Beverley Hopcutt – *Other Clinical Constituency* - Partnership working with Manchester City Council, local PCTs, the voluntary sector and service users has given therapy service manager Beverley a good insight into community issues. She joined the MRI in 1983 and relishes the opportunity to represent staff in influencing the way the Trust provides services and its longer term strategy.

Kim Laurie – *Nursing & Midwifery Constituency* - With over 23 years' experience in paediatric nursing, Kim has a very good understanding of what patients and their families want from hospital care. Kim also sees the benefits of the public having a much greater say in how the NHS is run and wants to help the Trust to provide a first class service for patients.

Mary Marsden – *Nursing & Midwifery Constituency* - Mary has worked within the NHS for the past 30 years and has been a Nursing and Midwifery Staff Governor for nearly two years. Mary has enjoyed taking on this role as during this period she has had the opportunity to participate in a number of engagement sessions with both staff and members of the public.

Mary states that "noticeably following these sessions there has been positive feedback from all concerned. I have taken the opportunity to take forward issues raised by staff with positive outcomes. My overall aim is to continue to provide support for my colleagues and the hospital Trust in providing high standards of patient care. I am looking forward to the next 12 months and the challenges this may bring".

Julian Wright – *Medical & Dental Constituency* - Julian has been a Consultant Nephrologist at the Trust since 2005. He is an Honorary Senior Lecturer and Research Fellow at The University of Manchester and is also the Trust's Director of Postgraduate Education. As a Governor, Julian aims to help deliver the Trust's vision and maintain high standards of healthcare for every patient that staff work hard to deliver.

Gillian Hobson – *Non-Clinical & Support Constituency*
Resigned (January 2011)

Alison Maw – *Other Clinical Constituency*
Resigned (September 2010)

Nominated Governors

Rabnawaz Akbar – *Manchester City Council* - Councillor Rabnawaz Akbar is Chair of Birchfields Primary School Governing Body, Secretary of the Manchester Council of Mosques (MCOM) and trustee of various other community based organisations. Rabnawaz is passionate about the NHS and his aim is to help the Trust to better understand the communities it serves. Rabnawaz's extensive experience in the community will allow him to positively contribute to the strategic vision of the Trust.

Kay Day – *The University of Manchester* - Kay has worked in the University for over 25 years initially in adult education, science and engineering followed by a period of eight years managing the academic quality unit. Kay became Head of Administration for the new Faculty of Medical and Human Sciences in 2004. Her responsibilities include managing a team of approximately 500 staff, managing the administrative processes across the faculty and being a member of the faculty senior management team. Kay has particular responsibilities for building strong links with local NHS Trusts.

Saklain Farooq – *Youth Forum* - Saklain has seen the NHS in action, caring for people close to him. He therefore has a passion to do what he can to make the patient experience as comfortable and as bearable as possible. He is keen to communicate the Youth Forum's ideas for making the children's hospital a better place for young people.

Angela Harrington – *Manchester City Council* - Angela is a Regeneration Manager with Manchester City Council and is responsible for employment and skills across the city. Angela is very interested in the Trust's contribution to employment and skills, education, public health, community engagement and corporate citizenship, especially in the five wards that surround it, where residents experience high levels of deprivation including poor health.

Helen Hosker – *NHS Manchester* – A Manchester GP for over 20 years, Helen is the Urgent Care Lead and Board Member of the shadow Central Manchester General Practice Commissioning Consortia. Helen is also a GP with Special Interest in Intermediate Care. She is involved in local and national projects for stroke and falls in older people. Helen's strengths include an understanding of the health needs of the local population, policy changes within the NHS and service redesign.

Jenny Scott - *Specialist Commissioning Group* - Jenny has 21 years' experience in healthcare planning, information, contracting and hospital management. Jenny project managed a reorganisation of Greater Manchester renal services before moving into healthcare commissioning. Jenny is now Director of Specialised Commissioning in the North West Specialised Commissioning Team, which works on behalf of the 24 PCTs in the North West in commissioning specialised services.

Abubaker Suleman – *Youth Forum* - Abu hopes to become a children's nurse and feels that the role of youth governor provides the valuable experience towards achieving this goal. He appreciates the hard work and commitment that representing the Youth Forum involves and is enthusiastic about using his initiative to think up new ideas and finding solutions to problems.

Gillian Wallis - *The University of Manchester* – As Professor of Genetics at The University of Manchester, Gillian is involved in pioneering research work into osteoarthritis and its translation into new treatments for patients. Gillian has studied in South Africa, Switzerland and the US. Gillian is also Associate Dean for Postgraduate Medical Education, playing a key role in the training of future doctors and researchers.

Sam King – *Youth Forum* – Resigned (September 2010)

Zanib Nasim – *Youth Forum* - Resigned (September 2010)

Jeff Smith - *Manchester City Council* – Resigned (February 2011)

Declaration of Interests

Details of the Council of Governors' declaration of interests are held by the Membership Office (contact: 0161 276 8661 or ft.enquiries@cmft.nhs.uk).

Working Groups

Governors play a vital role in helping to plan and develop future services and respond to feedback from their constituents and the wider community. We have four Governor Working Groups which look at practical ways to make a difference to patient care within our hospitals and to reduce health inequalities in the surrounding communities. The Working Groups cover:

Staff Health & Wellbeing – supports the development and implementation of the Staff Health and Wellbeing Strategy by being involved in work initiatives identified/generated as a result of the Trust's annual staff survey findings.

Recent work projects include pay progression, recognition, appraisal process and sickness absence.

Corporate Citizenship – advises and engages with the Trust's Corporate Citizenship programme with work projects being generated around three main themes namely Employment, Carbon Reduction and Travel & Transport.

In addition, the group supports joint initiatives with partner organisations including the Manchester Health Academy and The Corridor – Manchester.

Patient Experience - supports the implementation of the Trust's Patient Experience Strategy by advising on accessibility, customer focus, front of house/reception areas, interpretation services, patient information, and developing meaningful involvement with patient partnership groups.

Recent work projects include a complaints procedure review and analysis, Governor involvement in a patients' letters project and attending Modern Matron Ward Rounds.

Membership – helps to recruit and engage members, ensuring a representative base is established which accurately portrays the diverse communities that the Trust serves. Membership engagement best practice methodologies are currently being developed and supported by our Governors.

Recent work projects included the establishment of social networking facilities (Facebook page) with a statement from the Lead Governor promoting membership, the development of a dedicated Membership Stand, a newly formatted membership application form and involvement in the planning of membership engagement events.

Governor attendance at Council of Governor Meetings – 2010/11

Governor Name	Council of Governors Meeting 7th June 2010	Council of Governors Meeting 4th October 2010	Council of Governors Meeting 2nd February 2011
Rabnawaz Akbar	N/A	N/A	N/A
Ivy Ashworth-Crees	✗	✓	✓
Jayne Bessant	✓	✓	✓
Gordon Cairns	N/A	N/A	N/A
Malcolm Chiswick	✓	✓	✓
Abu Chowdhury	✓	✓	✓
Lawrence Cotter	✓	✓	✓
Kay Day	✓	✓	✓
Peter Dodd	✓	✗	✗
Brian Donaldson	✓	✗	✓
Peter Dungey	N/A	✓	✓
Saklain Farooq	N/A	✗	✓
Angela Harrington	✓	✗	✓
Beverley Hopcutt	✓	✓	✗
Helen Hosker	✓	✓	✗
Richard Jenkins	N/A	✗	✓
Sam King	✗	N/A	N/A
Kim Laurie	✓	✓	✗
Mary Marsden	✓	✓	✓
Alison Maw	✓	N/A	N/A
Alexena Morrison	✓	✓	✓
Zanib Nasim	✗	N/A	N/A
Margaret Parkes	✓	✓	✓
William Keith Paver	✓	✓	✓
Martin Rathfelder	✓	✓	✓
Bernice Reid	✓	✓	✓

Governor Name	Council of Governors Meeting 7th June 2010	Council of Governors Meeting 4th October 2010	Council of Governors Meeting 2nd February 2011
Lynne Richmond	✓	✗	✗
Jenny Scott	✗	✓	✓
Jeff Smith	✓	✓	✗
Abubaker Suleman	N/A	✓	✓
Gillian Wallis	✓	✓	✓
Roy Walters	✓	✓	✓
Sue Webster	✓	✓	✓
Julian Wright	N/A	✓	✓
Neelam Zaka	N/A	N/A	N/A

Director attendance at Council of Governor Meetings – 2010/11

Director Name	Council of Governors Meeting 7th June 2010	Council of Governors Meeting 4th October 2010	Council of Governors Meeting 2nd February 2011
Lady Rhona Bradley Non-executive Director	✓	✓	✓
Rod Coombs Non-executive Director	✓	✓	✗
Mike Deegan Chief Executive	✓	✓	✓
Gill Heaton Executive Director of Patient Services/Chief Nurse	✓	✓	✓
Anthony Leon Non-executive Director	✓	✓	✗
Peter Mount Chairman	✓	✗	✓
Steve Mycio Non-executive Director	✓	✓	✓
Robert Pearson Medical Director	✗	✓	✗
Adrian Roberts Executive Director of Finance	✓	✓	✓
Brenda Smith Non-executive Director	✓	✓	✓
Derek Welsh Executive Director of Human & Corporate Resources	✓	✓	✓
Alexander Wiseman Non-executive Director	✓	✓	✓

Governor attendance at Council of Governor Working Groups – 2010/11

Governor Name	Membership Working Group			
	28th April 2010	28th July 2010	27th October 2010	12th January 2011
Rabnawaz Akbar	N/A	N/A	N/A	N/A
Gordon Cairns	✓	N/A	N/A	N/A
Peter Dodd	✓	✓	✓	✓
Mary Marsden	✓	✓	✓	✓
Zanib Nasim	✓	✗	N/A	N/A
William Keith Paver	✗	✓	✓	✓
Martin Rathfelder	✗	✗	✗	✗
Susan Rowlands	N/A	N/A	✗	✓
Julian Wright	N/A	N/A	✓	✗

Governor Name	Patient Experience Working Group			
	14th May 2010	17th September 2010	19th November 2010	14th January 2011
Ivy Ashworth-Crees	✓	✗	✓	✓
Jayne Bessant	✓	✓	✓	✓
Gordon Cairns	N/A	N/A	N/A	N/A
Malcolm Chiswick	✓	✓	✗	✗
Abu Chowdhury	✓	✗	✗	✗
Kay Day	✓	✗	✓	✗
Peter Dodd	✓	✗	✓	✗
Brian Donaldson	✓	✗	✗	✗
Peter Dungey	N/A	N/A	✓	✓
Beverley Hopcutt	✗	✗	✓	✗
Richard Jenkins	N/A	N/A	✓	✓
Sam King	✗	N/A	N/A	N/A
Kim Laurie	✓	✗	✗	✗
Margaret Parkes	✓	✓	✓	✗
Lynne Richmond	✗	✓	✓	✓
Neelam Zaka	✗	N/A	N/A	N/A

Governor Name	Corporate Citizenship Working Group			
	23rd April 2010	23rd July 2010	15th October 2010	17th January 2011
Malcolm Chiswick	✓	✗	✓	✗
Angela Harrington	✓	✓	✓	✗
Gillian Hobson	✓	✓	✓	✓
Mary Marsden	✓	✓	✗	✗
Alison Maw	✓	✗	N/A	N/A
Jeff Smith	✗	✓	✗	✗
Roy Walters	✗	✗	✗	✓
Sue Webster	✓	✓	✓	✓

Governor Name	Staff Health & Wellbeing Working Group				
	24th May 2010	26th July 2010	20th September 2010	25th November 2010	19th January 2011
Lawrence Cotter	N/A	N/A	✓	✓	✗
Brian Donaldson	✓	✓	✗	✗	✗
Helen Hosker	✗	✓	✗	✗	✗
Kim Laurie	✓	✗	✗	✓	✗
Zanib Nasim	✗	✗	N/A	N/A	N/A
Alexena Morrison	✓	✓	✓	✗	✓
Margaret Parkes	✓	✓	✓	✗	✓
William Keith Paver	✓	✓	✓	✓	✓
Martin Rathfelder	✓	✗	✓	✓	✗
Bernice Reid	✗	✓	✓	✓	✓
Lynne Richmond	✗	✓	✓	✓	✓
Gillian Wallis	✓	✓	✓	✓	✓

Membership

Membership Aim & Key Priorities

Membership Aim:

- For the Trust to have a representative membership which truly reflects the communities that it serves with members being actively engaged and supported by Governors.

Key Priorities:

- Membership Community – to uphold our membership community by addressing natural attrition and membership profile short-fallings.
- Membership Engagement – to develop and implement best practice engagement methods.
- Governor Development – to support the developing and evolving role of Governor.

(see page 51 for details)

Membership Community

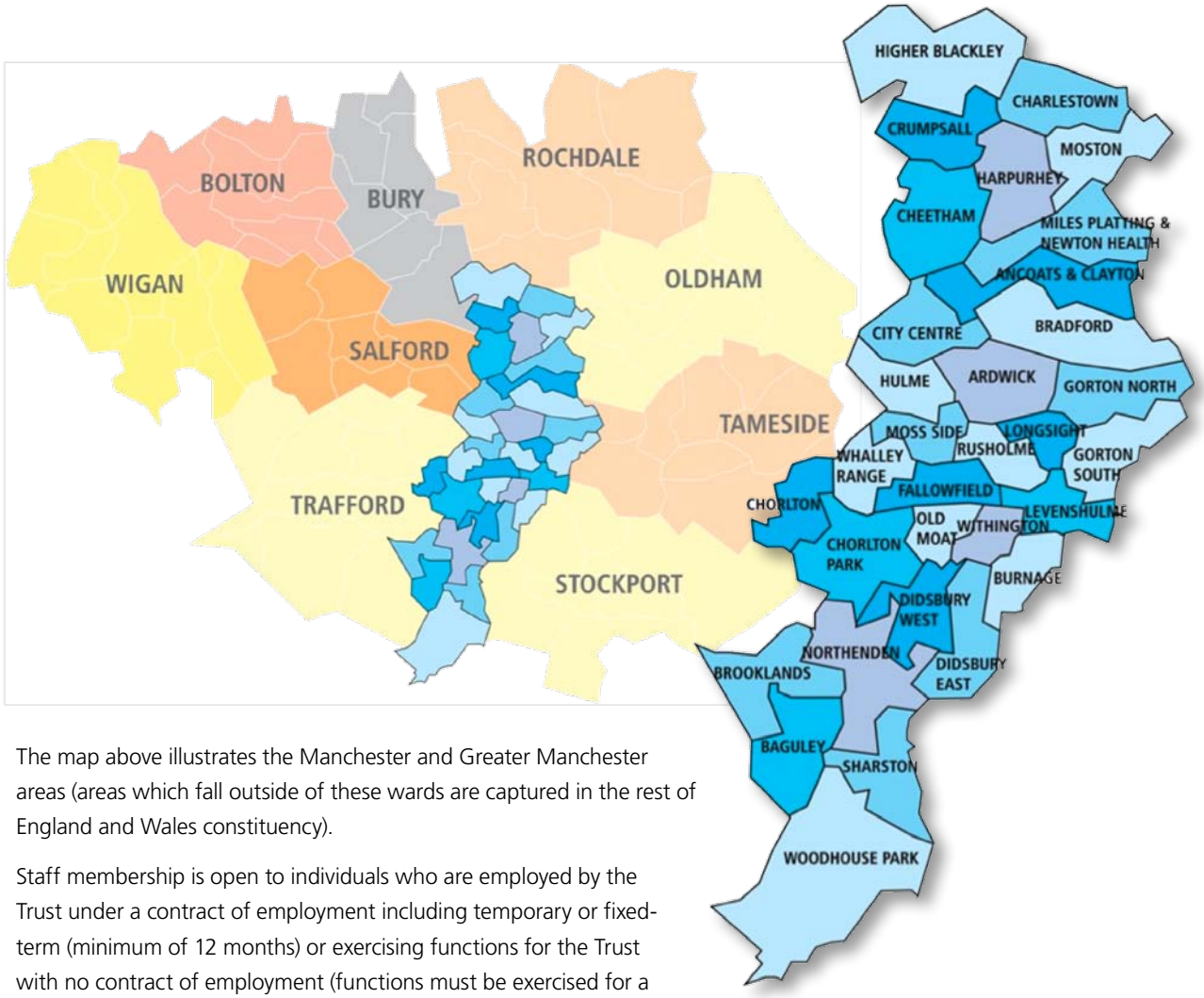
Our membership community comprises both public and staff constituencies with the public constituency being made up of Public Members (vote for and elect Public Governors) and the staff constituency being made up of Staff Members (vote for and elect Staff Governors).

Public Members

Public membership is voluntary and free of charge and is open to anyone who is aged 11 years or over and resides in England and Wales.

The Public Member constituency is subdivided into three areas:

- Manchester
- Greater Manchester
- Rest of England & Wales.



The map above illustrates the Manchester and Greater Manchester areas (areas which fall outside of these wards are captured in the rest of England and Wales constituency).

Staff membership is open to individuals who are employed by the Trust under a contract of employment including temporary or fixed-term (minimum of 12 months) or exercising functions for the Trust with no contract of employment (functions must be exercised for a minimum of 12 months).

All qualifying members of staff are automatically invited to become members as we are confident that our staff want to play an active role in developing better quality services for our patients. Staff are however able to opt out if they wish to do so.

The Staff Member constituency is subdivided into four groups:

- Medical & Dental
- Other Clinical
- Nursing & Midwifery
- Non-Clinical & Support.

Membership Strategy

A Membership Strategy has been produced with its purpose being to outline how the Trust recruits, engages, supports, maintains and develops its membership community in addition to facilitating effective member communication. The Membership Strategy is reviewed/updated annually by the Governors' Membership Working Group. A copy of this document can be obtained from the Membership Office (contact: 0161 276 8661 or ft.enquiries@cmft.nhs.uk)

Membership Growth

In 2010/11 the Trust achieved and exceeded its target membership growth of 12,000 Public Members in addition to having a staff membership of around 9,300. At year end, our membership community comprised over 21,000 members. However, the transfer of community staff to the Trust has created a combined overall membership community of around 23,000 members.

As we have achieved our overall public membership target set by Monitor (at authorisation), we aim to uphold our membership community by addressing natural attrition and membership profile short-fallings.

As facilitated via the Governors' Membership Working Group, membership recruitment for 2010/11 was focused upon growing our public membership numbers to reach our target. This was achieved via two recruitment events which were held at several local Health Centres and across all our hospitals. Membership promotion was further facilitated by the establishment of the Trust's new Facebook page which includes a statement from our Lead Governor outlining the benefits of becoming a member.

A key priority area for the forthcoming year is to target membership recruitment in the young people's age group to achieve an 11 – 16 year old membership population of around 4.5%. In addition, hard to reach groups will continue to remain a recruitment focus with particular targeting of mixed ethnic groups. Membership promotion will be facilitated by our membership display stand, our new Foundation Trust website and poster displays on hospital public transportation.

Monitoring

Our Membership community is continually monitored by the Governors' Membership Working Group to ensure natural attrition and profile short-fallings are identified with membership recruitment initiatives being developed to address any imbalances. The Working Group reports to the Council of Governors.

Public Membership Analysis Data

	Membership 2009/10	%	Membership 2010/11	%
Age				
0 – 16	518	4.9	348	2.9
17 – 21	941	8.9	1,121	9.2
22+	9,144	86.2	9,679	79.8
Not Stated	-	-	976	8.1
Ethnicity				
White	7,851	74.0	8,989	74.1
Mixed	218	2.1	250	2.1
Asian or Asian British	1,101	10.4	1,282	10.6
Black or Black British	784	7.4	892	7.4
Other	184	1.7	200	1.6
Not Stated	465	4.4	511	4.2
Gender				
Male	5,061	47.7	5,552	45.8
Female	5,378	50.7	6,394	52.7
Not Stated	164	1.6	178	1.5
Recorded Disability	1,925	18.2	2,061	17

Note: Although the 0 – 16 year old membership group figure may appear low, the Trust's membership base for this group is between the ages of 11 – 16 years.

Total Public Membership (31st March 2011) = 12,124 (976 members with no stated age, 511 members with no stated

ethnicity and 178 members with no stated gender). Staff membership at 31st March 2011 = 9,327 this includes facilities management contract staff. All staff are members and therefore had the same profiles for age, ethnicity, gender and recorded disability as for staff (see page 72).

Membership Engagement

In addition to upholding our membership community, the Trust has also strived to actively engage with members so that their contribution and involvement is turned into tangible service benefits thus improving our overall experiences for patients. Membership engagement is facilitated via our strong working relationship with our Governors, by developing engagement best practice methodologies.

In 2010/11 membership engagement initiatives have included:

- A Young People's Health Event which included interactive demonstrations, key speakers from varying health professions and various stands promoting key health service areas within the Trust in addition to advice on NHS careers/voluntary services.
- An Interactive Annual Members' Meeting which provided an overview of the Trust's past performance and plans for the future in addition to various stands promoting key health services with interactive demonstrations/health checks.
- A series of Chairman/Staff Governor Engagement Sessions with Staff Members at which discussion was facilitated and detailed action plans were developed to ultimately improve service provision for our patients.
- Members' views and opinions were acquired following the development of a questionnaire which enabled the Trust's membership engagement initiatives to be tailored to more accurately reflect members' needs.
- The establishment of two public ambassador roles (an adult and a young member) which has further enhanced communications between members and Governors.
- Governor attendance (youth and adults) at the Trust's Youth Forum Meetings which has facilitated effective engagement between young members and Governors.
- A Patient and Public Involvement representative regularly attends the Governors' Membership Working Group to assist in the development of membership engagement best practice methods.

Membership engagement will continue to be our key priority over the forthcoming year with the Membership Working Group in conjunction with the Council of Governors developing and monitoring initiatives.

By engaging with our members in a way that meets their needs and continuing to uphold a membership community that truly reflects the diverse communities that the Trust serves, we aim to ensure that as many people as possible have the opportunity to contribute and be involved in the development of our services that mirror our patients' needs.

Working with our staff

Staff Communications & Engagement

We aim to have an engaged workforce. An engaged employee is a person who is fully involved in, and enthusiastic about their work; they care about the future of the organisation and are willing to invest effort to see that the organisation succeeds. Increasing evidence shows that there is a clear relationship between staff satisfaction and patient satisfaction. Research shows that engaged and empowered staff not only generate better outcomes for patients but there are clear benefits in terms of clinical quality and business benefits, such as lower levels of sickness absence and greater productivity.

We are committed to developing staff engagement during the forthcoming year and following a second full census of the workforce to give us rich quantitative data for Divisions, Directorates and Staff Groups, coupled with extensive qualitative staff research, we are composing a staff engagement strategy to address the areas of improvement which matter most to staff.

All employment policies and procedures are consistent with employment legislation and best practice guidance from ACAS (Advisory, Conciliation and Arbitration Services).

All formal mechanisms within the Trust's employment policies allow for employees to be accompanied by a Trade Union representative to ensure that employees are appropriately represented and supported and all managers leading on employee relations cases are supported by a member of the HR team to ensure consistency of the application of policies and procedures.

Employment relations activity is monitored regularly by the Operational Management Group, Local Negotiating Committee and Trust Joint Negotiating and Consultative Committee (TJNCC) by reference to its costs to the organisation and also by balancing risk.

Staff receive detailed information on the Trust's performance. Campaigns such as the Quality Campaign continue to encourage staff to become involved in the Trust's performance against key indicators such as patient satisfaction, pain relief, and infection control.

Communications with our staff have improved over the last year with the introduction of a new intranet (staffnet) and weekly news bulletin. Staff engagements sessions are also held regularly in each division, led by the Chief Executive.

The NHS Constitution – embedding the staff pledges – Staff engagement in decision making

In line with our views in 2009, engagement has continued to play a large role this year. All 8,500 staff were invited to participate in the annual staff survey so that we could ensure everyone had the opportunity to contribute and influence change.

The Quality Campaign remains crucial with the newly introduced 'Change One Thing' programme enabling staff to make practical suggestions about changes which could benefit patients or colleagues. The high uptake on this scheme demonstrates the desire from staff to be involved in every aspect of the Trust and a range of suggestions has already been approved for implementation.

A key priority for 2011/12 is embedding the values found within the NHS Constitution. These six areas, including respect, compassion and dignity, will act as a 'golden thread' through all aspects of patient care and staff experience.

Staff Survey

We have developed our approach to the presentation, extensive dissemination and review of the National NHS Staff Survey findings. The far-reaching communication strategy includes the cascade of results via a dedicated intranet site publishing full details, divisional and directorate reports, newsletters and 'Insight', our staff magazine and team meeting agendas to Division and Directorate teams, to Board members, Trade Union members and Governors. All staff receive a leaflet explaining the results in the framework of the NHS Constitution, the Staff Pledges and the Care Quality Commission's Key Findings. Divisions are supported to update and develop realistic action plans around key challenges and their progress against their local plans is monitored through our formal divisional review process bi-annually in November and May.

Our overall engagement score has increased from last year, particularly in the domain of staff motivation, but remains in the lowest 20% when compared with trusts of a similar type. The engagement score is composed of staff motivation, staff ability to contribute towards improvements at work and staff recommending the Trust as a place to work or receive treatment, and will remain priority areas for focus over the coming year. The Trust Quality Campaign embraced the NHS Constitution and the associated Key Findings regarding staff perceptions of working in the Trust and determined that 10% year on year improvements should be made, using the 2009 census data as a baseline. The associated workforce programme reports into the Quality Forum four times a year with progress updates, and although these targets have not been fully realised, the work streams remain a crucial part of the Trust's commitment to improving staff engagement. An individual area of prime concern to the Trust is the deterioration of the availability of hand washing materials which is being addressed as a matter of urgency. A high degree of energy has been invested in order to simplify and streamline the Trust's appraisal system which has seen an increase in staff participation in appraisals and personal development. On-going work will focus on addressing the low score around appraisals being well structured.

Summary of performance - NHS staff survey

Historically we have seen a gradual downward trend in response rates from the first NHS Staff Survey year on year and following a reversal last year, it is encouraging to see this progress continuing with an improved response rate this year.

Each Division has established a key Staff Engagement Champion to drive through their Divisional action plans. Divisions will include activities still in progress from the 2009 survey in their action planning from the latest results. Further Divisional work includes smaller, qualitative surveys around specific local issues brought to light by the national survey and staff focus groups are being held to determine local priorities and focus for action.

Sample Data

Top 4 Ranking Scores	2009/2010		2010/2011		Trust Improvement or Deterioration
	Trust	National	Trust	National	
KF17: Percentage of staff suffering work-related injury in the last 12 months *(the lower the score the better)*	19%	17%	11%	16%	Improvement -8%
KF21: Percentage of staff reporting errors, near misses or incidents witnessed in the last month *(the higher the score the better)*	94%	95%	99%	95%	Improvement +5%
KF23: Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months *(the lower the score the better)*	N/A *(changed measure from 2009)*	N/A *(changed measure from 2009)*	6%	8%	N/A
KF36: Percentage of staff having equality and diversity training in last 12 months *(the higher the score the better)*	48%	35%	54%	41%	Improvement +6%

Bottom 4 Ranking Scores	2009/2010		2010/2011		Trust Improvement or Deterioration
	Trust	National	Trust	National	
KF19: Percentage of staff saying hand washing materials are always available (the higher the score the better)	49%	69%	40%	67%	Deterioration -9%
KF1: Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver (the higher the score the better)	65%	74%	63%	74%	Deterioration -2%
KF33: Staff intention to leave jobs (the lower the score the better)	2.76	2.51	2.78	2.53	Deterioration +0.02
KF13: Percentage of staff having well structured appraisals in last 12 months (the higher the score the better)	23%	30%	23%	33%	No Change

Priorities from the 2010 survey

- Establishment of a senior working group to focus on a small number of key themes
- Disseminating the findings to Divisions and staff - a more detailed communication plan has been established to ensure efficient dissemination
- Development of a staff engagement plan - several projects are currently being discussed to improve engagement e.g. suggestion schemes
- Tackling the perception of the availability of hand washing materials
- Focusing on Nursing and Midwifery as a priority staff group
- Continuing values and behaviours work in line with the NHS Constitution

- Development of a strategy for Health & Wellbeing – a Health & Wellbeing group has been established and a strategy drafted. There is a focus on promoting health and wellbeing issues and encouraging staff to choose healthy lifestyles.
- Continued key Governor group involvement in work programme development.
- Robust challenge to Divisions of progress against their action plans during formal divisional reviews.

The new Trust Appraisal Process

All staff have the right to an Appraisal (Performance and Development Review).

In April 2011, the Trust introduced a new Appraisal process to support the Trust in providing all staff with clear roles and responsibilities and rewarding jobs that make a difference to patients, as well as providing staff with personal development, access to appropriate training for their jobs and line management support to succeed, as outlined in the Staff Pledges within the NHS Constitution.

The annual Appraisal meeting provides an opportunity for managers and staff to have focused discussions around expectations and outcomes as well as providing a formal mechanism for identifying key achievements, development needs and opportunities to address them.

Formal Performance Appraisal Meeting

Preparation

↓

Performance Appraisal meeting

Review to include:

- Job Description (purpose of role)
- Personal Objectives (priorities/outcomes)
- Skills, Knowledge, Behaviours (expectations of the postholder)

↓

Agree Personal Objectives/Priorities for next 12 months

(contribution towards patient care and expected outcomes)

↓

Personal Development Plan

(training/development & support required)

This process enables employees to understand better their contribution towards improved Patient Care by linking personal objectives and development to Key Trust Priorities. By ensuring that every employee is able to meet the requirements of their post the Trust aims to improve job satisfaction for staff, as well as ensuring that patients are receiving the best care in terms of quality and consistency.

E-Learning

E-learning continues to be high on the agenda for the Trust and all Mandatory Training is now offered online. This gives staff the opportunity to complete their training with greater flexibility and reduces the amount of time required away from the workplace.

Courses offered in this way include:

- Corporate Mandatory Training
- Clinical (Adults & Paediatrics)
- Doctor's Induction
- Medicine Safety
- Antibiotic Prescribing
- Systems training

In 2010, the number of modules completed online was over double that of 2009, and according to Staff Survey responses, 63% of staff said that they had undertaken some form of e-learning, compared to 39% in 2009.

The Organisational Development and Training team are continuing to develop e-learning as a priority, and as well as offering Mandatory Training, are working with a number of departments to introduce new programmes for use in both clinical and non-clinical areas.

Community Engagement through Employment Initiatives

We remain committed to supporting local regeneration and to improving economic prosperity in the neighbourhood. As part of this, we work hard to identify key issues and to implement new initiatives designed to confront and address the barriers that local minority groups can sometimes face in securing employment.

A particular focus is around valuing diversity and continuing to operate as a true employer of choice that is representative of our local community and service users.

Education

In delivering this strategy, we have continued to work with local schools and colleges to help shape curricula and to ensure that qualifications are relevant and appropriate to the current job market.

Significant in this, is our on-going commitment to the Manchester Health Academy in Wythenshawe. As lead sponsor of the Academy, we support the development of an improved educational offer within the city of Manchester, and the Academy's specialisms of Health, Bio-science and Sport mirror our own aspirations as a leading Teaching Hospital. The overall ambition is to partner the Academy in providing clear career pathways for young people to join the NHS.

Additionally, we have an alliance with 'Aim Higher' which is a national government initiative that is aimed at supporting people at school, in college and at work to progress to higher education and be better prepared to take up NHS opportunities in the future. This initiative will broaden horizons and build confidence and so increase future opportunities for individuals consenting to take part.

The Community

We have improved our engagement and exposure in the local community by extending our presence at local community events and job fairs. A practical example of this is the work that we lead on in bringing together other large employers in the city to work together to improve employment opportunities for those residing locally. As a part of this, we remain a keen participant in all 'Corridor Manchester' activity.

Working ever more closely with voluntary organisations, we have promoted work around the provision of employability training and accessibility to all our vacancies and associated careers information.

Sickness Absence Figures 2010/11

Sum of whole time equivalent (wte) days sick in period	Sum of wte days available	Total number of full time equivalents (fte) days lost to sickness absence	Total number of fte years available	Average number of days sickness absence per fte	Overall NHS organisation ranking (from a position of high to low)
120,351	2,822,240	74,188	7,745	9.6	177*

** Based on 413 organisations in December 2010*

Source: The Electronic Staff Records system

Period covered: January to December 2010

Data Items: ESR does not hold details of the number of days worked by each employee. Data on days lost and days available are produced in reports that are based on a 365-day year.

The total number of full time equivalents (fte) days lost to sickness absence has been scaled down by a factor of 225/365 to provide the best estimate of the number of days available/lost.

Equality and Diversity in Employment

The Executive Director of Human & Corporate Resources has lead responsibility for the employment aspects of the Equality & Diversity agenda. The Human Resources Directorate recognises that the Equality and Diversity agenda is central to its day to day activities and the agenda falls across all areas of its work. All departments actively work together to ensure that all staff members can promote equality, fairness and respect, and behave in accordance with the Trust Equality and Diversity Policy.

The previous 12 months have been a productive year for progressing the equality and diversity employment agenda although there remains a significant challenge to be addressed in the future. The following section lists key achievements for the directorate for 2010/11.

Key Achievements

HR Equality & Diversity Steering Group

The Steering Group comprises all section heads from the Human Resources Directorate and meets quarterly. It is a relatively new group whose main purpose is to guide the HR directorate's approach to the management of the Equality & Diversity agenda across all aspects of employment.

HR Equality & Diversity Work Programme

The HR Equality & Diversity Steering Group is currently working through an Equality & Diversity Action Plan in relation to employment. The action plan is designed to improve HR processes and performance in ensuring compliance with the Equality Act 2010.

Equality & Diversity Employment Policy Framework

The Trust has a detailed set of Employment Policies and Procedures that ensure all aspects of Equality & Diversity are addressed in the workplace. The employment policy framework is designed to reflect the employment law provisions in relation to discrimination and this is reflected in the following Trust Equality & Diversity policies:

- Equality & Diversity in Employment
- Special Leave Policy
- Flexible Working
- Maternity, Paternity & Adoption Leave
- Fair Treatment Policy
- Disability Policy

Equality and Diversity Training for Staff

During 2010/11 Equality & Diversity training was provided as part of the Corporate Induction Programme and the annual Mandatory Training Scheme. In addition, Equality and Diversity Training Workshops for line managers to increase their knowledge around Equality in Employment were also delivered. All corporate HR Skills training programmes are regularly reviewed to ensure that equality aspects are fully integrated and updated. This is an ongoing piece of work which is valuable in supporting the mainstreaming of equality issues within the Trust.

Equality Networks

The Trust Equality and Diversity Policy is committed to valuing all staff. However, we recognise that real support is needed if all staff are to reach their full potential. For these reasons, we have the following two staff networks:

- Black and Minority Ethnic (BME) Staff Network
- Disabled Staff Network

The aims of the networks are:

- To support staff from different equality groups
- To enable us to gain a better understanding of issues faced by staff in the workplace
- To influence Trust policy
- To act as a consultative mechanism
- To support the implementation of the overall equality & diversity framework
- To share experiences and provide mutual support

Positive about Disabled People

We continue to support the disability 'two ticks' symbol, guaranteeing interviews for those potential employees who declare a disability and making any reasonable adjustments in the recruitment process to enable disabled applicants to take part in the process effectively.

The Trust Disability Policy ensures that any disability issues that arise during the management of sickness absence are proactively and clearly managed, providing strong occupational health support and a full assessment of possible adjustments, or other employment options that are available to the member of staff to enable them to remain in the workplace.

The Disabled Staff Network not only offers our disabled staff the opportunity to learn new skills and contribute to policy development, but also the opportunity to link into other working groups within the Trust.

	Staff 2010/11	%	Staff 2009/10	%
Age				
0-16	0	0	0	0
17-21	92	1%	67	1%
22+	8,592	99%	8,314	99%
Ethnicity				
White	6940	80%	6,672	80%
Mixed	168	2%	169	2%
Asian or Asian British	780	9%	773	9%
Black or	244	3%	312	4%
Black British Other	109	1%	111	1%
Not stated	443	5%	344	4%
Gender				
Male	1,746	20%	1,651	20%
Female	6,938	80%	6,730	80%
Not Stated	-	-	-	-
Recorded Disability	103	1%	91	1%

All staff are members of the Trust and therefore the profiles across age, ethnicity, gender and recorded disability are the same.

Summary of Workforce Statistics 2010/11 – key points

- There continues to be no significant change to the age profile of the workforce with 99% of the Trust workforce aged 22+.
- Approximately ¾ of the Trust workforce is White. 15% are from a Black and Minority Ethnic (BME) background which is slightly lower than 2009/10. 5% of the staff have not stated their ethnicity.
- The percentage split between male and female staff across the Trust has remained the same over the last two years.
- Only 1% of the Trust staff has recorded a disability. This data does not truly reflect the number of disabled staff within the Trust.

Infection Prevention and Control

The Trust has a zero tolerance approach to all avoidable infections. During 2010/11, infection prevention and control remained a high priority for the organisation as we continued to sustain our performance in the reduction of Healthcare Associated Infections (HCAIs.)

A key measure of our commitment was demonstrated by unconditional registration with the Care Quality Commission (CQC) against 10 criteria based on the Health and Social Care Act (2008). These criteria are used to measure compliance with regulation regarding cleanliness and infection control.

In March 2011, the CQC made an unannounced visit to assess compliance with the essential standards of quality and safety. In relation to caring for people in a clean environment and protected from the risk of infection, the CQC found that we were meeting this essential standard.

Key achievements this year

The actual number of attributable MRSA bacteraemias for the Trust for 2010/11 was seven. An in-depth review of these cases was undertaken and lessons learnt identified. These were provided to the clinical areas across the organisation and will be incorporated into future practice.

The Trust continually applies a range of interventions and sustained monitoring of performance across the organisation

and was compliant with national guidance on MRSA screening of all elective/emergency admissions as of December 2010.

We have an agreed target of 231 attributable cases of Clostridium difficile infection (CDI) in all patients over the age of two for the year 2010/11. The actual total number of attributable cases was 106, which is significantly lower than the target agreed.

This is a remarkable achievement and was accomplished through increased compliance with antibiotic prescribing guidelines which has improved since 2009/10, as demonstrated by the annual Trust-wide audit. Other initiatives that have been implemented this year include; divisional surveillance of antibiotic usage, increased uptake of the antibiotic e-learning teaching package and extension of the joint microbiology and pharmacy antibiotic ward rounds that target high risk areas.

A local challenge for the organisation has been the incidence of multi-resistant coliforms from some of the wards. The Infection Prevention and Control Team have tackled the issue proactively and undertaken an extensive communication and education programme in addition to a review of antibiotic policy and extended surveillance to other patients.

Following the successful implementation of Aseptic Non Touch Technique (ANTT) and Visual Inspection of Phlebitis (VIP) score audit tools in 2009/10 within the Divisions of Medicine and Surgery, the audit programme was extended in 2010/11 to incorporate all the remaining divisions.

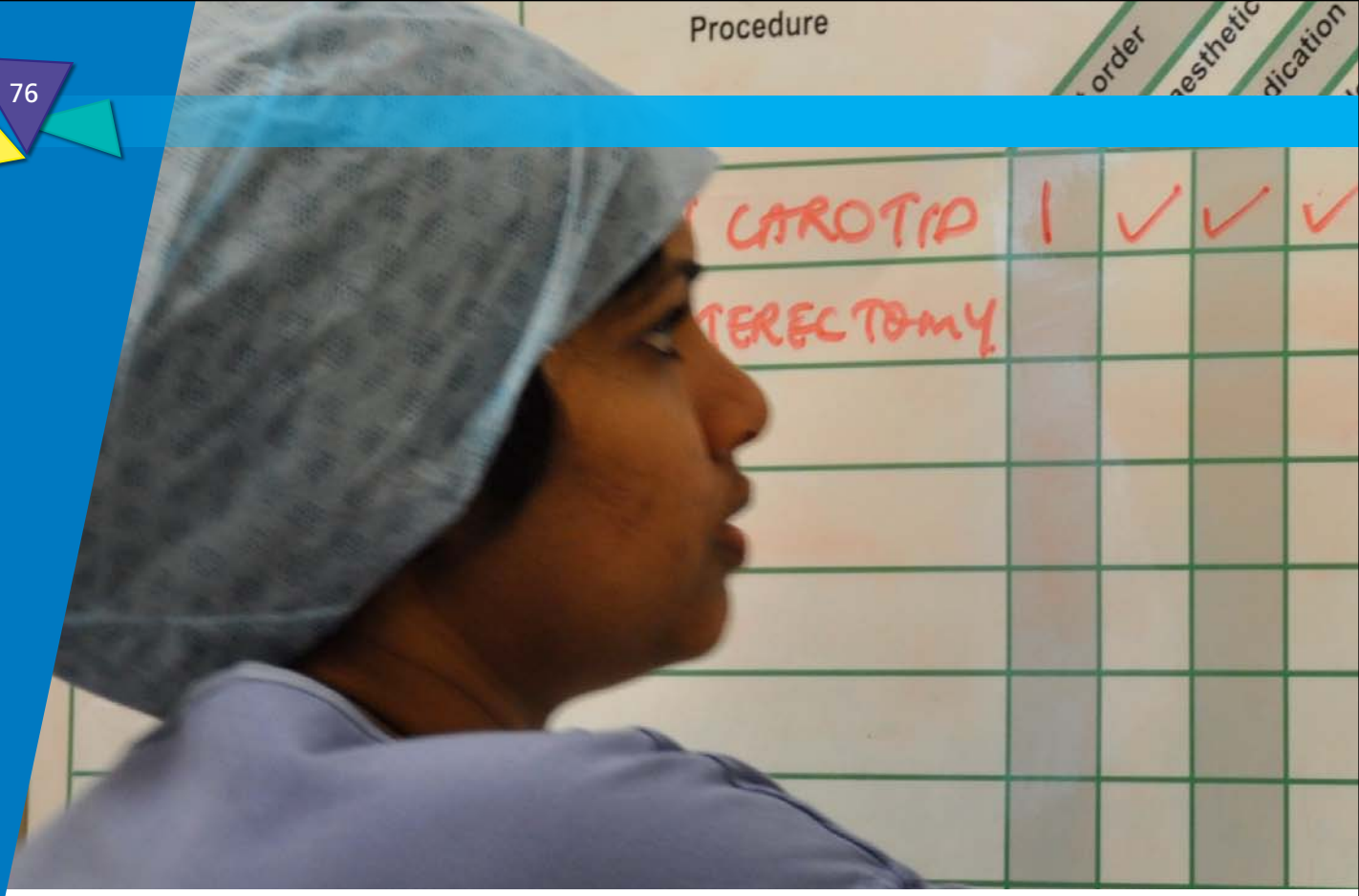
The trend for hand hygiene trust wide indicated an increase in compliance during 2010/11 to 97-98% from the previous year.

Locally, activity for seasonal influenza peaked in the last week of 2010 when 36.5% of samples were positive for influenza. The rate fell to 20.2% in the first week of 2011 which represented a similar pattern across the North West. Preparation for prevention and control arrangements included ensuring staff were trained in the use of respiratory protection.

In addition we vaccinated 2,700 members of staff against seasonal influenza during the winter period of 2010/11. This was achieved by the organisation of local vaccination clinics within each division, in addition to the drop-in sessions organised by the Occupational Health Department.

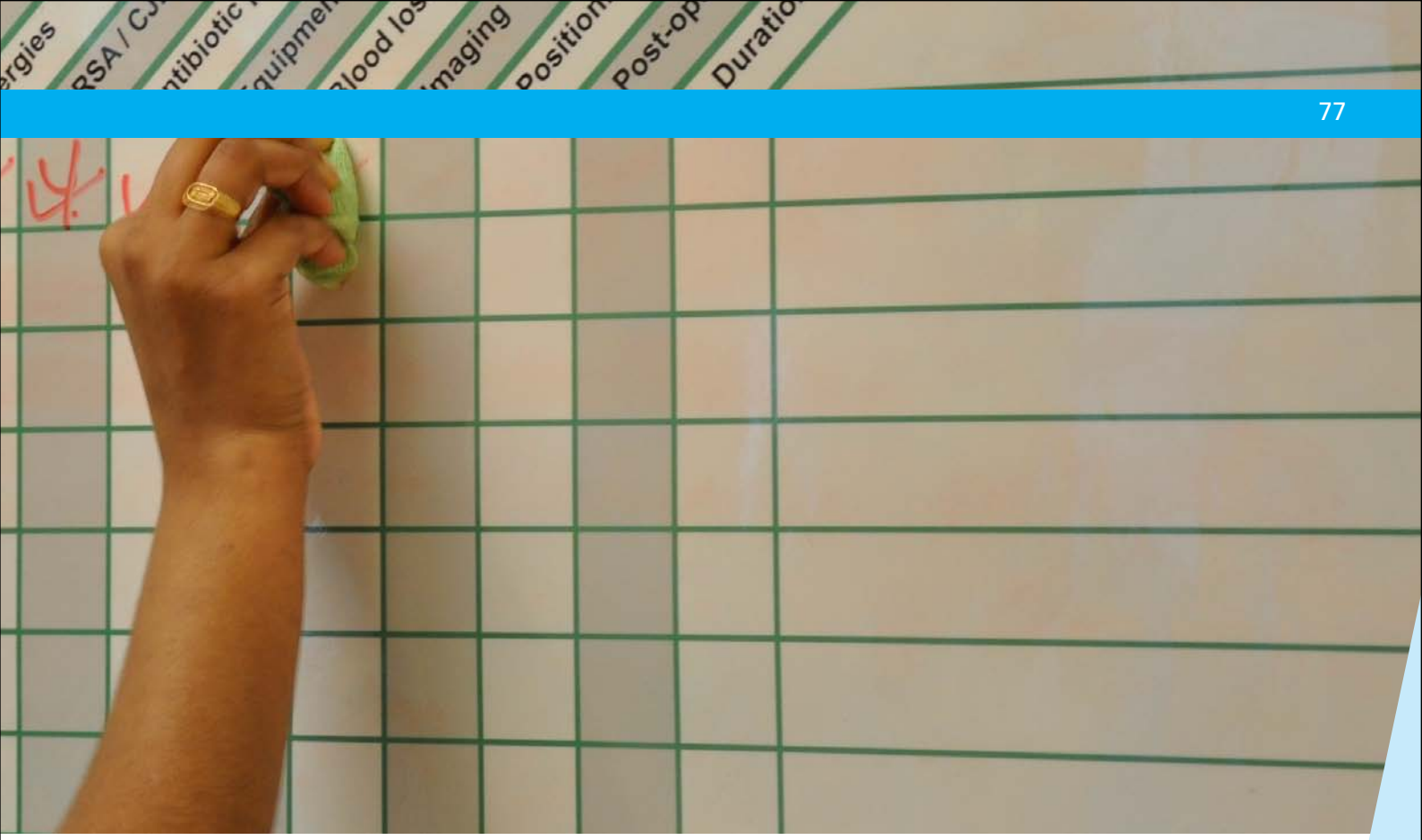
We are preparing a business case for the future centralisation of endoscopy services. In the interim this year, the Estates and Facilities Directorate has made significant improvements to the systems and equipment used to decontaminate endoscopes.

We have been the North West representative for the Department of Health Showcase Hospitals Project for the past three years. This year's activities included a trial of 'design bugs out' patient furniture which has been well evaluated and a system for monitoring cleaning including feed back of weekly cleanliness reports to wards and departments. In addition we also hosted two very successful national showcase hospitals conferences which were well attended and evaluated.



Performance against Trust business objectives 2010/11

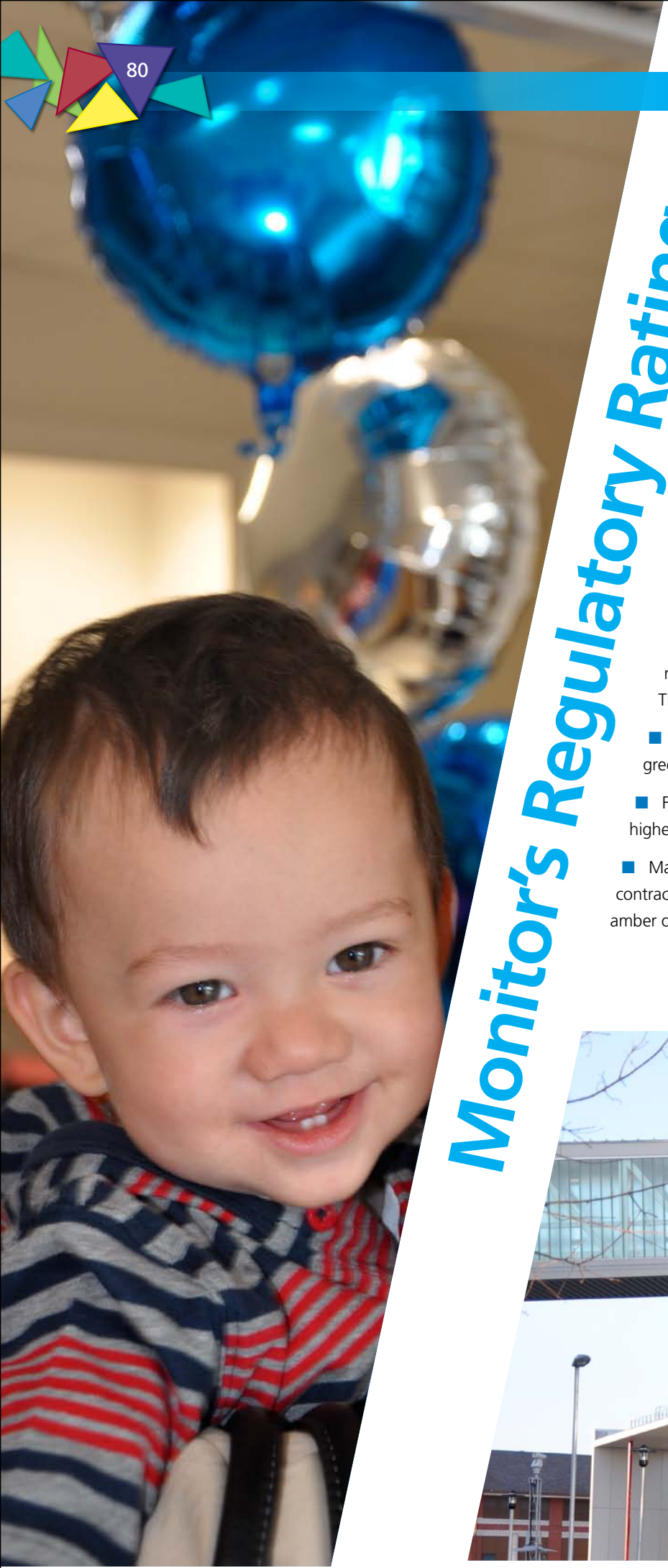
Business Objectives	Performance 2010/11
To maintain a Monitor financial risk rating of 3 throughout 2010/11.	Financial risk rating of 3 maintained. Income and expenditure surplus below plan at year end.
To develop financial plans, budget setting and activity for 2011/12.	Detailed plans advanced in all Divisions for addressing underlying challenges and 2011/12 efficiency requirements.
To finalise trading gap plans for 2011/12.	Full range of core finance, productivity and workforce programmes of work set out for Board review in October 2010. All appropriate interlinkages in place across these.
To deliver the 2010/11 capital programme.	Capital programme on track within reduced financial envelope.
To implement ongoing productivity and efficiency programmes.	Service line reporting/management rolled out across a number of specialities focusing on productivity. Implementation of expected date of discharge commenced September 2010 with operational practices amended from January 2011 and reductions in length of stay and capacity under taken in an efficient and safe manner. Continuation of theatre and ward productivity programmes.
To ensure robust reporting mechanisms are in place through the continued development of the Intelligent Board Report.	Developments continued to reflect Board priorities.



Business Objectives	Performance 2010/11
To ensure ongoing compliance with terms of authorisation from Monitor including meeting existing national targets, in particular:	
■ Infection control targets (C Diff/MRSA)	The Trust delivered on infection control targets.
■ 62 day Cancer waits	The Trust has breached the standard for the bowel screening pathway in Quarter 4 of 2010/11 but was successful in achieving the GP referral standard. A series of actions have been undertaken to achieve the target during 2011/12.
■ A&E quality indicators	The Trust has achieved the 2010/11 A&E targets and made preparations for achieving the expanded A&E indicators for 2011/12. Revised assessment and treatment processes are being implemented which will streamline the patient's pathways.
To continue progress towards achievement of 100% dispatch of discharge letters to GPs in 24 hours.	Progress has been made on discharge letter compliance and currently stands at 71% and is ongoing.
To manage the effective integration of Community Services into the Trust.	A project plan was developed and implemented during 2010/11 which included an organisational and development plan, a stakeholder engagement programme, a workforce plan, a staff engagement and communication strategy and a revision to the Trust's organisational structure. The transfer of Community Services took place successfully on 1st April 2011.

Business Objectives	Performance 2010/11
To increase the research and innovation profile nationally and internationally.	Outputs from the Biomedical Research Centre have significantly increased during 2010/11 demonstrating a good return on investment across a spectrum of National Institute for Healthcare Research Indicators. The Manchester Academic Health Sciences Centre has continued to maintain a focus on issues of direct relevance to our patients and communities. Recruitment of key individuals to clinical academic posts has continued throughout 2010/11 further enhancing the strength of the research and innovation profile of the Trust.
To demonstrate improvements in patient safety.	The Trust has achieved a system to review all deaths and monitor performance of Hospital Standardised Mortality Ratio (HSMR) in each Clinical Division. The Trust has achieved a year on year reduction in HSMR. The Trust has undertaken activities to demonstrate improved performance against a set of clinical indicators.
■ Reducing failure to recognise or act upon patient deterioration.	Good progress has been made during 2010/11 with the introduction of Patientrack.
■ Minimise incidents of hospital acquired venus thrombosis or embolism.	The Trust has scored highly in the indicator on minimising venus thrombosis or embolism which is part of the Clinical Quality Indicators (CQUIN).
■ Ensuring safe practice in relation to medicine management.	Ongoing.
To implement the Trust's quality strategy through the Quality Campaign.	Quality Campaign events within each Division one year on have been held and a briefing to the Board of Directors' Seminar also held. Significant progress has been demonstrated in improving patient and staff experience which includes some significant improvements in patient perceptions from a National In-patient Survey. Quality initiatives and implementation have been assessed at each Divisional Review. Patient experience performance measures have been developed and are now included in the Intelligent Board Report for the Board of Directors. Further developments have taken place with the productive ward and theatre initiatives in order to build a continuous improvement culture.
To make measurable improvements in the Staff Survey relating to the factors affecting staff job satisfaction.	A number of quality improvement programmes to improve organisational capability have been developed through local programmes. The results of the 2010 staff survey show some improvements although some deterioration and a Senior Staff Working Group will be implemented in early 2011/12 to drive forward further initiatives to improve the Staff Survey results for the coming year.
To ensure that the Trust is conscious of its effect on its environment and take steps to mitigate the effect.	The Trust's Carbon Management Policy is now in place and the Trust has registered as part of the National Carbon Reduction Scheme. Plans are in place to deliver 20% carbon reduction by April 2013 against the 2007/08 baseline. The Trust is actively engaged with Corridor Manchester partners, attending carbon reduction and green transport meetings. Trust Carbon Reduction Groups are in place and over 80 green champions have been appointed representing all Divisions and departments.

Business Objectives	Performance 2010/11
To continue to provide appropriate training to Governors and produce assurance reports for the Council of Governors and Working Groups.	Governors have received ongoing training including induction training for newly elected Governors. An annual planning workshop took place in February 2011. Assurance and risk reports are prepared and presented at each Council of Governors' meeting. The four Governor Working Groups are functioning effectively with developed work programmes and a focus on deliverables.
To continue to monitor the Board Committee structure for effective assurance and reporting arrangements to the Board.	Some revisions to Board Committees have taken place during 2010/11. The Charitable Funds Committee has revised Terms of Reference and functions independently of the Board. The Risk Management Committee now reviews actual not residual risks and the Health and Safety Committee has been established which reports to the Risk Management Committee. The Audit Committee has continued to increase its focus on non financial issues calling to account Trust officers when limited Audit assurance has been received.
To grow public membership to 12,000 members during 2010/11.	Recruitment campaigns took place in Health Centres and Clinics in the community during February and March 2011 to reflect transferring Community Services and the population served. The membership at the end of March 2011 stands at 12,100 public members.
To develop further membership engagement.	Two successful membership engagement events were held during 2010/11, these were the Young People's Health Event in June 2010 with over 400 attendees and an Annual Members Meeting in September 2010 with over 200 attendees. Regular newsletters and website postings continue for members. The Chairman's extended staff Governor sessions with up to 12 staff members from each constituency have been implemented and have proved a successful method of engagement with members.
To manage the organisational development and challenge of integrating three separate Children's Hospitals into one location.	Managerial structures are now in situ along with new focused clinical leadership in several specialties. There are well established Divisional and Directorate specific Clinical Governance Committee structures and noticeable improvements have taken place across a range of patient safety and quality indicators including HSMR, medical errors, clinical and mandatory training. There is an excellent interface with young people/users via the youth forum. Tailored management development programmes have been undertaken by Directorate Managers and leadership development programmes have been undertaken by Clinical Directors and Clinical Leads.
To ensure systems are in place to manage and monitor the PFI contract for Facility Management Services.	An Estates and Facilities Management Board has been established linking directly with Divisions. Significant work has been underway to develop a commercial accountability process in order to ensure best practice and probity in regards to raising and managing variations. Further development of the contract monitoring team and meeting infrastructure with PFI partners to hold partners to account has been developed. There has also been further development of performance monitoring schedules including implementing patient journey standards.
To review and further strengthen the strategic positioning of the Trust within the conurbation and beyond.	A portfolio review process is in place in each Division. Service Line Management activity has been utilised in every Division. Specific strategic positioning activities have been highlighted and implemented through a strategic priority organisation process. A Manchester Clinical Board is now well established with jointly agreed work programmes in place.



Monitor's Regulatory Ratings

Explanation of Ratings

The Trust submits quarterly reports to Monitor. Performance is monitored by Monitor, the Independent Regulator of Foundation Trusts, against plans to identify where actual and potential problems might arise. Monitor publishes quarterly and annual reports on these submissions and decides an annual and quarterly risk rating. The risk ratings are designed to indicate the risk of a failure to comply with the terms of authorisation. Risk ratings are published for the following areas. These are:-

- Governance (Rated red, amber/red, amber/green or green)
- Finance (Rated 1-5, where 1 represents the highest and 5 the lowest)
- Mandatory Services i.e. services that the Trust is contracted to supply to its commissioners (rated red, amber or green)

Summary of Rating Performance throughout the Year and Comparison to Prior Year

The table below details the rating performance for 2010/11 with a comparison for 2009/10:

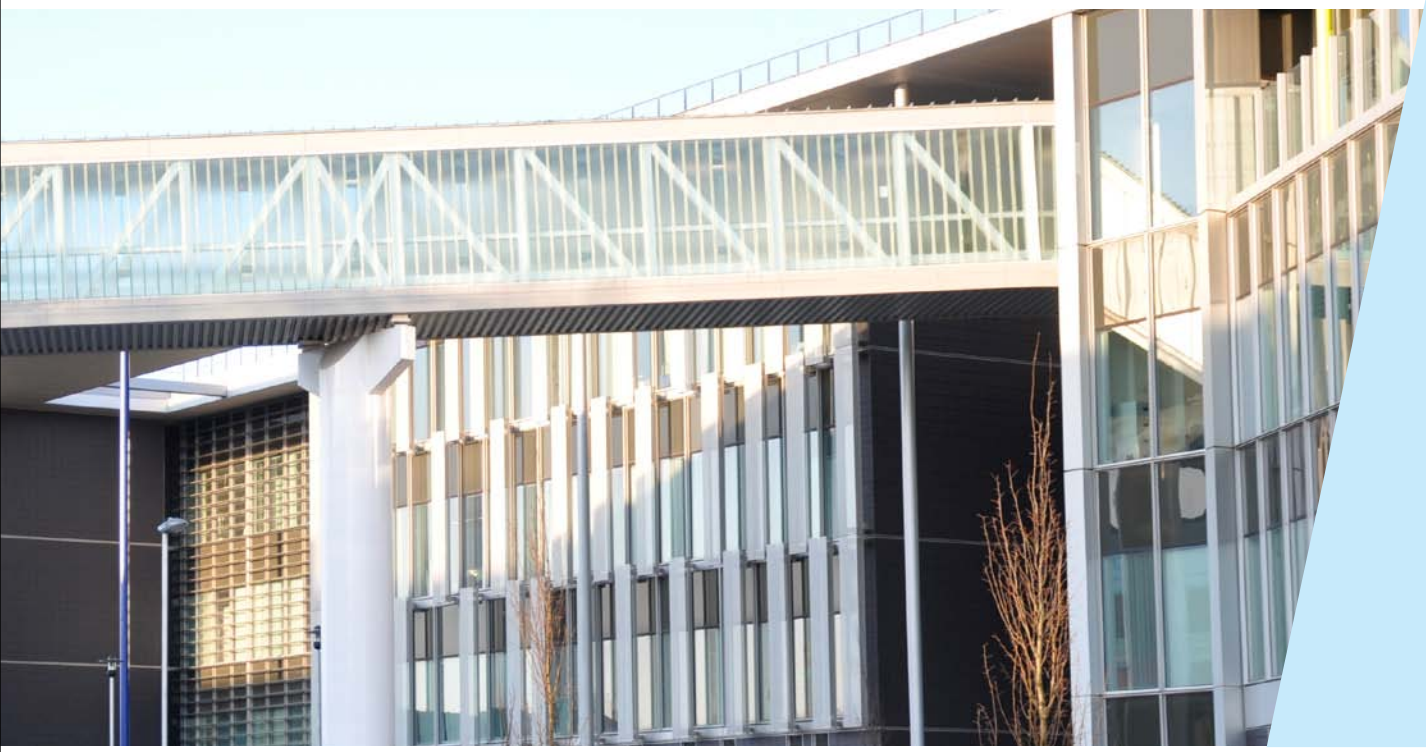
	Annual Plan 2009/10	Quarter 1 2009/10	Quarter 2 2009/10	Quarter 3 2009/10	Quarter 4 2009/10
Financial Risk Rating	3	3	3	3	3
Governance Risk Rating	Green	Green	Green	Green	Green
Mandatory Risk Rating	Green	Green	Green	Green	Green

	Annual Plan 2010/11	Quarter 1 2010/11	Quarter 2 2010/11	Quarter 3 2010/11	Quarter 4 2010/11
Financial Risk Rating	3	3	3	3	3
Governance Risk Rating	Green	Amber/Green	Amber/Green	Amber/Red	Amber/Red
Mandatory Risk Rating	Green	Green	Green	Green	Green

Analysis of Actual Quarterly Rating Performance Compared with Expectation in the Annual Plan

The Trust has achieved according to plan in the areas of finance and providing mandatory services in each quarter of 2010/11. The Trust has not achieved according to plan in the area of Governance in each of the four quarters of 2010/11.

The heightened Governance risk rating during 2010/11 was for consistent under-performance against the 62 day cancer wait target. This was primarily due to a lack of diagnostic capacity which was addressed in Quarter 4. The Trust expects delivery of this key target to be back on track from Quarter 1 of 2011/12.



Working with our patients & visitors

The Patient and Public Involvement (PPI) Service this year has had a focus on improving the patient experience across the Trust by supporting and helping services to improve on the quality of service they provide. The following reports are snapshots of only some of the work that we were actively involved in.

Choose Well

As part of the regional Choose Well campaign with NHS Northwest, the PPI service has led the implementation of a year long strategy to improve patient and public understanding of access to services. Multiple strands of work have been pulled together to allow for this co-ordinated approach. Community engagement has been moved forward to allow for targeted approaches with local community groups. Using historical data from the National Patient Survey work, our local Asian communities were targeted due to their retrospective low ratings of services provided. Work has been undertaken with the Indian Senior Citizens' Society to look at their experiences of healthcare and the services they feel are appropriate to access.

Work is planned for both the Chinese Health Information Centre and the Wai Yin society with their multiple sub-groups to ensure we are able to target a wide audience including the elderly, young parents, young carers, young people, older carers and those with mental health issues. The events are information provision and information gathering to allow feedback to be provided to the Trust to improve the patient experience for these community groups and others.

This has now been developed into a year long strategy for 2011/12 and will continue with the support of the Divisions, especially the Division of Medicine and Community Services and the Children's Division.

Trust Quality Initiative

Patient Stories

We have also placed a focus on the gathering of patient stories. This forms part of the Trust Quality Initiative as well as the need for patient stories to be used throughout the organisation for learning and development and also at Trust Board to improve the patient experience. We have worked with patients and carers to collate transcripts and videos which have then been used in training and in development sessions for staff to hear first hand how the patient experience is delivered. The stories have allowed those who are seldom heard or represented, such as carers, to have their voice heard and their experience listened and responded to.

A guidance document has been created to aid staff to safely and constructively undertake patient stories with their clients and this has been ratified through the Trust process.

As part of the patient stories' work we have worked with consultants from the Children's Division to look at patients with complex needs and the support that they and their family receive, particularly regarding transition. This ongoing piece of work will allow for improvements to be made regarding communication, information and planning for these families and will be fed back into the Division as well as through the Trust.

Equity and Inclusion

Patients and carers whose first language is not English have also been included in the work particularly with the Interpretation and Translation Service. The Interpretation Service has set up a reporting mechanism for patient experience through the Ulysses database which can then be used monthly to form the basis of analysis and learning sessions as well as disseminated to Divisions as appropriate. The Interpretation Service has also supported project activity to allow for patients and carers who are unable to speak or read English fluently to have a say and take part.

Hospital Communication Toolkit

The Hospital Communication Toolkit is a project which was undertaken in collaboration with the Division of Surgery. The project has also allowed for a scoping of the use of the tool for those patients with compromised communication including language, speech, hearing disabilities or learning disabilities. This scoping has led to an action plan being developed for the Division to re-educate staff about the toolkit and how to use it, as well as how other Divisions can improve the use of it. This will lead to an improved patient experience for those patients who have communication difficulties which in turn may affect their experiences of being in hospital.

Staff Engagement

As part of Transforming Community Services (TCS), we undertook a staff engagement session with over 100 community staff. This session was organised to empower the staff to be involved in the transition process over to the acute setting. We used an Experience Based Design approach to allow the delegates to consider seven touchpoint areas focusing on positive emotional impact, negative emotional impact, the reasons why and their solutions and suggestions for improvement. We created a multi-disciplinary and multi-agency facilitating team for the event and worked with the TCS lead to ensure that all staff had the opportunity to attend and be involved. The feedback from the event, both from delegates and corporately, was that is was a highly successful event that allowed the staff to be involved in a way that otherwise would not have taken place. An action plan has since been developed to allow for better communication for the staff and keep them involved in decision making and service planning.

Outcomes

The Youth Forum has had continued success in project activity including a follow up question and answer session with senior management. The Chairman, Deputy Director for Nursing (Children's), Head of Nursing for Children's and other senior managers attended the session where members of the Youth Forum had liaised with patients to produce questions to put to the staff members based on the Sir

Ian Kennedy document 'Getting it right for Young People'. The session was extremely successful and all the staff attendees were again extremely impressed with the professional and confident manner in which the Youth Forum chaired their own meeting. Work streams have been created to look into some of the areas raised from the session including involving the members on a Grand Round opportunity to discuss communication with young patients as well as work with IT to look at ownership of patient records and information being passed over to the young people where possible.

The two Youth Governors have been supported by the team to deliver reports quarterly to the children's Clinical Governance Board as well as the Council of Governors' meetings. We have also developed the role of a Youth Ambassador who has been involved in project activity and the development and content of the young person Foundation Focus newsletter. All three also attended a conference in London for young people's health and were the only young people in attendance amongst the professionals. Their learning and ideas were then fed into the question and answer session and have formed part of the coming year's work streams.

The service has developed closer working links with the Audit department and has successfully helped to carry out two patient engagement projects as part of wider Trust audits. The VTE audit and the consent audit both used patient surveys to look at how these two issues have an impact on the patient experience. These results were then used within the overall audit report to allow for a more considered and patient focused action plan.

Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service continues to provide an easily accessible service to patients, their relatives, carers, the public, Trust staff and external organisations in responding to health service queries and concerns. Over the past year PALS has assisted staff in responding to over 3500 contacts ranging from enquiries, expressions of concerns, and complaints. The PALS focus has been to support the people accessing its service to obtain clear, concise and timely information and also to highlight to Divisions across the Trust any shortfall in service provision identified through patients' comments.

The service provides two main functions: PALS responds to concerns raised in person, e-mail or by telephone which have the potential for a quick resolution. The complaints service works with complainants and the Divisions and/or external organisations to provide responses to written complaints or concerns which cannot be resolved at the time.

To ensure ease of access the PALS team is located in the Manchester Royal Infirmary Out-patient Department focusing on contacts relating to adults, and the Royal Manchester Children's Hospital's Family Support Centre, responding to enquiries relating to children and young people.

PALS has been working closely with the Divisions providing complaints prevention and handling training for staff at all levels within the organisation. The primary aim of training is to resolve expressions of dissatisfaction on the spot where possible, through face to face meetings with patients and their relatives at the earliest opportunity. PALS has also facilitated patients and their relatives to become involved in the Trust's service developments programmes such as End of Life Care. The aim is to improve the end of life care across adult in-patient areas. The families we engaged kindly contributed their experience to a staff training DVD.

As well as dealing with concerns, PALS also receives patients' compliments regarding the care they have received. Here is a sample of these compliments:

"I would also like to praise all the staff in A&E - people always complain but never give praise when it's due. I have rubbish veins, making it very difficult to draw blood - the staff were patient and tried very hard. I appreciated this very much as I also realise that the staff work under great pressure."

"Following a short stay and treatment in wards 35 and 6 for a heart problem, I am writing to express my thanks. I was overwhelmed by the professionalism of staff at all levels and the courtesy, care and kindness shown by everyone was so reassuring.

"The treatment surpassed any that I have experienced previously and I feel sure this is down to the management and also because everyone was working as part of a team.

"My sincere thanks to everyone."

"I recently visited your x-ray department for venous hormone sampling.

"I feel obliged to respond to the outstanding, diligent care that I received. Your registrar and Ellie and her colleagues made my stay very comfortable. You can be justifiably proud of the service you provide."

"My daughter was admitted for surgery in February on ward 76. The difference in my daughter's care was astounding - both myself and my husband were amazed by the attention and the excellent standard of care she was given and sad at the same time that my daughter did not receive this level of care in November. It was such a big difference compared to the last time. My daughter's pain relief was managed so much better and her aftercare too was excellent - this has made a dramatic difference to my daughter's recovery. This whole experience has made me see that I was absolutely right to raise your awareness.

"Thank you so much for all your time looking and investigating into this matter. And thanks you for putting my mind at ease as I did have so many reservations."

"In February I gave birth to my son at St Mary's Hospital. I had all my antenatal care at the hospital.

"I am writing to thank you and all your staff for the wonderful care I was given. I truly think that all the maternity staff at St Mary's are utterly brilliant, dedicated and an asset to the hospital. I did not come across one midwife or doctor who did not impress me with their professionalism, empathy and caring nature.

"Prior to this recent pregnancy I had a molar pregnancy so I was very anxious at the start of the pregnancy. Your midwives did everything to put me at ease and reassure me. My molar pregnancy was managed at a different hospital, and with this new pregnancy I decided I wanted my care at St Mary's despite a much longer journey. It was the best decision I could have made. The care and attention of the staff is a class above what I had experienced before."

Research and Innovation

Research and innovation is a key focus within each of our five hospitals. Over the past 12 months we have excelled in putting research findings into clinical practice. This has resulted in new testing, treatments and technologies now available, providing better care for our patients.

Along with our main academic partner The University of Manchester, we are one of 12 Biomedical Research Centres in the country, created by the National Institute for Health Research (NIHR). Biomedical Research Centres are outstanding centres of research excellence and leaders in turning university science into hospital care. Our NIHR Manchester Biomedical Research Centre specialises in genetics and developmental medicine.

We are also proud to be a founding partner of the Manchester Academic Health Science Centre, set up to help develop our city region as a world leader in healthcare research.

Our research and innovation mission

Over the next five years our aim is to ensure that the Trust is one of the top five NHS hospitals for research and innovation in the UK. Our capacity for translating research into improved patient care will be internationally recognised, both in its own right and in partnership with Manchester Academic Health Science Centre.

Putting research at the heart of healthcare

The research and innovation we deliver will be:

- Patient-centred
- Quality driven
- Multi-disciplinary

Improving year on year

We established a division for research and innovation in 2008, demonstrating our commitment to the strengthening of our research portfolio. We have continued to improve year on year, and during 2010/11:

9729 patients were recruited to take part in research

£29m of external research funding was awarded to researchers working within the Trust

723 clinical research studies were underway

262 new studies were approved

81 external researchers applied to conduct studies within the Trust

5 studies at our Wellcome Trust Children's Clinical Research Facility were the first in the world to recruit participants

Helping our patients

Our patients are at the centre of all our research efforts, and we are using research to make a real difference to people's lives.

Leslie Jones was diagnosed with type 1 diabetes as a child and relied entirely on multiple daily insulin injections to control his blood sugar levels. Despite this, he regularly suffered from hypoglycaemia, where his blood sugar levels became dangerously low. This severely limited his day-to-day life.

Manchester Royal Infirmary team Linda Birtles and Dr Martin Rutter, with patient Leslie Jones

In February 2011, Leslie became the first patient in the North West to receive a new treatment called islet cell transplantation. The procedure was performed by a team from Manchester Royal Infirmary, and involved taking insulin-producing 'islet cells' from organ donor tissue and injecting these cells into a vein behind Leslie's liver. The islet cells make insulin and stabilise blood sugar levels.

"They have changed my life", said Leslie. "I can't even find the words to say how grateful I am. My condition was so unpredictable and I would often collapse with no warning."

Ambreen Yasin was 15 years old when she was told she was at risk of developing type 2 diabetes, a condition that runs in her family. She was given the opportunity to take part in a clinical trial at our Wellcome Trust Clinical Research Facility.

Clinical trial participant Ambreen Yasin

The six-month study aimed to find out whether a drug called metformin would help to reduce a child's body mass index and improve their ability to regulate blood sugar.

Speaking of the study, Ambreen said: "I was a bit nervous at first and didn't really know what to expect, but the nurses were great and explained everything that would happen. I feel quite proud for taking part in something that hopefully will bring new information and could possibly change many lives. I discovered a whole new side to science and medicine and realised how important the trials were."

All of these factors contribute to improving patient outcomes and experience across the NHS.

Investing in unique facilities

We have continued to significantly strengthen our research infrastructure during 2010/11:

- Our Biomedical Research Centre opened the new £3 million Centre for Advanced Discovery and Experimental Therapeutics (CADET), which is dedicated to developing new drugs to prevent and treat major diseases such as diabetes, dementia and heart failure.
- ICON Development Solutions, a large contract research organisation, opened a 34-bed research unit on the hospital campus next to Manchester Royal Infirmary.
- Over £1 million was invested in new technologies so that our researchers can undertake highly complex investigations into the genetic causes of diseases.

Developing our researchers

Our Biomedical Research Centre created an Academy for Training and Education to provide opportunities for researchers from all backgrounds to develop their careers. This will help young researchers mature into leading, independent investigators.

The Biomedical Research Centre has awarded 19 training fellowships to develop the next generation of clinical academics. It also provides career support, advice and mentorship, and has helped 24 researchers across Manchester obtain successful external fellowships.

This dedicated investment will secure the future of research and innovation across our hospitals.

Meanwhile, we continue to attract high-profile researchers to Manchester, notably during 2010/11 with the appointment of Professor Garth Cooper. Professor Cooper leads our new CADET facility and is a world-leading expert in drug discovery. With over 200 articles published in leading journals, as well as being named as inventor on more than 40 US and European patents.

Our nurses, midwives and allied health professionals (AHPs) have had great success in receiving awards to enable further study and development. Seven Trust employees have secured prestigious NIHR research bursaries to study for Masters in Research (MRes). These are taking place at The University of Manchester and Liverpool University. In addition, Karen Kemp, inflammatory bowel disease nurse specialist at Manchester Royal Infirmary, was awarded a prestigious NIHR clinical academic training PhD fellowship, based at The University of Manchester. Their research, along with other staff who already have research degrees or are currently studying for degrees, will help us provide evidence for nursing, midwifery and AHPs e.g. Therapists practice and improve quality of care.

Nurses, midwives and AHPs have a research strategy that links with the overall Trust research strategy and reinforces our goals of outstanding multi-professional research and innovation. We have strong links with nursing and midwifery researchers at the School of Nursing, Midwifery and Social Work at The University of Manchester. The strong leadership support and academic links will ensure that nurses, midwives and AHPs are able to continue to develop and use their research knowledge and skills to improve patient care.

Working with commercial partners

Our work with industry partners has strengthened during 2010/11. ICON Development Solutions are now based on our hospital campus and many research projects underway within our facilities are commercially sponsored.

The Biomedical Research Centre has joined forces with GlaxoSmithKline (GSK) and The University of Manchester to create a new Manchester Centre for Nuclear Hormone Research in Disease. The centre is the first of its kind to see the NHS, academics and industry working together to find new treatments for inflammatory conditions such as asthma and rheumatoid arthritis. This work also includes the appointment of GSK's Professor Stuart Farrow as Chair in Experimental Therapeutics at the Biomedical Research Centre.

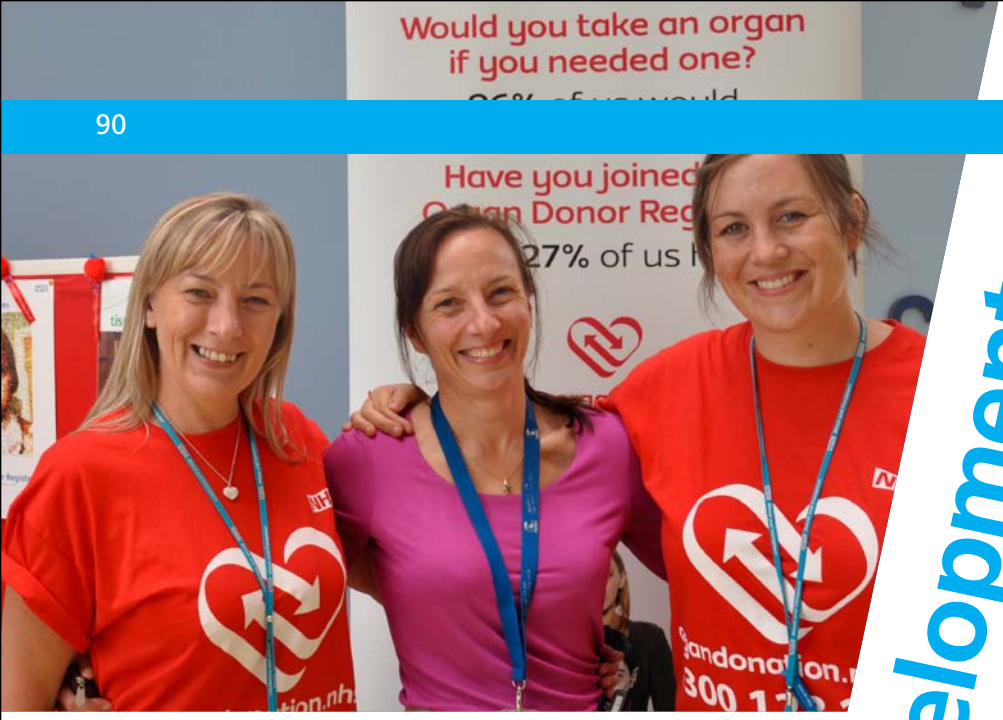
The next 12 months

"Over the coming year, we will build on the success of our NIHR Manchester Biomedical Research Centre. We aim to bring about further benefits to our patients as a result of continued investment in world-class researchers and facilities.

"We look forward to increasing our collaborations with commercial partners, particularly as we redevelop the former Manchester Royal Eye Hospital into an international centre for companies working in healthcare research. This will help us to speed up the pace of innovation in the NHS and lead to improved care and treatment for our patients."

Professor Colin Sibley
Head of Research and Innovation Division

Former Manchester Royal Eye Hospital, due to open in 2012 as a centre for biomedical research companies.



Highlights and Developments

Trust staff named among 'the nation's most outstanding leaders of research'

Congratulations went to Professors Graeme Black, Director of the NIHR Manchester Biomedical Research Centre and Honorary Consultant in Genetics and Ophthalmology, and Gareth Evans, Consultant Geneticist, for being appointed as Senior Investigators by the National Institute for Health Research (NIHR).

Senior Investigators are NIHR's finest researchers and include some of the nation's most outstanding leaders of patient and people based health and social care research. They provide research leadership, speak at events, mentor trainees and provide expert advice to the Department of Health's Director General for Research and Development.

40 appointments were made by an international expert panel selecting the best researchers from around the country, five of whom are based here in Manchester.

Graeme Black has been instrumental in developing the Biomedical Research Centre's capacity and infrastructure, and in January 2010 he was also appointed to the Executive Management Team of Manchester Academic Health Science Centre (MAHSC). As Clinical Academic Section Lead for Human Development and Genetics, he will help spearhead MAHSC's strategic development in an area very closely aligned to the Biomedical Research Centre.

MAHSC is a partnership between The University of Manchester and six NHS organisations in Greater Manchester, set up to assist in developing the region as a world leader in health research. (April 2010)

Harrington Building officially opened

The widow of a renowned professor opened The Harrington Building which treats children and young people with mental health conditions.

Dick Harrington was Professor of Child and Adolescent Psychiatry in Manchester from 1993 until his death in 2004. The Harrington Building was formally opened on 12th May by his wife Lesley and other members of his family.

Professor Harrington was a much loved, internationally distinguished academic and clinician who played a leading role in the development of child mental health in Manchester. (May 2010)

Russian delegation visit

We showed off our impressive new facilities to a Russian delegation. St Petersburg is one of Europe's largest cities and a key economic city of the Baltic region. It has been a pioneer in the use of Public-Private Partnership (PPP) and Private Finance Initiative (PFI) in transport and infrastructure and now plans to extend this into social infrastructure such as hospitals. The visit to the UK aimed to help senior St Petersburg decision makers on the way forward. (June 2010)

Time capsule unearthed at Pendlebury

Contractors carrying out excavation work at the former Royal Manchester Children's Hospital at Pendlebury uncovered a time capsule in the grounds at the entrance to the former Zachary Merton building. The date stone on the small lead box was unreadable so no information as to when the capsule was buried or what it might contain was available.

We sought the expertise of Irit Narkiss, the Curator of Objects and Access at the Manchester Museum, who painstakingly opened the capsule which contained a newspaper from 1805, two newspapers from 12th March 1935, annual reports, old coins, and an invitation to the opening of the Zachary Merton Convalescent Home on 13th March 1935 which is when it is thought it was buried.

Zachary Merton was a businessman with interests in Manchester and in his will, left funds to build convalescent homes around the country. RMCH applied for funds and was given £22,000 to build a home for 40 patients 'for the sole purpose of restoring the bloom of health to children after illness'. (June 2010)

OBE for Chief Nurse

Gill Heaton, Director of Patient Services/Chief Nurse (and Deputy Chief Executive) was awarded an OBE in the Queen's Birthday Honours.

Gill has made a major contribution to health service management nationally, regionally and locally. One of her major achievements is her dedication and commitment to infection prevention and control. She has personally investigated individual cases and the Trust has achieved and surpassed national targets for both MRSA and Cdifficile.

Gill's commitment to improving patient experience continued with her launch of our Quality Campaign. Through her enthusiasm, she has engaged staff and patients in the development of local initiatives to improve quality.

She has also led on a number of national initiatives including the Productive Ward initiative which has freed time for staff to be more involved in direct patient care. (June 2010)

Children's Hospital star launched young people's health event

Star of the hit ITV1 show 'Children's Hospital' Jack Norfolk launched an open day for youngsters. Jack, who melted the hearts of millions of viewers with his positive attitude towards his poor health, formally opened the event.

The aim of the event was to show young people what happens in our hospitals, offer information about a wide range of careers in the NHS and provide advice about health and well-being. We were also keen to give more young people a voice in the planning and delivery of our health services. (June 2010)

Saint Mary's Clinical Head given prestigious lifetime achievement award

Professor Dian Donnai, Clinical Head of Saint Mary's Hospital and Consultant in Genetics, was the 2010 recipient of the March of

Dimes/Colonel Harland Sanders Award for lifetime achievement in the field of genetic sciences. This award is given annually to an individual who has made a significant contribution to the genetic sciences. (June 2010)

Success in the Advancing Quality performance targets

We were the only Trust in the North West to receive a performance reward in each of the five key clinical areas in recognition for our consistent performance in the care of heart attack, heart failure, heart bypass, hip and knee replacement and pneumonia patients. These results recognised the consistently high level of care we provide to our patients.

Advancing Quality, which was launched across the North West in 2008, is a three-year patient care quality improvement programme that aims to transform the experience of patients across the North West which will ultimately result in them having a better quality of life.

The programme measures performance through the use of a clearly defined set of measures and data used by doctors and nurses. So, for example, if a patient has a heart attack, clinical staff need to demonstrate that the correct drugs such as aspirin were administered at the correct times and that the patient was given advice on giving up smoking. (June 2010)

Neonatal Transfer Service celebrated 5th birthday

Staff from Greater Manchester Neonatal Transport Service (GMNeTS) were presented with a specially donated cake to celebrate the service's fifth birthday. GMNeTS helps save the lives of sick and premature babies by transferring them between neonatal intensive care units or specialist hospitals for surgery across the North West.

Since it was set up in 2005, GMNeTS has carried out over 1,422 emergency transfers and 2,480 planned non-emergency transfers, including more than 1,000 babies who have been treated in Saint Mary's Hospital's Newborn Intensive Care Unit. They have also clocked up over 120,000 ambulance miles and have been on call for over 43,800 hours. (June 2010)

New BRC Minor Procedures Suite opens

June 2010 saw the official opening of the NIHR Manchester Biomedical Research Centre's newly established Minor Procedures Suite, located within the Wellcome Trust Clinical Research Facility and funded by the Northwest Regional Development Agency.

The new suite is open to researchers and industry partners and can be used for a whole host of research studies. All procedures are performed under sterile conditions with the aid of a dedicated Senior Surgical Research Nurse. A wide range of procedures can be carried out under local anaesthetic.

The Minor Procedures Suite provides a quiet and comfortable environment for participants and benefits from a team of staff on hand and a range of dedicated equipment. (June 2010)

National Transplant Week

Our Organ Donor Co-ordinators worked hard across our hospitals to encourage people to sign up to the Organ Donor Register. They were on hand to explain the importance of donation and the work they do, offering people leaflets and balloons to help spread the word. They also encouraged people to hold a 'Heart to Heart' discussion with their families about organ donation. (July 2010)

Saint Mary's celebrated a record first year

One year since moving into their brand new hospital, Saint Mary's Hospital celebrated an incredible first year. Since the first patient move on Monday 13th July 2009, Saint Mary's welcomed nearly 6,000 babies into the world. They also cared for 767 babies on their Newborn Intensive care Unit and carried out almost 90,000 out-patient appointments.

The Newborn Intensive Care Unit, which cares for babies from across the region, celebrated their first year by welcoming back the first baby to be transferred to the new unit on 13th July 2009. (July 2010)

First subject screened in global study

Congratulations went to Dr Nicholas Webb and the Wellcome Trust Children's Clinical Research Facility team

who screened the first patient globally as part of the Medicines for Children Research Network study TAK491 in hypertensive children.

This was the first Greater Manchester study within the North West Exemplar programme to recruit the all important first global patient. (July 2010)

Nuclear Medicine launched ground-breaking Heart Scanner Service

The Nuclear Medicine Centre began a new programme of heart scans that can cut appointment times by up to three and a half hours.

Although 'rubidium-82' PET scans have been used for a number of years in the United States, Manchester is only the second city in the UK after London to introduce a service and is one of only a few centres across the world to offer the procedure. (July 2010)

Boulevard completes the way for 21st century healthcare

The revolution of Manchester's healthcare was completed as the final stage of our £500m complex was unveiled – two weeks ahead of schedule.

The new 10,000m² boulevard links each part of the hospital complex, giving patients, visitors and staff direct and easy access to all of the site's facilities.

The opening of the boulevard marked the culmination of a five-year build period that has transformed Manchester's health services. Now the four state-of-the-art hospitals have an additional 71 disabled parking spaces and dedicated drop-off points. The boulevard also forms part of the number 147 bus route and has a designated stop for the hospitals. (August 2010)

Success for Academy students!

Manchester's Health Academy, the first NHS led Academy in the country marked a successful first year with amazing GCSE results. 41% of the Academy's Year 11 group of students achieved 5 or more A*-C grades at GCSE, including English and Maths with an overall 72% of students gaining 5 A*-C in all subjects.

Our Trust is the main sponsor for the Manchester Health Academy, with additional support from the co-sponsors, Manchester College and Manchester City Council.

As part of the ongoing partnership between us and the Academy, students have had the opportunity to not only learn about things in the classroom but also to come here and experience it first hand; speaking to staff and undertaking practical demonstrations. A number of students have also undertaken work placements at the Trust. (August 2010)

BRC bringing genetics research into schools: New teachers' TV programmes

Human genomics, the study of genetics and the human genome, became part of UK science lessons thanks to a new programme launched by Nowgen (Northwest Genetics Centre).

The Nowgen Schools Genomics Programme brings cutting-edge scientific research into schools, exciting pupils about the pace of discovery, and engaging them in thinking about how advances in genetics will affect their future lives. The innovative three-year programme is being run by a team of Nowgen clinicians, scientists, national curriculum developers and educationalists.

As part of the programme, a series of television programmes about genomic research has been produced by Nowgen, working with Teachers TV and Glasshead Productions, for GCSE and A-Level students and teachers. (September 2010)

Funding for new study in childhood nephrotic syndrome

Dr Nicholas Webb, Consultant Paediatric Nephrologist at the Royal Manchester Children's Hospital and Director of the Wellcome Trust Children's Clinical Research Facility, was awarded a grant of £734,697 by the NIHR Health Technology Assessment programme.

The funding is to perform a national, multi-centre, randomised controlled study of different prednisolone treatments in childhood nephrotic syndrome. The study, known as the PREDNOS study, involves 225 children in over 50 centres.

The purpose of the study is to see whether increasing the duration of therapy reduces the number of children who have disease relapses without significantly increasing side effects. (September 2010)

Scientists' breakthrough

Manchester scientists have turned embryonic stem cells into the cells that produce cartilage which could be used to repair damaged and diseased joints.

The team, based at the Trust and The University of Manchester, hope this work will lead the way to the use of human embryonic stem cells to provide cheaper and more readily available treatments for joint diseases and that the principles can be developed for other chronic human conditions. (October 2010)

Manchester geneticist leads €5.4m immune disorders research programme

A specialist in genetic medicine at the National Institute for Health Research's Manchester Biomedical Research Centre is leading a multi-national team investigating the genetics of immune system disorders.

Professor Yanick Crow was awarded a European Union grant of £5.4m over three years to investigate Nuclease Immune Mediated Brain and Lupus-like (NIMBL) conditions. These are devastating genetic disorders which lead to greatly reduced quality of life, high mortality especially in children, and significant risks of recurrence within affected families. NIMBL conditions are rare but under-diagnosed. No effective treatments or cures currently exist. (October 2010)

Manchester team gets £1.2 million grant for 'cell control' study

A team investigating how genes respond to hormonal changes and inflammation was awarded a Wellcome Trust grant of £1.24 million for a five-year study.

The research programme at the National Institute for Health Research's Manchester Biomedical Research Centre (BRC) is led by Professor Julian Davis, a Consultant Endocrinologist at Manchester Royal Infirmary.

The aim of the study is to learn more about how tissues control themselves and influence how the body reacts to changes such as puberty or external challenges such as inflammation. (October 2010)

Researcher's major role in government drive to deliver lab bench to patient bedside treatments

A researcher is helping Manchester lead the way in a world-first initiative to boost the partnership between academics, medics and the pharmaceutical industry to deliver tomorrow's treatments to today's patients.

Manchester Academic Health Science Centre (MAHSC) is one of a small group of centres of clinical research excellence chosen to deliver a new £10 million Government programme that will get medicines of the future faster to patients and secure the UK's position as the global partner of choice for research and development collaboration. (October 2010)

Wellcome Trust Clinical Research Facility welcomes 100,000th study participant

The Wellcome Trust Clinical Research Facility Manchester (WTCRF) celebrated its 100,000th participant visit to the Facility since its opening in November 2001.

The 100,000th participant is taking part in Professor Rayaz Malik's trial funded by the National Institutes of Health (USA): Corneal confocal microscopy: A non-invasive surrogate for diabetic neuropathy.

With around 10,000 participant visits a year, the Facility provides specialist space for clinical researchers as well as other NHS partners. During the first nine years the Facility has housed over 400 researchers from across more than 30 different research areas. (November 2010)

Student's art strikes a 'cord' with Placenta Clinic staff

Researchers in the Maternal and Fetal Health Research Centre based at Saint Mary's Hospital played host to local students interested in learning about the centre's work.

The students, from Manchester Health Academy in

Wythenshawe, were told about research within the centre's Placenta Clinic looking at fetal growth restriction or FGR, a condition that can lead to complications in childbirth.

Back in the classroom, the pupils were tasked with creating a piece of artwork depicting what they had learned about the work of the clinic during their visit. (November 2010)

Antibiotics Awareness Day

On the 18th November we supported European Antibiotic Awareness Day. This is a public health campaign across Europe and supported by the Department of Health to promote awareness of antibiotic resistance and prudent use. (November 2010)

RMCH specialist nurse receives inaugural award

Lindsey Rigby, a Royal Manchester Children's Hospital specialist nurse in congenital hyperinsulinism (CHI) was awarded the 1st Ipsen BSPED Paediatric Endocrine Nurse Award at the 38th Meeting of the British Society for Paediatric Endocrinology and Diabetes (BSPED). (November 2010)

One year on: Major success for Children's Clinical Research Facility

The Wellcome Trust Children's Clinical Research Facility at the Royal Manchester Children's Hospital has had overwhelming success since opening in November 2009, with the aim of testing new medicines in children and young adults to make sure that they are safe and effective.

The facility is the first of its kind in the North West and one of only a small number of dedicated paediatric research facilities across the UK. To mark the one year anniversary, a 1st birthday party was thrown for the children, families and researchers who have been involved in studies over the past year. (November 2010)

Team wins the 'Improving Care with Technology' award at Health Service Journal Awards

The Acute Care Team celebrated winning the HSJ 'Improving Care with Technology' award for their work implementing the Patientrack system.

During the successful 14 month trial of Patientrack, we saw a number of patient safety gains:

- All patients in the trial had their bedside observations performed in a timely fashion
- Patients recovered their health faster than previously
- There was a 20% reduction in hospital length of stay
- The use of critical care was less
- No patient had a cardiac arrest in the intervention phase of the trial
- There was a reduction in mortality of 2%.

Now that the technology has been implemented on a number of wards, we are continuing to see these encouraging improvements. (November 2010)

Three Trust doctors named in the Times' 'Britain's top 100 Doctors' list

Three of our doctors were acknowledged as leaders in their field in Britain's 100 Top Doctors list published by the Times.

Kevin Mackway Jones, a Consultant from our Accident and Emergency Department; Nigel Harper, Consultant Anaesthetist, and Fred Wu, Professor of Medicine and Endocrinology in the School of Biomedicine, were all part of a list compiled by a team of Times researchers consulting charities, specialists and professional bodies and associations. (November 2010)

Lorraine Kelly lights up Royal Manchester Children's Hospital

The presenter of the hit ITV1 show 'Children's Hospital' turned on the Royal Manchester Children's Hospital Christmas lights. Lorraine Kelly, with the help of Bolton Boys' School, the Royal Northern College of Music, and the hospital choir illuminated RMCH on 7th December. Charity patrons England and Everton footballer Phil Neville and his wife Julie also joined in the fun.

Lorraine was just one of many people who helped to make the festive period that little bit more special for children who have to stay in hospital over Christmas. Throughout December, many organisations including

the Royal Air Force, Barclays Bank, Woolworths, Sale Grammar School, GMP Tactical Aid Unit, and Manchester Phoenix Ice Hockey team dropped in.

Lorraine added: "I'm honoured to be switching on the Christmas lights at this wonderful hospital. The staff do an amazing job making Christmas special for children who are undergoing treatment here over the festive season." (December 2010)

Thousands of premature babies benefit from North West breathing support trial

A North West trial of alternatives to ventilators for helping premature babies to breathe could reduce the risk of lung problems and other complications for around 7,000 babies a year.

Led by Dr Suresh Victor from the Newborn Intensive Care Unit at Saint Mary's Hospital, the study also involves experts from The University of Manchester and several neonatal units from the North West of England. The team from the 'Extubate Trial' are looking at two alternatives to long-term use of a ventilator to see which helps premature babies the most. They were awarded funding of £240,000 by the National Institute for Health Research (NIHR) to carry out the three-year trial. (December 2010)

Leading teaching Trust in the North West for trainees

We were ranked the top large hospital Trust in the North West for trainee satisfaction, according to the results of the General Medical Council (GMC) Annual Trainee Survey carried out in April.

We made significant improvements in our ranking for overall satisfaction since the 2009 survey, and as a result moved from the third quartile to the first quartile in the region. This means we are now the leading North West teaching hospital Trust for trainees. (December 2010)

Manchester Royal Infirmary provides pioneering diabetes treatment

A clinical team based at Manchester Royal Infirmary (MRI) treated its first patient with a pancreatic islet cell transplant – a first for the North West of England.

This potentially life-saving therapy is given to patients with type I diabetes who rely entirely on multiple daily insulin injections and needle-stick blood glucose monitoring. Even though they eat healthily and take their insulin injections properly, some patients find it impossible to stop their blood sugar levels from going dangerously low, called a 'hypo' or hypoglycaemia.

MRI is one of six UK centres that are able to offer this new treatment. Patients from the North West, Wales, South Yorkshire and the Midlands come to Manchester to be assessed for their suitability for the treatment. Manchester was chosen as a regional site because of its expertise in transplantation and excellence in treating diabetes. More than 4,000 transplants, mainly of kidneys, have been carried out at the MRI since 1968. (January 2011)

Manchester BRC research team publishes key findings on autoimmunity

A genetic medicine team at the National Institute for Health Research's Manchester Biomedical Research Centre (BRC) had the results of a ground-breaking study into autoimmune disease published in the prestigious international journal 'Nature Genetics'. (January 2011)

Team seeks genetic clues to childhood bladder problems

Genetic medicine and kidney disease experts in Manchester were awarded £180,000 by Kidney Research UK to investigate the genetic causes of bladder problems in children which can lead to severe kidney damage.

Dr Bill Newman, a genetics expert from Saint Mary's Hospital and The University of Manchester, and Professor Adrian Woolf of Royal Manchester Children's Hospital and the University are working together to study the genetic causes of kidney damage in children.

The three-year research study involves collaboration with doctors in Turkey, Spain and Israel to screen blood

samples from patients with UFS (urofacial syndrome) to find out more about the UFS gene. The Manchester team also works with children being treated for other bladder and kidney problems at the Royal Manchester Children's Hospital to find out whether the same gene is responsible for these conditions. (January 2011)

MRI surgeon performs four kidney transplants in one week in Ghana

A Manchester Royal Infirmary surgeon travelled to Ghana where he performed four life-saving kidney transplants in a week.

Hany Riad, Consultant Surgeon in Transplantation, visited the Korle Bu Teaching Hospital in Ghana with a charity that saves the lives of children and adults in the developing world who suffer from fatal kidney disease. They carry out living donor kidney transplants and share their knowledge with local medical teams so that sustainable transplant programmes can be run in the long term. (February 2011)

Patient's life saved by Vascular Team

The vascular team at Manchester Royal Infirmary continued their life saving specialist technique for patients with Abdominal Aortic Aneurysms (AAA). Mr Higgins, 81 from Macclesfield, suffers from advanced kidney disease which meant the procedure usually used to repair AAA was too risky.

Mr Higgins was found to be suffering from an abdominal aortic aneurysm, 7cm in diameter. An aortic aneurysm is when the aorta, the largest artery in the body, balloons and widens. The aneurysm develops as a result of weakness in the wall of the artery. This weakening could lead to the aneurysm bursting, a life-threatening event. In February, he became the first patient in the North West and only a handful worldwide to have successful surgery using a new technique, protecting both kidneys from further damage. (February 2011)

Manchester Royal Eye Hospital first to offer sight to the blind

Manchester Royal Eye Hospital was one of the first centres in the world to offer the revolutionary bionic eye retinal implant which restores sight to blind patients.

After a successful clinical trial involving more than 30 blind patients around the world and a thorough review of the product's safety and performance by an independent expert body, the Argus II retinal implant device is now the first approved treatment ever available for sightless people.

The trial at the Eye Hospital was the largest and saw the most success out of all the centres which took part – including the trials carried out in Geneva, Paris and London.

One patient who took part in the Manchester trial, who became blind due to advanced retinitis pigmentosa – an inherited and degenerative disease of the retina, had an intraocular electronic retinal prosthesis fitted on 3rd June 2009. He had been blind for all 51 years of his life but can now read large print-short words from a monitor. (March 2011)

Manchester Heart Centre heroes receive national award

Specialist nurses Linda Griffiths, Jane Hill and Mark Heyhoe from Manchester Royal Infirmary were given a national award for their outstanding work with young heart patients in Manchester. The British Heart Foundation (BHF) presented the team with this prestigious award at its Healthcare Professional (HCPS) Awards celebration event.

Linda, Jane and Mark won the Outstanding Achievement Award. They and the rest of their team focus on the needs of young heart patients growing up with congenital heart disease. They work in particular on ensuring the transition from paediatric to adult care is seamless and hold a cardiac transition workshop for 12 to 18 year olds. They have also developed a dedicated website for young people, a cardiac youth forum that engages in many activities including outdoor pursuits, and a text messaging service. (March 2011)

Activity and Performance

Accident and Emergency Attendances

	2009/10	2010/11
First attendances	197,365	203,012
Follow-up attendances	584	153
Total	197,949	203,165

In-patient/Day case Activity

	2009/10	2010/11
In-patient (emergency)	59,803	61,347
In-patient (elective)	19,615	16,738
Day cases	50,718	56,035
Total	130,136	134,120
Day cases as a % or elective activity	72.1%	77.0%
Day cases as a % of total activity	39.0%	41.8%

In-patient Waiting List

	31st March 2011		
	In-patient	**Day case**	**Total**
Total on Waiting List	3,361	5,174	8,535
Patients Waiting 0-3 months	2,031	3,331	5,362
Patients Waiting 3-9 months	1,098	1,639	2,737
Patients Waiting over 9 months	232	204	436

Out-patient Activity

	2009/10	**2010/11**
Out-patients first attendances	174,313	177,764
Out-patients follow-up attendances	465,168	471,980
Total	639,481	649,744

Bed Usage

	2009/10	**2010/11**
Average in-patient stay	3.1 days	2.7 days

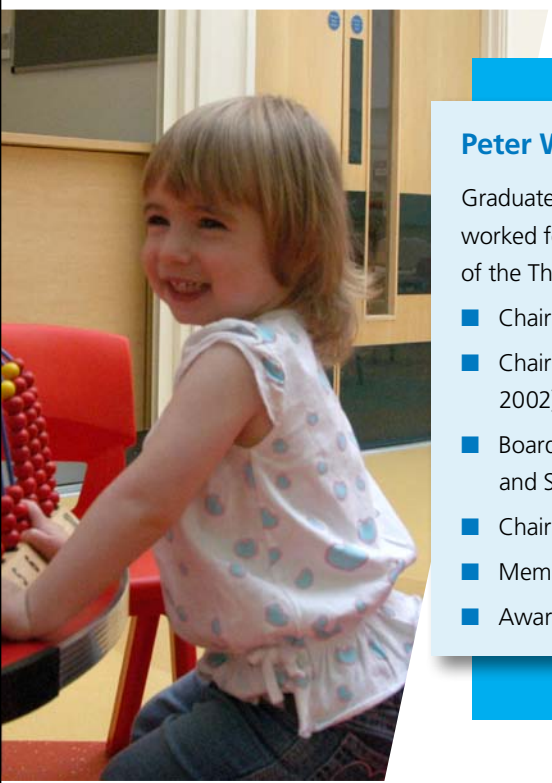
General Information

	2009/10	**2010/11**
Number of babies born	5,532	6,543
Total number of operations/procedures	115,062	155,460
Renal Transplants (including kidney/pancreas)	195	202
Number of Cataract Procedures	10,825	9,230

Board of Directors

Our Board is collectively responsible for the exercise of the powers and the performance of the Trust and:

- Ensures that the Trust complies with its terms of authorisation, constitution, mandatory guidance and contractual and statutory duties.
- Provides effective and proactive leadership of the Trust within a framework of processes, procedures and controls which enable risk to be assessed and managed.
- Sets the Trust's strategic aims, taking into consideration the views of the Council of Governors.
- Ensures the quality and safety of healthcare services, education and research delivered by the Trust, applying the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission and other relevant NHS bodies.
- Sets the Trust's vision, values and standards of conduct and ensures its obligations to its members, patients and other stakeholders are understood, communicated and met.



Peter W Mount CBE, Chairman (Appointed April 2001)

Graduated in Mechanical and Production Engineering from UMIST and worked for Rolls Royce, Price Waterhouse and was Chief Executive of several of the Thorn EMI Fire and Security Companies in Europe and USA.

- Chairman of the Salford Royal Hospitals NHS Trust (1993-2001).
- Chairman of the Greater Manchester Workforce Confederation (1993-2002).
- Board Member of Sector Skills Development Agency (Department for Education and Skills 2002–2005).
- Chairman of the NHS Confederation (2003-2007).
- Member of Audit Committee of the Department of Health (2001-2007).
- Awarded the CBE in 2007 New Years Honour List.

Mike Deegan,
Chief Executive
(Appointed September 2001)

Holds a first degree in Law and a Masters degree in Industrial Relations from the University of Warwick.

- Previously Chief Executive at Warrington Hospital and then North Cheshire Hospitals NHS Trust.
- Involved in the preparation of the Government's NHS Plan in 2000.
- Held post of Director of Human Resources for the NHS.
- Has worked widely across the public sector including roles in local government and education.

Brenda Smith,
Non-executive Director
(Appointed November 2008)

Chartered Accountant, Master of Business Administration, BSc (Hons) Finance and Law.

- Currently member of the Board of Governors of The University of Manchester and a member of the Investment Advisory Panel of North West Business Finance.
- A media business executive with a professional commercial background and experience in a FTSE100 company at executive level. Continues to work as an advisor.
- Previously Deputy Chairman and Managing Director of Granada Television Ltd and more recently President EMEA for Accent Media Group (global media company). Also served as a Non-executive Director for Manchester Airport Group and the North West Development Agency.

Professor Rod Coombs, Non-executive Director (Appointed 2007)

BSc in Physics; Holds an MSc and PhD from Manchester in the Economics of Innovation.

- Deputy President and Deputy Vice-Chancellor at The University of Manchester.
- Previously Professor of Technology Management at UMIST from 1993 to 2004.
- Non-executive Director of Manchester Science Park; MIDAS, and One Central Park.

Lady Rhona Bradley, Non-executive Director (Appointed November 2008)

Qualified Social Worker, MA, BA (Hons).

- Currently Chief Executive of a leading North West third sector organisation and charity.
- Background in public sector criminal justice and social care.
- Previously an elected member of Manchester City Council and Non-executive director of Manchester Airport Group and Manchester Ship Canal Company.
- Previously Chair of Local Children's Safeguarding Board and the Children and Young People's Strategic Partnership Board.
- Appointed Deputy Lieutenant for Greater Manchester.

Anthony Leon, Non-executive Director (Appointed April 2001)

Trained as a chartered accountant and was a senior partner of the Manchester practice Binder Hamlyn until his retirement in 1996.

- Previously Chairman of the Mancunian Community Health NHS Trust from 1995 to 2001.
- Currently Non-executive Director of two AIM companies.
- Treasurer of The University of Manchester Institute of Science and Technology to 2003.
- Chair of the Audit Committee.
- Appointed Deputy Lieutenant for Greater Manchester.

Steve Mycio,
Non-executive Director
(Appointed January 2010)

Qualified as a Fellow of the Chartered Institute of Housing, Fellow of the Royal Society of Arts.

- Deputy Chief Executive (Regeneration), Manchester City Council.
- From 1998 until 2008 he was the Deputy Chief Executive (Performance), Manchester City Council.
- Background in Housing Management and Regeneration culminating in the role of Director of Housing for six years until 1998.
- Member of the Public Service Board for Manchester and chair of the Employment, Skills and Enterprise Board.

Robert Pearson, Executive Medical Director:
(Appointed April 2006)

BSc, MB ChB (Hons) MD FRCS
Trained in Manchester, London and Nottingham.

- Consultant Surgeon MRI appointed 1990. Surgical practice now focused on upper gastrointestinal surgery, including laparoscopic surgery, and surgery of complex abdominal hernia.
- Spent 12 years on the Northwest Surgical training committee, the last four as Chair and Programme Director for General Surgery and associated subspecialties.
- Previously Clinical Head of the Division of Surgery.
- Chair of the NHS National Technology Adoption Hub Stakeholder Board.
- Previously Honorary President of National Association of Assistants in Surgical Practice.

Alexander Wiseman,
Non-executive Director
(Appointed February 2010)

Qualified as a Management Accountant in 1999; MBA Manchester University; MSc (Operational Research) Sussex University; MA (Maths) Cambridge University.

- Five years' experience as Regulation Director for Northern Gas Networks.
- Head of Strategic Planning (1997-2004) at United Utilities (a FTSE50 company).
- Non-executive Director for Xoserve for four years, chairing its Audit Committee.
- Ten years as a Management Consultant for PricewaterhouseCoopers.

Gill Heaton OBE, Executive Director of Patient Services/Chief Nurse
(Appointed December 2001)

Undertook nurse training at the Manchester Royal Infirmary in the late 1970s. Trained as a Health Visitor within community services. In early 1990s completed the General Management Training Scheme.

- April 2007 designated as the Deputy Chief Executive.
- Worked as a senior nurse in various clinical areas, such as intensive care and medical wards.
- Has held senior management posts in large acute Trusts, including Mental Health, as well as leading the General Management Training Scheme for the North West Region.
- Responsible for operational performance and management of the eight Adult Divisions.
- Provides professional leadership to nurses and midwives across both the Adult and Children's Divisions.

Adrian Roberts,
Executive Director of Finance
(Appointed May 2007)

Qualified as a Chartered Certified Accountant in 1988 and designated a Fellow of ACCA in 1994.

- 16 years' experience as an NHS Director of Finance, predominantly in Stockport, including through Stockport's authorisation as a first-wave Foundation Trust in April 2004.
- Has spent his entire career so far in NHS Finance.

Derek Welsh, Executive Director of Human and Corporate Resources (Appointed May 2007)

Member of the Institute of Healthcare Managers.

- Acting Director of Human and Corporate Resources from January 2006 to May 2007.
- Previously held posts of Associate Director of Corporate Services and Director of Corporate Services.
- Has held a number of senior operational posts at a number of NHS organisations.

Martin Hodgson
– Executive Director of Children's Services (Appointed June 2005 - on secondment from 1st November 2009).

Graduated from Sheffield University in 1989. Qualified as a HR professional via a postgraduate diploma in Personnel Management in 1992. Completed the NHS Management Training Scheme in 1995.

- Has 14 years of operational management experience in the NHS in out-patients, Surgical, Medical and Paediatric disciplines.
- His NHS experience has been gained in a variety of acute and community based services.
- Worked for Coopers and Lybrand for three years in the audit and corporate finance functions prior to joining the NHS.

Attendance at Board Meetings

Board of Directors' Attendance

	May 10	Jul 10	Sept 10	Nov 10	Jan 11	Mar 11
Peter Mount *Chairman*	✓	✓	✓	✓	✓	✓
Mike Deegan *Chief Executive*	✓	✓	✓	✓	✓	✓
Robert Pearson *Medical Director*	✓	✓	✓	✓	✓	✗
Gill Heaton *Executive Director of Patient Services/Chief Nurse*	✗	✓	✓	✓	✓	✓
Derek Welsh *Executive Director of Human & Corporate Resources*	✓	✓	✓	✓	✓	✓
Adrian Roberts *Executive Director of Finance*	✓	✓	✓	✓	✗	✓
Anthony Leon *Non-executive Director and Deputy Chairman*	✗	✓	✓	✓	✓	✓
Brenda Smith *Non-executive Director and Senior Independent Director*	✓	✓	✗	✓	✓	✓
Professor Rod Coombs *Non-executive Director*	✓	✓	✓	✗	✓	✓
Rhona Bradley *Non-executive Director*	✓	✓	✓	✓	✓	✓
Steve Mycio *Non-executive Director*	✓	✓	✓	✓	✓	✓
Alex Wiseman *Non-executive Director*	✓	✓	✓	✓	✓	✓

Register of Interests

Peter W Mount, Chairman: Member of General Assembly – The University of Manchester; Chairman Trustee and Founder of Charity called Helping Uganda Schools (HUGS).

Mike Deegan, Chief Executive: Non-executive Director for the NHS Institute of Innovation and Improvement; Director of the Manchester Academic Health Sciences Centre.

Professor Rod Coombs, Non-executive Director: Deputy President and Deputy Vice Chancellor, The University of Manchester and Non-executive Directorships for: The University of Manchester Intellectual Property Ltd; The University of Manchester Incubator Company Ltd; Manchester Technology Fund Ltd; Manchester Science Park Ltd; One Central Park Ltd; MIDAS Ltd; Daresbury Science & Innovation Campus Ltd; Corridor Manchester.

Anthony Leon, Non-executive Director: Non-executive Director – Mercury Re-Cycling Group PLC; Consultant – Horwich Cohen Coghlan (Solicitors); Non-executive Director EXC PLC; Non-executive Director Cleardebt Group PLC; Deputy Lieutenant in Greater Manchester.

Brenda Smith, Non-executive Director: Advisor for Media and Technology Services; Member of the Board of Governors, The University of Manchester; Member of the Strategic Fundraising Advisory Group for East Cheshire Hospice; Member of Finance and Subsidiary Undertaking Committees; Member of North West Business Finance Investment Advisory Panel.

Lady Rhona Bradley, Non-executive Director: Chief Executive and Company Secretary, ADS (Addictions Dependency Solutions); Deputy Lieutenant in Greater Manchester.

Steve Mycio, Non-executive Director: Manchester Care Ltd; Manchester Health Academy; Manchester Science Park Ltd; Cityco Board of Directors; The Corridor Partnership Board; Manchester Knowledge Capital Board; Manchester Solutions; National Football Museum; Manchester United Foundation Trust.

Alexander Wiseman, Non-executive Director: Director of Alex Wiseman Associates Ltd; Trustee of the William Walter Will Trust Fund.

Robert Pearson, Medical Director: Trustee: National Association of Assistants in Surgical Practice; Chair, National Technology Adoption Centre.

Derek Welsh, Director of Human and Corporate Resources: Director and Governor of the Manchester Health Academy (non paid appointment).

No interests to declare: **Gill Heaton** OBE, Director of Patient Services/Chief Nurse; **Adrian Roberts**, Executive Director of Finance; **Martin Hodgson**, Director of Children's Services.

(a) Remuneration (audited)

Name and title	2010-11			2009-10		
	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in kind (Rounded to the nearest £100)	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in kind (Rounded to the nearest £100)
	£000	£000		£000	£000	
P Mount, Chairman	60-65			60-65		
A Leon, Non-executive Director	15-20			15-20		
J Somerset, Non-executive Director (to 31 December 2009)	-	-	-	10-15		
R Coombs, Non-executive Director	15-20			15-20		
R Bradley, Non-executive Director	15-20			15-20		
S Mole, Non-executive Director (to 31 December 2009)	-	-	-	10-15		
B Smith, Non-executive Director	15-20			15-20		
S Mycio, Non-executive Director	10-15			0-5		
A Wiseman, Non-executive Director	10-15			0-5		
M Deegan, Chief Executive	210-215			210-215		
D Welsh, Executive Director of Human & Corporate Resources	125-130			125-130		
G Heaton, Executive Director of Patient Services/Chief Nurse	160-165			160-165		
M Hodgson, Executive Director of Children's Services	125-130			100-105		
R Pearson, Medical Director	95-100	130-135		95-100	130-135	
A Roberts, Executive Director of Finance	150-155			150-155		

(b) Pension Benefits (audited)

Name and title	Real increase/ (decrease) in pension at age 60 (bands of £2,500)	Real increase/ (decrease) in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31st March 2011 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31st March 2011 (bands of £5,000)	Cash Equivalent Transfer Value at 31st March 2011	Cash Equivalent Transfer Value at 31st March 2010	Real increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
M Deegan, Chief Executive	-7.5 to -5	-17.5 to -15	25 to 30	80 to 85	425	563	-158
G Heaton, Executive Director of Patient Service/Chief Nurse	-2.5 to 0	-5 to -2.5	40 to 45	120 to 125	770	819	-77
M Hodgson, Executive Director of Children's Services	5 to 7.5	15 to 17.5	25 to 30	80 to 85	345	314	20
R Pearson, Medical Director	0 to 2.5	0 to 2.5	75 to 80	230 to 235	1,697	1,754	-118
D Welsh, Executive Director of Human & Corporate Resources	-2.5 to 0	-2.5 to 0	55 to 60	175 to 180	1,292	1,346	-102
A Roberts, Executive Director of Finance	0 to 2.5	0 to 2.5	45 to 50	140 to 145	700	775	-10

The above table gives pension benefits up to 31st March 2011, and as Non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures, and from 2005/06 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

In the budget of 22nd July 2010 the Chancellor announced that the up rating (annual increase) of public sector pensions would change from the Retail Price Index (RPI) to the Consumer Prices Index (CPI). As a result the Government Acturaries Department undertook a review of all transfer factors. The new CETV factors have been used by the NHS Pensions Agency in their calculations and are lower than the previous factors used and therefore the value of the CETVs for some members has fallen since 31st March 2010.

Emergency Preparedness

The Trust has a Major Incident Plan in place, detailing how we prepare for and respond to an incident or special emergency. Staff receive training in their roles and responsibilities in the event of a Major Incident and the procedures are exercised and reviewed annually.

Throughout the year we have enhanced our existing Business Continuity Management arrangements, detailing the management of disruptions to services at our sites. Building on the existing Trust-wide Business Continuity Plan, critical services have reviewed and developed additional local plans to increase resilience in the event of a disruption.

To ensure we are prepared to respond to internal or external incidents and emergencies during 2011/12, we will continue to train, exercise and review our Emergency Planning arrangements with particular emphasis on integrating all new Adult and Children's Community Health Services that transferred to the Trust on 1st April 2011 as part of the Government's Transforming Community Services (TCS) Programme.

Statement of Internal Control
1st April 2010 to 31st March 2011

Scope of Responsibility

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

The Trust's management structure has established accountability arrangements through a scheme of delegation covering both corporate and clinical division arrangements. This is reflected in the corporate and divisional work programmes/objectives and the governance arrangements within the Trust. The responsibilities of each Executive Director are detailed below:

Director of Finance

Has responsibility for bringing together at corporate level the wide range of inter-related work around finance, strategic planning, contracting and information.

Has responsibility for developing and overseeing delivery of financial plans across the Trust for current and future financial years, ensuring these are integrated with operational and service delivery requirements.

Produces Annual Plan submission to Monitor and maintains ongoing Compliance relationship with Monitor through monitoring submissions and exception reporting as required.

Has regular meetings with NHS Manchester (host commissioner) and with the North West Specialist Commissioners, maintaining dialogue across service delivery and planning issues including forward projections, developments and strategic service changes.

Has responsibility for developing and delivering on any transactions which may be contemplated by the Board which may extend the scope of the Trust's activities and responsibilities.

Medical Director

This is a part time managerial post with corporate responsibility for leading on patient safety and clinical effectiveness, research and innovation and medical education. The post chairs the Clinical Effectiveness Committee, the Safeguarding Effectiveness Committee and the Research Governance Board. The post has continued to focus particularly on patient safety and clinical effectiveness during 2010/11.

Has responsibility for ensuring compliance with statutory requirements regarding Safeguarding Children and Vulnerable Adults. Has responsibility for ensuring the Trust compliance with the Human Tissue Act.

Director of Patient Services/ Chief Nurse

Has responsibility for the professional nursing agenda, patient partnership work, overall day to day operational management of clinical services including delivery of key targets, service developments/improvements and facilities management.

The post holder is also the Trust's Director of Infection Prevention and Control.

Director of Human and Corporate Resources

Has lead responsibility for human resources and corporate support functions.

A regular pattern of meetings has been established with the Strategic Health Authority to discuss national and regional HR policy issues. The Director is also a member of the City Corridor Workforce Sub Group and the Manchester Employment Alliance where local employment issues and training needs are discussed.

The purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the policies, aims and objectives of Central Manchester University Hospitals NHS Foundation Trust.
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in the Central Manchester University Hospitals NHS Foundation Trust for the year ended 31st March 2011 and up to the date of approval of the Annual Report and Annual Accounts.

Capacity to Handle Risk

The Chief Executive chairs the Risk Management Committee and actual risks scoring 15 or above are reported. Risk reports are received from each Divisional Director and each Executive Director with details of the controls in place against which assessment is made by the Committee.

The Audit Committee monitors assurances and assurance processes across all risks in order to provide independent assurance to the Board of Directors that risks have been properly identified and controls are in place.

The Board has designated the Medical Director as the lead executive and chairman of the Clinical Effectiveness Committee. The Clinical Effectiveness Committee has an increased focus on patient safety and clinical effectiveness. A significant amount of work has been undertaken to develop clinical effectiveness indicators across all clinical divisions. The Medical Director is supported by a Clinical Governance Team which includes an Associate Medical Director (Clinical Effectiveness), Director of Clinical Effectiveness, Associate Director of Clinical Effectiveness and Clinical Audit and Risk Management Departments. A Trust risk management training programme has been designed and delivered which undergoes an annual evaluation process. The risk management team includes a training post dedicated solely to risk management training.

The Trust has operational risk and safety meetings which review high level incidents and trends so that lessons can be learnt for the future. The Trust has developed robust mechanisms for recording untoward events and learning from them. As part of our Clinical Governance Performance Framework each division records

its activity and performance against the key clinical effectiveness indicators and produces a summary for discussion at their divisional review with areas of good practice collated on a corporate basis to be shared throughout the Trust. The Trust is also represented on a number of National and Regional Working Groups.

The key elements of the quality governance arrangements are as follows:

The organisation has developed clinical effectiveness indicators which are reviewed at all levels of the organisation from Departments to Board of Directors on a regular basis. These form a component part of the Intelligent Board Framework and an integral part of the Divisional review process. These indicators are reviewed by those staff who lead and manage performance; this includes Clinicians who regularly review data as part of the clinical effectiveness process in every Division.

These indicators are triangulated with other data such as Dr Foster analysis, national survey data and CQUINS performance to ensure complete understanding and response.

The quality of that information is regularly assessed and challenged and the clinical teams work closely with the Information Department to ensure accuracy and timeliness of dissemination and review.

The organisation has had a process in place for self assessment against the CQC Standards for some years. This has been amended in the light of the new requirements of registration. As an annual submission is no longer required the organisation has developed a system of ongoing periodic review with evidence stored on a data base (CIRIS). Compliance and review are monitored at the Clinical Standards Committee chaired by the Director of Clinical Effectiveness. The organisation has a system in place for monthly review of the CQC Quality and Risk Profile which also serves as an indicator of risk areas for consideration.

Registration was successfully achieved in April 2010 and this has been reviewed again in preparation for the CQC planned review in March 2011 with a report made following that review to the Board of Directors. The organisation was found to be compliant with all standards reviewed with minor recommendations made to maintain that compliance.

The organisation will continue a programme of audit and self assessment culminating in a detailed report prepared in advance of the next Statement of Internal Control in March 2012.

The Risk and Control Framework

A risk management process, covering all risks has been developed throughout the organisation at all levels including the Board with key indicators being used to demonstrate performance. The whole system of risk management is continuously monitored and reviewed by management and the Board in order to learn and make improvements to the system.

In order to achieve this, the risk management strategy provides the Trust with a process of risk identification, evaluation and planning that has formed an assurance framework. The process involves layers of risk identification and analysis for all individual management units e.g. directorates, departments, functions or sites for significant projects and for the organisation as a whole. Analysis of the severity and likelihood of the risk occurring determines the overall risk ranking of the hazard identified. This assists in the assessment of risk throughout the organisation with a common currency and methodology being used. The strategy clearly sets out the individual and corporate responsibilities for the management of risk within the organisation. Implementation of the strategy ensures the Board is informed about significant residual risks and is then able to communicate those effectively to external stakeholders.

The risk management strategy is distributed throughout the organisation and to all local stakeholders and is reviewed on an annual basis.

There is increasing involvement of key stakeholders through mechanisms such as the Essential Standards of Quality and Safety consultation process and Care Quality Commission assessment and registration and involvement in the annual Clinical Audit and Risk Management fair.

Each of the divisions and corporate services systematically identify, evaluate, treat and monitor action on risk on a continuous basis. This work is reported back through the divisional review process. This report connects the significant risks to the corporate/organisation objectives and assesses the impact of the residual risks on those objectives. The outcome of the review is communicated to the Risk Management Committee in order that the plans can be monitored. The Risk Management Committee

undertakes further evaluation of the risks presented and their action plans and updates the Assurance Framework in order that at any given time the significant risks to the organisation are identified. Risk Management and Assurance Framework processes are closely aligned and the Assurance Framework is dynamic and embedded in the organisation. Controls and assurances provide evidence to support the Statement on Internal Control.

A significant level of assurance has been given by Internal Audit on both the Assurance Framework and Risk Management processes.

All Divisions report on all categories of risk quarterly to both the Trust Risk Management Committee, chaired by the CEO and the Trust Clinical Effectiveness Committee, chaired by the Medical Director.

All policies developed by the Trust undergo Equality Impact Assessments.

Operationally the document which contains all identified risks within the organisation is the Risk Register. The risk register is an on-line function within the Trust to which all appropriate personnel have access. This document also contains the detailed risk assessments and resulting action plans associated with the external assurance sources detailed under "review of effectiveness". The Board is therefore able to monitor progress against such action plans.

Risk assessment is a fundamental management tool and forms part of the governance and decision making process at all levels of the organisation.

The Medical Director and Executive Director of Patient Services/Chief Nurse work closely on the alignment of patient safety and the patient experience.

Clinical risk assessment is a key component of clinical governance and forms part of the Risk Register.

We have taken a number of steps in 2010/11 to assess our information governance practices and further reduce any risks.

The annual review of all transfers of personal data in or out of the Trust was completed in March 2010 and all potential risks and solutions were identified. Where any weaknesses were identified, immediate action was taken to advise of alternative methods for sending this information. The need for security has continued to be reinforced throughout the year.

We continue to operate a specific policy for staff on encryption and information security and continue to improve the tracking of paper medical records. During 2010/11 there has been continued rigour in ensuring all confidential data is encrypted for onward transmission or removal from the Trust (eg on laptops/memory sticks) and advice has been regularly disseminated to staff. Great emphasis has been placed on the importance of continued security of any health records taken out of the hospitals and all staff are reminded to observe the Record Keeping Policy.

Information Governance training is now provided through an e-learning package. This is a comprehensive training package on how to handle and use confidential/personal information. This is currently being rolled out across the Trust.

The Board recognises that not all risks can be eliminated and that there will always be residual risks which will require careful monitoring and review.

Compliance with NHS Pension Scheme Regulations

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

Compliance with Equality, Diversity and Human Rights Legislation

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

The Trust is compliant with Race, Gender and Disability Equality Legislation, in both the service it provides and the employment of its staff.

Compliance with Carbon Reduction

The Trust has undertaken risk assessments in accordance with emergency preparedness and civil contingency requirements, as based on the UKCIP 2009 climate weather projections, to ensure that this organisations obligation under the Adaptation Reporting (response to the predicated impacts of unavoidable climate change) are complied with. Furthermore the Trust is in full compliance with the mandatory requirements of the Climate Change Act and its carbon reduction delivery plans. This includes the establishment locally of a Carbon Management Implementation Plan; Carbon Reduction Policy; regular monitoring and feedback to the Environment Agency and other Government bodies.

Review of Economy, Efficiency and Effectiveness of the use of Resources

The Trust continues to invest significant focus to improving the underlying systems and controls to engender a more embedded range of monitoring and control processes.

The Trust has achieved NHSLA (NHS Litigation Authority) Acute Trust Risk Management Standards at Level 2 and CNST (Clinical Negligence Scheme for Trusts) Risk Management Standards for Maternity Services at Level 3. The Trust is preparing for assessment for NHSLA Acute Trust Risk Management Standard at Level 3 during 2011/12.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, clinical audit and the Executive Managers and Clinical Leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report in this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

My review is also informed by other major sources of assurance such as:

- Internal Audit Reports
- External Audit Reports
- Clinical Audit Reports
- Patient Survey
- Staff Survey
- Royal College accreditation
- Health and Safety Executive Inspection Reports
- Compliance at CNST General Standards at Level 2
- Compliance Against CNST – Maternity Standards at Level 3
- Patient Environment Action Team Inspections
- Clinical Pathology Accreditation
- Care Quality Commission - registration without conditions

The Trust has identified over 50 external agencies who may visit the Trust.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Risk Management Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust applies a robust process for maintaining and reviewing the effectiveness of the system of internal control. The roles of key committees are as follows:

Board of Directors

The statutory body of the Trust is responsible for the strategic and operational management of the organisation and has overall accountability for the risk management frameworks, systems and activities, including the effectiveness of internal controls.

The Terms of Reference and responsibilities of all Board Committees are reviewed each year in order to strengthen their roles in governance and focus their work on providing assurances to the Board on all risks to the organisation's ability to meet its objectives.

Audit Committee

The Audit Committee provides an independent contribution to the Board's overall process for ensuring that an effective internal control system is maintained and provides a

cornerstone of good governance. The Audit Committee monitors the assurance processes of all other Board Committees.

Clinical Effectiveness Committee

The Clinical Effectiveness Committee is responsible for ensuring the delivery of clinical effectiveness at both corporate and divisional level, through developing the Trust's clinical effectiveness strategy, monitoring progress across the Trust and in each division against patient safety and clinical effectiveness targets and defining the principles and priorities for clinical effectiveness.

Internal Audit

Internal Audit provides an independent and objective opinion to the Accounting Officer, the Board and the Audit Committee, on the degree to which the Trust's systems for risk management, control and governance support the achievement of the Trust's agreed objectives.

Risk Management Committee

The Risk Management Committee provides the Board of Directors with an assurance that risks are well managed with the appropriate plans in place. Reports demonstrate that the Risk Management reporting process includes all aspects of risk arising out of clinical and non clinical practice.

Clinical Audit

The Clinical Audit Department oversees the development and delivery of an annual Clinical Audit Calendar. This plan includes mandatory national audits, locally agreed priority audits and monitoring audits in respect of external regulation and accreditation.

The calendar is presented to the Trust Audit Committee and provides assurance on both clinical outcomes and compliance with guidance such as NICE and NCEPOD (National Confidential Enquiry into Patient Outcome and Death).

Approximately 400 audits are undertaken annually with their results disseminated and action taken in response.

Divisional Review Process

The Divisional Review Process informs the Board of Directors, the Risk Management Committee and the Divisional Governance Groups on aspects of all risks identified through the analysis of incidents, complaints, clinical audit, concerns and claims reported throughout the Trust.

Assurance Framework

The Assurance Framework structures the evidence on which the Board of Directors depends to assure it is managing risks which could impact on the organisation's objectives.

Significant internal control issues

The Trust has identified the following significant internal control issues which have been or are being addressed:

- **Trading Gap Plans – Financial**

  An annual efficiency requirement of 4% removed from tariff uplifts each year will require significant efficiencies over the next five years.

  The Trust is proactively identifying, developing and implementing plans, in advance of need wherever possible. Budgetary control systems closely monitor the delivery of the trading gap solutions across each Division of the Trust. Plans are risk-assessed and kept under regular review.

  Core cross-Divisional themes for productivity and efficiency have identified Executive leadership at Trust level and an established set of processes to ensure consistent implementation across all Divisions.

- **Workforce Strategy to support Financial Plans – Organisational**

  A Workforce Strategy has been developed to support the financial plans. This ensures that as controls are tightened on locum and agency spend vacancies are reduced and posts disestablished, assurance mechanisms will be developed to ensure high levels of clinical safety and quality are maintained.

- **Transferring Community Services – Clinical**

  Community Services transferred to the Trust in April 2011. To mitigate

risks robust project management arrangements have been in place throughout the year. A well structured and detailed due diligence process focusing on key material risks has been executed. A Transfer Integration Plan and the establishment of management arrangements have been implemented.

- **Adult Critical Care Capacity – Clinical**

Increasing demands on adult critical care services particularly for specialist referrals have necessitated the Trust to develop increased capacity for critical care beds. Before further planned capacity is provided, other measures are in place to mitigate the risk including robust management of rotas, focused recruitment and the development of an extended recovery area.

A full business case for a new Critical Care Unit was approved by the Board of Directors in January 2010 with a scheduled opening date of December 2011.

- **Infection Control – Clinical**

The Trust has continued to demonstrate significant performance during 2010/11 on all aspects of infection prevention and control. The MRSA target was achieved and the Trust was under trajectory; in addition the target for managing C.Difficile was also achieved and the Trust was under trajectory.

The Trust continues to adopt a zero tolerance approach to infection prevention and control and is continually improving services to meet these challenges.

- **European Working Time Directive – Clinical**

The Trust in line with most other Trusts has had difficulty recruiting to all vacant junior doctor posts. This potentially could impact on service delivery and patient safety. The new limits on non-European migration may impact on the Trust's ability to sponsor doctors from overseas in the future.

A number of innovative recruitment measures have been put in place including appointments to resident consultant posts. A framework of solutions has been implemented across each Division of the Trust.

- **Building and Maintaining Staff Engagement through the current economic climate – Organisational**

Following the results of the 2008 staff survey a staff reward and recognition programme was implemented in the Trust. Following the 2009 survey results each Division has developed action plans to address concerns raised and these plans are reviewed on a regular basis. Further work will be undertaken following an analysis of the 2010 staff survey.

- **Information/Data – Organisational**

The Trust is currently undertaking a review of the Information Asset Register which refers to assets across the organisation holding personal information. These assets underpin service user/patient care processes. This review will focus on the safeguards set against each asset, a risk assessment and also identification of the Information Asset Owner and Administrator. There is also specific training required for these roles and forms part of the Information Governance toolkit.

There were no Serious Untoward Incidents of data loss or confidentiality breaches reported during 2010/11.

Annual Quality Accounts

The directors of Central Manchester University Hospitals NHS Foundation Trust are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of Annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

We have appointed a member of the Board, the Medical Director, to lead, and advise us, on all matters relating to the preparation of the Trust's annual Quality Accounts.

Central mechanisms in place to assure the quality of data in the Trust's Quality Accounts

The Trust has robust data quality procedures in place that ensure the robustness of data used in the Quality Accounts. These data quality procedures span from ensuring data is input into transactional systems correctly, information is extracted and interpreted accurately and that it is reported in a way that is meaningful and precise. All staff who have a responsibility for inputting data are trained fully in both the use of the systems and in how the information will be used.

Furthermore, there are corporate data quality links with each of the clinical divisions that work with operational staff to ensure the highest levels of integrity.

Before the Quality Indicators are made available in the Quality Accounts or any Trust monitoring report they go through a series of sign off steps resulting with Executive Director sign-off. The content of the Quality Account and the indicators that make up the metrics section are added to and amended as priorities change or whenever a shift in focus is required.

There is a formal annual review whereby the metrics are decided on for the coming year however this does not prevent changes in year. All changes to the Quality Accounts and any of the metrics reports are signed off by the Executive Medical Director, Director of Informatics and Director of Clinical Effectiveness.

The Trust is fully compliant with the Care Quality Commission's essential standards of quality and safety.

Conclusion

The Board confirms that it is satisfied that, to the best of its knowledge and using its own processes and having had regard to Monitor's Quality Governance Framework (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints and including any further metrics it chooses to adopt), its NHS Foundation Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

Mike Deegan, Chief Executive Officer June 2011

Statement of Compliance with the NHS Foundation Trust Code of Governance

The Board of Directors and the Council of Governors are committed to continuing to operate according to the highest corporate governance standards.

The Trust is compliant with the principles and provisions of the NHS Foundation Trust Code of Governance.

The Board of Directors meets formally on a bimonthly basis in order to discharge its duties effectively. Systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery.

The Board of Directors regularly reviews the performance of the Trust against regulatory and contractual obligations and approved plans and objectives. The Board of Directors has ensured that relevant metrics, measures and accountabilities have been developed in order to assess progress and delivery of performance.

All Directors have responsibility to constructively challenge the decisions of the Board. Non-executive Directors scrutinise the performance of the executive management in meeting agreed goals and objectives and monitor the reporting of performance.

The Board of Directors has a balance of skills that is appropriate to the requirements of the Trust.

The Chairman has ensured that the Board of Directors and the Council of Governors work together effectively and that Directors and Governors have received accurate, timely and clear information that is appropriate for their respective duties.

The Council of Governors represents the interests of the Trust's members and partner organisations in the local health economy in the governance of the Trust. Our Governors act in the best interests of the Trust and adhere to its values and code of conduct.

The Council of Governors holds the Board of Directors to account for the performance of the Trust and receives appropriate assurance reports on a regular basis. The Governors are consulted on the development of forward plans for the Trust and any significant changes to the delivery of the Trust's business plan.

The Council of Governors meets on a regular basis sufficient to discharge its duties. The Governors have nominated a Lead Governor.

The Directors and Governors continually update their skills, knowledge and familiarity with the Trust and its obligations to fulfil their role both on respective boards and committees.

A performance review process involving the Governors, the Chairman and Non-executive Directors has been developed. The Senior Independent Director supports the Governors through the evaluation of the Chairman. Each Executive Director's performance is reviewed by the Chief Executive who in turn is reviewed by the Chairman.

Members of the Board of Directors have continued to attend the Council of Governors meetings and the Governor Working Groups and jointly attended the Annual Planning Workshop in February 2011.

The Board of Directors has undertaken a Board Development Programme which considered individual and Board impact and effectiveness. The Development Programme was carried out by an external body and a development plan will be implemented during 2011/12.

Audit Committee Report

The Audit Committee Annual Report reviews the work and performance of the Audit Committee during 2010/11 in satisfying its terms of reference.

The production of an Audit Committee Annual Report represents good governance practice and ensures compliance with the Department of Health's Audit Committee Handbook and the principles of integrated governance.

Overview

Through the Audit Committee, the Board of Directors ensures that robust and effective internal control arrangements are in place and regularly monitored.

The Audit Committee receives regular updates of the Board Assurance Framework and is therefore able to focus on risk, control and related assurances that underpin the delivery of the organisational objectives.

Committee Membership

The Audit Committee membership during 2010/11 comprised:

Mr Anthony Leon	–	Deputy Chairman of the Board and Chair of the Audit Committee
Professor Rod Coombs	–	Non-executive Director
Lady Rhona Bradley	–	Non-executive Director
Ms Brenda Smith	–	Non-executive Director
Mr Steve Mycio	–	Non-executive Director
Mr Alexander Wiseman	–	Non-executive Director

Compliance with the Terms of Reference

The Terms of Reference of the Audit Committee are reviewed annually.

The Audit Committee met five times during 2010/11 and all meetings have been quorate.

Audit Committee minutes are submitted to the next available Board of Directors' meeting.

The Executive Director of Finance, Director of Finance, Chief Accountant, Head of Internal Audit and Internal Audit Manager, representatives of External Audit and the Local Counter Fraud Specialist have been in attendance.

Executive Directors, Corporate Directors and other members of staff have been requested to attend the Audit Committee as required.

The Chair of the Audit Committee gave a presentation to the Council of Governors in June 2010 on the work of the Audit Committee.

The Terms of Reference were reviewed by the Audit Committee in February 2011.

Audit Provision

Internal Audit has been provided by NHS Audit North West.

External Audit has been provided by the Audit Commission. The Council of Governors at its meeting in June 2009 approved the Audit Committee's recommendation for the continuing appointment of the Audit Commission. Following completion of the 2010/11, audit year a review will be undertaken including consideration of market testing and a recommendation will be made to the Council of Governors.

Assurance

The Audit Committee agenda is constructed in order to provide assurance to the Board of Directors across a range of activities including corporate, clinical, financial and risk governance and management.

The Audit Committee agenda covers the following:

- Monitoring of the Audit Committee's work programme 2010/11
- Consideration of reports from the following Board Committees:
  - The Risk Management Committee
  - The Clinical Effectiveness Committee
  - The Human Resources Committee
- External Audit progress reports
- Internal Audit progress reports
- Counter fraud reports
- Losses and compensations reports
- Tenders waived reports

Work and Performance of the Committee during 2010/11

The Audit Committee has continued to focus its attention throughout the year on the Risk Management Committee reports. Non-executive Directors are invited to attend the Risk Management, Clinical Effectiveness and Human Resources Committees.

A number of risks reported through the Risk Management Committee and scrutinised by the Audit Committee were further highlighted at the Board of Directors' meetings or Finance Scrutiny meetings, in particular the appraisal uptake, sickness absence levels and financial performance.

Attendance

Date	A.Leon	R.Coombs	R.Bradley	B.Smith	S.Mycio	A. Wiseman
14/04/10	√	X	√	√	√	√
02/06/10	√	√	√	X	√	√
08/09/10	√	X	√	√	√	√
03/11/10	√	√	√	√	√	X
23/02/11	√	√	√	√	X	√

External Audit

The Audit Commission presented its plan setting out the proposed work in relation to the 2009/10 accounts.

The accounts were audited by the Audit Commission and the findings presented to the Audit Committee in June 2010. An unqualified opinion on the accounts was given.

The Audit Committee considered the External Audit Annual Governance report, the report from the Executive Director of Finance and changes to accounting policies.

The Audit Committee approved the accounts for the period 1st April 2009 to 31st March 2010.

The Council of Governors subsequently received the report on the accounts from the Independent Auditor in June 2010.

The Audit Commission carried out a 'dry run' audit on the Quality Accounts 2009/10 and provided recommendations to the Audit Committee in September 2010.

Internal Audit

The Audit Committee received the Internal Audit plan for 2010/11 in April 2010. The plan provides evidence to support the Head of Internal Audit Opinion which in turn contributes to the assurances available to the Board in its completion of its Statement on Internal Control (SIC).

The Head of Internal Audit Opinion 2009/10 was presented to the Audit Committee in June 2010 and a significant assurance was given on the adequacy of the system of internal control. Internal Audit Reports have been received by the Audit Committee throughout the year. Of the 34 reports received, one was given a full assurance rating, 27 were given a significant assurance rating and 6 were given a limited assurance rating.

Limited Assurances

The Committee focused on audit reports which had received a limited assurance and where appropriate requested the presence of key individuals to present their action plans to fulfill the recommendations.

Counter Fraud

The Counter Fraud service to the Trust is provided by Audit North West and a nominated counter fraud specialist works with the Trust.

The Audit Committee received regular progress reports. Details of investigations carried out during the year were provided to the Committee.

A Counter Fraud annual report was presented to the Audit Committee in June 2010 and provided a summary of the counter fraud work undertaken based upon the annual work plan.

In February 2011, the Committee was informed that the Trust had been assessed on its compliance with instructions and guidance outlined by NHS Counter Fraud policy. The Trust was assessed at Level 2. This rating indicates that the Trust is performing effectively across the full range of counter fraud actions.

Losses and Compensations

The Audit Committee was provided with information regarding the levels and values of losses and compensation payments within the Trust, at each meeting.

Tenders Waived

A summary of all tenders waived above a £50k value was presented at the Audit Committee meetings.

Other Reports

The Audit Committee received further information on the following:

- The revisions to the Risk Management Strategy in September 2010 which were approved.
- The Clinical Audit Strategy 2010-2013 in September 2010 presented by the Head of Clinical Audit.

Statement on Internal Control

The Audit Committee received the Statement on Internal Control 1st April 2009 to March 2010, in June 2010.

The Statement on Internal Control described the system of internal control that supports the achievement of the organisation's policies, aims and objectives.

The Statement of Internal Control was supported by independent assurances and reflected that there were no control issues that required disclosure.

The revision to the standing orders, standing financial instructions and scheme of delegation in September 2010.

Trust Annual Report

The Audit Committee received the Trust's Annual Report 1st April 2009 to 31st March 2010, in June 2010.

Priorities for 2011/12

The Audit Committee will review the arrangements to be put in place/developed in relation to:-

- Compliance with Foundation Trust authorisation
- International Financial Reporting Standards
- Care Quality Commission and compliance
- Consolidation of Charitable Funds
- Approval of internal regulatory documents
- Board Assurance Framework
- Clinical Audit Strategy and Plan
- Integrated Governance and Assurance
- Monitoring audit recommendations
- Further developing the role and skills of the Audit Committee

Conclusion

The Audit Committee has continued to develop significantly over the past year in considering a much wider spectrum of risk. This will continue to be strengthened during 2011/12. Also in co-operation with the Finance Scrutiny Committee, particular emphasis will continue to be given to the finances of the Trust, bearing in mind the difficulties faced by all public organisations.

The Committee has been proactive in requesting reports in areas of concern particularly in non financial areas. The Committee will continue its increased focus during 2011/12 on following up Internal and External Audit reports where limited assurances have been given and monitoring the clinical audit process.

The Audit Committee has met its terms of reference as detailed throughout this report.

Anthony Leon, Chairman Audit Committee
April 2011

The Remuneration and Nominations Committee Report

The Remuneration and Nominations Committee of the Council of Governors did not meet during 2010/11 as no Non-executive Director appointments were made. The performance review process for the Chairman and Non-executive Directors was approved by the Council of Governors.

A panel of Governors received the appraisal reports for the Chairman and Non-executive Directors and these were shared with the Council of Governors in June 2010. An external appraisal specialist was utilised to undertake a 360 degree appraisal of the Chairman. In addition a Governor questionnaire fed in views on Non-executive Directors and the Chairman to the Lead Governor and Senior Independent Director respectively.

The Remuneration Committee of the Board of Directors has met during the year as required to determine the remuneration of the Executive Directors. Comparisons with similar posts in the NHS are used. However, because of the current economic climate, all inflationary pay increases to Executive and Non-executive posts have been frozen for the second year. Executive Directors undergo annual appraisals which monitor their performance against the Trust's objectives.

Statement of Chief Executive's Responsibilities as the Accounting Officer of Central Manchester University Hospital NHS Foundation Trust

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

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

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

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the NHS Foundation Trust Financial Reporting Manual have been followed and disclose and explain any material departures in the financial statements; and
- Prepare the financial statements on a going concern basis.

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

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

Mike Deegan, Chief Executive
3rd June 2011

Report of The Executive Director of Finance

1. Introduction

In the context of overall government finances and the spending review settlement for the NHS over the next four years, the Trust continues to deliver significant change programmes to improve our operational efficiency, whilst maintaining the highest standards of patient safety, quality of care and positive patient experiences across all our services.

The Trust's income and expenditure out-turn for 2010/11 financial year is a surplus of £116k.

The year-end cash balance of £35m reflects some slippage in capital expenditure, as well as a strengthened working capital position achieved in the fourth quarter of the year.

2. Analysis of Financial Out-Turn

2.1 The income and expenditure out-turn for the year was a surplus of £116k; just 0.02% of our total income for the year.

3. Financing

3.1 In the year the Trust entered into a loan facility agreement with the Department of Health's NHS Foundation Trust Financing Facility to make available £20m to fund the physical co-location and expansion in capacity of our Adult Critical Care services. This fell within the extended borrowing limit approved by the Board of Monitor, following an updated review of our forward plans for this purpose. We are anticipating drawing on further loan facilities this year of £16.0m as the capital works associated with this project are substantially progressed over the coming 12 months.

3.2 In addition to the above the Trust has an un-utilised working capital 'overdraft' facility, as required by our terms of authorisation, which we increased to £40m from September 2010.

3.3 The Trust has an approved Treasury management policy, which has been kept under review in the light of prevailing economic circumstances. The Trust will continue to minimise risk to deposits in the future.

Key Performance Indicators

The following tables show the Trust's performance against Monitor's mandatory performance measures, which the Board of Directors also uses to track overall financial performance. The Trust maintained sound overall results across these performance measures, resulting in an overall financial risk rating of '3' (where '5' is the strongest rating and '1' the weakest):

Financial Risk Rating

Metric	Actual	Rating for the Year
EBITDA (Earnings Before Interest, Taxes and Amortisation) margin	7.4%	3
EBITDA % of plan achieved	87%	4

Metric	Actual	Rating for the Year
Return on Assets	0.0%	2
I&E surplus margin	0.0%	2
Liquid ratio	17.7	3
Overall Financial Risk Rating		3

4. Conclusion

The Trust has met the overall financial requirements set by Monitor, throughout the 2010/11 financial year. Robust financial plans are in place for 2011/12; these are plans which take full account of the issues and challenges which the NHS as a whole faces, in the current economic climate. The Trust remains well placed (and demonstrably continues) to further develop high quality services with strong clinical outcomes and to further improve patient experience, fully supported by modern 21st century hospital facilities and technology.

Adrian Roberts
Executive Director of Finance

Independent Auditor's Report to the Council of Governors of Central Manchester University Hospitals NHS Foundation Trust

I have audited the financial statements of Central Manchester University Hospitals NHS Foundation Trust for the year ended 31st March 2011 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies.

I have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes; and
- the table of pension benefits of senior managers and related narrative notes.

This report is made solely to the Council of Governors of Central Manchester University Hospitals NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My audit work has been undertaken so that I might state to the Council of Governors those matters I am required to state to it in an auditor's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for this report or for the opinions I have formed.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

My responsibility is to audit the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the

financial statements. I read all the information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the state of affairs of Central Manchester University Hospitals NHS Foundation Trust's affairs as at 31st March 2011 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the Statement of Internal Control on which I report to you if, in my opinion the Statement of Internal Control does not reflect compliance with Monitor's requirements.

Certificate

I certify that I have completed the audit of the accounts of Central Manchester University Hospitals NHS Foundation Trust in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Jackie Bellard
Officer of the Audit Commission

The Audit Commission
Second Floor
Aspinall House
Aspinall Close
Middlebrook
Bolton, BL6 6QQ

2nd June 2011

Foreword to the accounts

These accounts for the year ended 31st March 2011 have been prepared by Central Manchester University Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service 2006 Act, in the form which Monitor, the Independent Regulator of NHS Foundation Trusts, with the approval of the Treasury directed.

These accounts have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Mike Deegan
Chief Executive

2nd June 2011

Financial Statements

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2011

	NOTE	**2010/11 £000**	2009/10 £000
Operating income from continuing operations	**2**	**665,282**	660,552
Operating expenses of continuing operations	**3**	**(639,382)**	(632,739)
Impairment of property, plant and equipment	**3**	**0**	(183,798)
Operating surplus / (deficit)		**25,900**	(155,985)
Finance costs:			
Finance income	**8**	**95**	96
Finance expense - financial liabilities	**9**	**(25,804)**	(20,794)
Finance expense - unwinding of discount on provisions		**(75)**	(62)
Public dividend capital dividends payable		**0**	(3,030)
Net finance costs		**(25,784)**	(23,790)
Surplus / (Deficit) from continuing operations		**116**	(179,775)
Surplus / (deficit) of discontinued operations and the gain / (loss) on disposal of discontinued operations	**6**	**0**	0
Surplus / (Deficit) for the year		**116**	(179,775)
Other comprehensive income			
Impairment		**0**	(6,331)
Revaluations		**0**	226
Receipt of Donated Assets		**81**	10,739
Other reserve movements		**(3,415)**	(1,000)
Total comprehensive expense for the period		**(3,218)**	(176,141)
Prior period adjustments		**0**	0
Total comprehensive expense for the year		**(3,218)**	(176,141)

The deficit for the year 2009/10 arose due to the impairment in respect of the Modern Equivalent Asset valuation carried out in year, note 10. Without this impairment the Trust would have shown a surplus of £4.0m. There has been no impairment during 2010/11.

The notes on pages 131 to 163 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2011

	NOTE	31 March 2011 £000	31 March 2010 £000
Non-current assets			
Intangible assets	11	**2,015**	2,426
Property, plant and equipment	12	**413,948**	420,544
Trade and other receivables	22	**1,768**	1,733
Total non-current assets		**417,731**	424,703
Current assets			
Inventories	21	**8,710**	9,409
Trade and other receivables	22	**35,883**	38,575
Non-current assets and assets in disposal groups	18	**7,000**	7,000
Cash and cash equivalents	25	**35,231**	29,693
Total current assets		**86,824**	84,677
Current liabilities			
Trade and other payables	26	**(58,110)**	(57,210)
Borrowings	27	**(8,880)**	(8,225)
Provisions	31	**(13,315)**	(7,703)
Other liabilities	29	**(610)**	(441)
Total current liabilities		**(80,915)**	(73,579)
Total assets less current liabilities		**423,640**	435,801
Non-current liabilities			
Trade and other payables	26	**(4,017)**	(4,714)
Borrowings	27	**(370,462)**	(378,342)
Provisions	31	**(2,885)**	(2,954)
Other liabilities	29	**(4,712)**	(6,387)
Total non-current liabilities		**(382,076)**	(392,397)
Total assets employed		**41,564**	43,404
Financed by Taxpayers' equity:			
Public dividend capital		**178,674**	178,428
Revaluation reserve	33	**28,219**	28,219
Donated asset reserve		**9,406**	12,740
Income and expenditure reserve		**(174,735)**	(175,983)
Total Taxpayers' Equity		**41,564**	43,404

The financial statements on pages 127 to 163 were approved by the Audit Committee with delegated authority from the Board on 1st June 2011 and signed on its behalf by: Anthony Leon, Non-executive Director.

Mike Deegan, Chief Executive 2nd June 2011

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

2010/11	Public dividend capital	Revaluation reserve	Donated asset reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2010	178,428	28,219	12,740	(175,983)	43,404
Surplus / (deficit) for the year	0	0	0	116	116
Receipt of donated asset	0	0	81	0	81
Public Dividend Capital received	246	0	0	0	246
Other reserve movements	0	0	(3,415)	1,132	(2,283)
Taxpayers' Equity at 31 March 2011	**178,674**	**28,219**	**9,406**	**(174,735)**	**41,564**

2009/10	Public dividend capital	Revaluation reserve	Donated asset reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2009	**171,913**	**26,801**	**7,681**	**6,619**	**213,014**
Surplus / (deficit) for the year	0	0	0	(179,775)	(179,775)
Impairments	0	(1,425)	(4,906)	0	(6,331)
Revaluations	0	0	226	0	226
Receipt of donated asset	0	0	10,739	0	10,739
Public Dividend Capital received	6,515	0	0	0	6,515
Other reserve movements	0	2,843	(1,000)	(2,827)	(984)
Taxpayers' Equity at 31 March 2010	**178,428**	**28,219**	**12,740**	**(175,983)**	**43,404**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2011

	2010/11 £000	2009/10 £000
Cash flows from operating activities		
Operating surplus / (deficit) from continuing operations	**25,900**	(155,985)
Operating surplus / (deficit) of discontinued operations	**0**	0
Operating surplus / (deficit)	**25,900**	(155,985)
Non-cash income and expense:		
Depreciation and amortisation	**23,543**	27,249
Impairments	**0**	188,599
Transfer from donated asset reserve	**(3,415)**	(5,680)
Amortisation of the government grants	**(715)**	(356)
(Increase) / decrease in trade and other receivables	**2,415**	(6,297)
(Increase) / decrease in inventories	**699**	(896)
Increase / (decrease) in trade and other payables	**2,544**	(10,226)
Increase / (decrease) in provisions	**5,543**	6,216
Other movements in operating cashflow	**180**	(247)
Net cash generated from operations	**56,694**	42,377
Cash flows from investing activities		
Interest received	**95**	96
Purchase of intangible assets	**(506)**	(500)
Sale of intangible assets	**11**	0
Purchase of property, plant and equipment	**(18,347)**	(38,094)
Sale of plant, property and equipment	**151**	185
Net cash used in investing activities	**(18,596)**	(38,313)
Cash flows from financing activities		
Public dividend capital received	**246**	6,515
Loans received	**1,000**	20,000
Loans repaid	**(2,224)**	0
Capital element of PFI obligations	**(6,001)**	(9,027)
Interest paid	**(1,091)**	(778)
Interest element of PFI obligations	**(24,702)**	(19,873)
PDC dividend paid	**287**	(3,747)
Cash flows from (used in) other financing activities	**(75)**	0
Net cash generated from / (used in) financing activities	**(32,560)**	(6,910)
Net increase / (decrease) in cash and cash equivalents	**5,538**	(2,846)
Cash and cash equivalents at the 1st April 2010	**29,693**	32,539
Cash and cash equivalents at the 31st March 2011	**35,231**	29,693

Notes to the accounts - 1. Accounting Policies

1.1 Accounting Policies

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2010/11 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the FT Annual Reporting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment and intangible assets at their value to the business by reference to their current costs.

1.3 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one NHS body to another.

1.4 Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

Estimates and judgements have to be made in preparing the Trust's annual accounts. These are continually evaluated and updated as required, although actual results may differ from these estimates.

Key sources of estimation uncertainty

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

Modern equivalent asset valuation

At the 30 September 2009 and at 31st March 2010, the Valuation Office provided a valuation of the Trust's land and building assets (estimated financial value and estimated remaining useful life) applying a modern equivalent asset method of valuation. This valuation, based on estimates provided by a suitably qualified professional, lead to a

significant reduction in the reported value of the Trust's land and building assets. Future revaluations of the Trust's asset base may result in further material changes to the carrying value of non-current assets.

Financial value of provisions for liabilities and charges

The Trust makes financial provision for obligations of uncertain timing or amount at the date of the Statement of Financial Position. These are based on estimates using as much relevant information as is available at the time the accounts are prepared. They are reviewed to confirm that the values included in the financial statements best reflect the current relevant information. Where necessary, the value of the provision is amended.

Actuarial assumptions for costs relating to the NHS pension scheme

The Trust reports, as operating expenditure, employer contributions to staff pensions. This employer contribution is based on a national (NHS) actuarial estimate of the required contribution to meet the scheme's liabilities. It is an expense that is subject to change.

Partially completed patient care spells

The Trust values this activity at average specialty cost for the specialty of admission.

Property, plant and equipment - useful economic lives

The Trust uses best judgement to determine the most appropriate life for each asset or class of assets.

1.5 Income

Income is accounted for applying the accruals convention. The main source of income for the Trust is from commissioners for healthcare services. Partially completed patient care spells are counted at 31 March and valued at average specialty cost for the specialty of admission. This approach has been agreed with the host commissioner.

Where income is received for a specific activity that is to be delivered in following years, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

The Trust receives income for both research and training activities; the majority of which are commissioned by NHS bodies and are in respect of health related activities.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.6 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from the employee. It is Trust policy that holidays are taken in the year in which they accrue, therefore no accrual is made.

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable an NHS body to identify its share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill health. The full amount of the liability for the additional costs is charged to operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.7 Expenditure on other goods and services

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

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are grouped into categories of similar asset lives then the groups are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are undertaken with sufficient regularity to ensure that the carrying amounts are not materially different to those that would be determined at the end of the reporting period. Fair values are determined as follows:-

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Until 31 March 2009, the depreciated replacement cost of specialised buildings has been estimated based on an exact replacement of the asset in its present location. HM Treasury has now adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The Trust's building assets were revalued on the basis of a modern equivalent asset valuation as at 31st March 2010.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Equipment assets are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as 'other comprehensive income' in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to a specification appropriate for its economic life, the expenditure is treated as a revenue expense.

1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (using a modern equivalent assets basis), as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.10 Depreciation, amortisation and impairments

Freehold land and properties under construction are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed periodically with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively. All assets commence being depreciated the month following the month of them being brought in to use, either from assets under construction or direct purchase.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.11 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to the donated asset reserve. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to offset the expenditure. On sale of donated assets, the net book value is transferred from the donated asset reserve to retained earnings.

1.12 Government grants

Government grants are grants from government bodies other than income from NHS bodies for the provision of services. Revenue grants are reported through the Statement of Comprehensive Income to match the expenditure incurred. Capital grants are treated as deferred income initially and credited to income over the expected life of the asset on a basis consistent with the depreciation / amortisation charge for that asset.

1.13 Non-current assets held for sale

In general, the following conditions must be met for an asset to be clasified as held for sale:

- management is committed to a plan to sell;
- the asset is available for immediate sale;
- an active programme to locate a buyer is initiated;
- the sale is highly probable;
- the asset is being actively marketed for sale at a sales price reasonable in relation to its fair value;
- actions required to complete the plan indicate that it is unlikely that the plan will be significantly changed or withdrawn.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.14 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating leases

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

Leases of land and buildings

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

1.15 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

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

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs and, if applicable, prepayments for assets not yet in operational use; and"

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

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

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

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

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

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

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

Lifecycle replacement

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

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement.

Assets contributed by the Trust to the operator

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

1.16 Inventories

Inventories are valued at the lower of cost and net realisable value, with the exception of pharmacy inventories which are valued at average cost. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.17 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.18 Contingencies

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is possible.

Where the time value of money is material, contingencies are disclosed at their present value.

Contingent liabilities are not recognised, but are disclosed in note 32, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

a) possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Trust's control; or

b) present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.19 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms.

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 31.3.

1.20 Non-clinical risk pooling

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

Other commercial insurance held by the Trust includes (building) contract works, motor vehicle, personal accident, group travel (for clinical staff required to work off-site and overseas travel). The annual premiums and any excesses payable are charged to operating expenses when the liability arises.

1.21 EU Emissions Trading Scheme

EU Emission Trading Scheme allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from the government grant reserve. The provision is settled on surrender of the allowances. The asset, provision and government grant reserve are valued at fair value at the end of the reporting period.

1.22 Financial instruments and financial liabilities

The Trust does not (as with most Public Bodies) generally hold any Financial Instruments or liabilities. The exception being those listed below:

Financial assets and financial liabilities at "Fair Value through Income and Expenditure" Loans and receivables

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

Other financial liabilities

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

Impairment of financial assets

At the end of each reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced.

1.23 Value Added Tax

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

1.24 Foreign currencies

The Trust's functional currency and presentational currency is sterling. The Trust does not record or trade in any transactions denominated in a foreign currency.

1.25 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 25 to the accounts.

1.26 Public Dividend Capital (PDC) and PDC dividend

Public Dividend Capital (PDC) represents taxpayers' equity in the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as Public Dividend Capital Dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Government Banking Service. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

Where average net relevant assets is negative, no PDC will be payable.

1.27 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the Health Service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure, note 3, on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risk (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments, note 42, is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.28 Consolidation - Joint operations

Joint operations are activities undertaken by the Trust in conjunction with one or more other parties but which are not performed through a separate entity. The Trust records its share of the income and expenditure; gains and losses; assets and liabilities; and cashflows.

1.29 Consolidation - Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust's or where the subsidiary's accounting date is before 1 January or after 30 June.

For 2010/11, in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the NHS Charitable Funds for which it is the Corporate Trustee.

1.30 Corporation Tax

Under s519A ICTA 1988 Central Manchester University Hospitals NHS Foundation Trust is regarded as a Health Service body and is, therefore, exempt from taxation on its income and capital gains. Section 148 of the 2004 Finance Act provided the Treasury with powers to disapply this exemption. Accordingly the Trust is potentially within the scope of Corporation Tax in respect of activities which are not related to, or ancillary to, the provision of healthcare and where the profits exceed £50,000 per annum. Activities such as staff and patient car parking and sales of food are considered to be ancillary to the core healthcare objectives of the Trust (and not entrepreneurial) and therefore not subject to corporation tax. Any tax liability will be accounted for within the relevant tax year.

1.31 Accounting standards that have been issued but have not yet been adopted

There are no accounting standards issued by the International Accounting Standards Board (IASB) and International Financial Reporting Interpretations Committee (IFRIC) that are applicable to the Trust that have not been adopted by the Trust.

1.32 Accounting standards issued that have been adopted early

No accounting standards issued have been adopted early.

1.33 Pension costs

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

The scheme is subject to a full actuarial valuation every four years and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

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

c) Scheme provisions

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

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

maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the Statement of Comprehensive Income at the time the Trust commits itself to the retirement, regardless of the method of payment.

The scheme provides the opportunity to members to increase their benefits through money purchase additional voluntary contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

1.34 Operating segments

Under IFRS 8, the Trust is required to disclose financial information across significant operating segments which reflect the way the management runs the organisation. A significant segment is one that represents more than 10% of the income or expenditure of the entity.

The Trust operates with one segment, being the provision of healthcare services and, as such, has not disclosed a breakdown of the income, expenditure and net assets beyond what is shown in these accounts.

2.1 Operating Income (by classification)

	2010/11 £000	2009/10 £000
Income from Activities		
Elective income	**94,554**	92,467
Non-elective income	**107,254**	104,726
Out-patient income	**84,713**	82,863
A&E income	**14,625**	14,429
Other NHS clinical income	**249,790**	231,553
Private patient income	**2,004**	1,740
Other non-protected clinical income	**8,127**	8,192
Total income from activities	**561,067**	535,970
Other operating Income		
Research and Development	**9,485**	17,014
Education and training	**44,933**	43,614
Charitable and other contributions to expenditure	**756**	241
Transfers from Donated Asset Reserve in respect of depreciation on donated assets	**3,415**	1,633
Non-patient care services to other bodies	**32,035**	44,971
Other income	**13,477**	16,924
Profit on disposal of property, plant and equipment	**114**	185
Total other operating income	**104,215**	124,582
Total Operating Income	**665,282**	660,552

2.2 Private patient income

The NHS Act 2006 requires that the proportion of private patient income to the total patient related income of the Foundation Trust should not exceed its proportion whilst the body was an NHS Trust in 2002/03 (the 'base year')

Subsequent to Monitor's guidance issued during 2009/10, a review was undertaken and a further £690k was identified as potentially eligible for inclusion. This would take the cap up to 1.39% of turnover, however due to no operational requirement to do so the Trust did not seek an amendment, from Monitor, to it's terms of authorisation and therefore the "base year" remains as reported below.

Monitor's recent guidance sets out more clearly the basis for calculating those items deemed to be income generated by Private Patients but has no material affect on the way the Trust reports it's Private Patient income and therefore no amendment in this respect has been made.

	Base Year 2002/03 £000	2010/11 £000	2009/10 £000
Private patient and overseas visitors (non-reciprocal) income	3,242	2,161	1,765
Total patient related income	283,399	561,067	535,970
Proportion (as a percentage) not to exceed the base year cap	**1.14%**	**0.39%**	**0.33%**

2.3 Operating lease income

The Trust did not receive any operating lease income in either 2010/11 or 2009/10.

2.4 Operating Income (by source)

	2010/11 £000	2009/10 £000
Foundation trusts	**900**	748
NHS trusts	**237**	0
Strategic health authorities	**23,034**	25,107
Primary care trusts	**517,048**	481,303
Local authorities	**2,498**	2,161
Department of Health	**6,389**	7,866
NHS other	**5,952**	3,842
Non-NHS:		
Private patients	**2,004**	1,740
Overseas patients (non-reciprocal)	**157**	25
NHS Injury costs recovery scheme *	**1,926**	1,946
Non-NHS other	**922**	3,040
	561,067	527,778

** Injury cost recovery income is subject to a provision for impairment of receivables of 9.6% to reflect expected rates of collection.*

Other operating Income

Research and Development	**9,485**	17,014
Education and training	**44,933**	43,614
Charitable and other contributions to expenditure	**756**	241
Transfers from Donated Asset Reserve in respect of depreciation on donated assets	**3,415**	1,633
Non-patient care services to other bodies	**32,035**	53,163
Profit on disposal of land and buildings	**114**	185
Car parking	**2,535**	2,399
Estates recharges	**682**	619
Pharmacy sales	**245**	268
Accommodation rentals	**129**	107
Clinical excellence awards	**5,425**	5,599
Property rentals	**1,878**	2,089
Other income	**2,583**	5,843
Total other operating income	**104,215**	132,774
Total Operating Income	**665,282**	660,552

2.5 Mandatory and non-mandatory income from activities

	2010/11 £000	2009/10 £000
Mandatory	**556,058**	521,027
Non-mandatory	**5,009**	6,751
	561,067	527,778

3. Operating Expenses

	2010/11 £000	2009/10 £000
Services from other Foundation Trusts	**3,292**	3,293
Services from NHS Trusts	**2,212**	2,246
Services from other NHS bodies	**1,006**	999
Purchase of healthcare from non NHS bodies	**1,885**	4,369
Employee expenses - Executive Directors	**1,265**	1,217
Employee expenses - Non-executive Directors	**175**	173
Employee expenses - Staff	**369,038**	359,551
Drug costs	**56,690**	49,717
Supplies and services - clinical (excluding drugs costs)	**88,344**	86,659
Supplies and services - general	**3,491**	4,675
Establishment	**8,331**	9,169
Research and development	**6,667**	12,336
Transport	**1,938**	1,809
Premises	**54,016**	53,489
Increase / (decrease) in bad debt provision	**1,080**	(296)
Depreciation on property, plant and equipment	**22,763**	26,202
Amortisation on intangible assets	**780**	1,049
Audit fees		
- audit services - statutory audit	**83**	81
- audit services - other audit fees	**41**	15
Clinical negligence	**7,217**	5,884
Legal fees	**1,855**	374
Professional fees and consultancy costs	**2,645**	3,767
Training, courses and conferences	**1,133**	1,772
Patient travel	**132**	131
Redundancy	**483**	341
Other	**2,820**	3,717
Sub-total operating expenses before impairments of property, plant and equipment	**639,382**	632,739
Impairments of property, plant and equipment	**0**	183,798
Total	**639,382**	816,537

The Trust's operating expenses include payments made in respect of operating leases as set out in note 5.1.

4. Employee expenses and numbers

4.1 Employee expenses

	2010/11			2009/10
	Total	Permanently Employed	Other	Total
	£000	£000	£000	£000
Salaries and wages	**306,923**	**306,923**	**0**	295,816
Social Security Costs	**20,002**	**20,002**	**0**	19,239
Pension cost - defined contribution plans Employers contributions to NHS Pensions	**32,160**	**32,160**	**0**	30,019
Termination benefits	**483**	**483**	**0**	341
Agency / contract staff	**11,218**	**0**	**11,218**	15,694
Total	**370,786**	**359,568**	**11,218**	361,109

4.2 Average number of people employed

	2010/11			2009/10
	Total	Permanently Employed	Other	Total
	Number	Number	Number	Number
Medical and dental	**1,075**	**694**	**381**	1,009
Administration and estates	**1,554**	**1,554**	**0**	1,498
Healthcare assistants and other support staff	**1,148**	**1,148**	**0**	1,267
Nursing, midwifery and health visiting staff	**2,760**	**2,760**	**0**	2,652
Scientific, therapeutic and technical staff	**1,200**	**1,200**	**0**	1,179
Bank and agency staff	**206**	**-**	**206**	344
Other	**395**	**395**	**0**	284
Total	**8,338**	**7,751**	**587**	8,233

4.3 Employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from the employee. It is Trust policy that holidays are taken in the year in which they accrue, therefore no accrual is made.

4.4 Early retirements due to ill-health

During 2010/11 there were 13 (2009/10 there were 15) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £535k (for 2009/10: £873k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

4.5 Directors' remuneration and benefits

The aggregate amount of Directors' remuneration for 2010/11 was £1,170k (£1,150k 2009/10). The Trust made a contribution to the NHS Pension Scheme, a defined benefit scheme, of £132k in respect of six Directors (2009/10 £129k in respect of six Directors).

4.6 Staff exit packages

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	1	11	12
£10,000 - £25,000	7	19	26
£25,001 - £50,000	4	15	19
£50,001 - £100,000	0	3	3
£100,000 - £150,000	0	1	1
£150,001 - £200,000	1	0	1
Total Departures	**13**	**49**	**62**
Total Cost (£000)	**470**	**1,220**	**1,690**

The Trust ran a "mutually agreed resignation/voluntary early retirement" scheme through February and March 2011. Numbers and costs relate to those applications approved during the year, 2010/11, up to 31 March 2011.

4.7 Management Costs

	2010/11	2009/10
	£000	£000
Management costs	**18,985**	19,373
Income	**665,282**	660,552
Management costs as a proportion of income (%)	**2.85%**	2.93%

Management costs are defined as those on the management costs website at www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSManagementCosts/fs/en.

5.1 Operating leases

	2010/11	2009/10
	£000	£000
Lease payments	**1,426**	1,152
	1,426	1,152

5.2 Arrangements containing an operating lease

	2010/11	2009/10
	£000	£000
Future minimum lease payments due:		
Not later than one year	**1,365**	1,346
Later than one year and not later than five years	**2,770**	3,473
Later than five years	**0**	0
Total	**4,135**	4,819

The future minimum lease payments are in respect of 54 operating leases, of varying contract values and terms, giving an average payment per lease during the next twelve months of £25k.

5.3 Auditor's Liability

There is no specified limitation in the Trust's contract with its external auditors, the Audit Commission, that provides for limitation of the auditor's liability.

5.4 The Late Payment of Commercial Debts (interest) Act 1998

There were no payments made under the Late Payment of Commercial Debts (interest) Act in either 2010/11 or 2009/10.

5.5 Audit Remuneration

Other than remuneration for statutory and regulatory audit services, our auditor the Audit Commission did not undertake any other services for which remuneration was due in either 2010/11 or 2009/10. Remuneration details for statutory and regulatory services are disclosed at note 3.

6. Discontinued operations

There were no discontinued operations during 2010/11 or 2009/10.

7. Corporation tax

There was no corporation tax payable or receivable during 2010/11 or 2009/10.

8. Finance income

	2010/11	2009/10
	£000	£000
Interest Received	**95**	96
Total	**95**	96

9. Finance Costs

	2010/11	2009/10
	£000	£000
Loans from the Foundation Trust Financing Facility	**1,102**	921
Interest on obligations under PFI contracts:		
- main finance cost	**20,390**	16,672
- contingent finance cost	**4,312**	3,201
Total	**25,804**	20,794

10. Impairment of assets (Property, plant and equipment and intangibles)

	2010/11 £000	2009/10 £000
Other - charged to expenditure	**0**	183,798
Other - charged to reserves	**0**	6,331
Total impairments	**0**	190,129

In accordance with International Accounting Standard 16 the Trust carries out regular valuations of all property in use and is carried out by the Valuation Office. This is completed on the basis of a Modern Equivalent Asset basis of valuation.

2010/11 Valuation

The valuation report issued in 2010/11 showed an overall valuation with only a minor deviation from the current balance sheet values and the Trust deemed the changes in value not to be material and therefore no further action was taken.

2009/10 Valuation

The valuation indicated significant impairments, £183,798k was charged to the Statement of Comprehensive Income. The remainder of the impairment for the financial year 2009/10, £6,331k, was charged to the relevant reserve for the classification of asset.

11 Intangible assets

11.1 Intangible assets current year

2010/11:	**Software licences - purchased**
	£000
Gross cost at 1 April 2010	**5,987**
Additions - purchased	506
Reclassifications	(126)
Disposals	(11)
Gross cost at 31 March 2011	**6,356**
Amortisation at 1 April 2010	**3,561**
Provided during the year	780
Amortisation at 31 March 2011	**4,341**

11.2 Intangible assets prior period

31 March 2010:	Software licences - purchased
	£000
Gross cost at 1 April 2009	**5,487**
Additions - purchased	500
Additions - donated	11
Reclassifications	(11)
Gross cost at 31 March 2010	**5,987**
Amortisation at 1 April 2009	**2,512**
Provided during the period	1,049
Gross cost at 31 March 2010	**3,561**

11.3 Intangible Assets Financing

	Software licences - purchased
Net book value	
Purchased as at 31 March 2011	1,992
Donated as at 31 March 2011	23
Total at 31 March 2011	**2,015**
Net book value	
Purchased as at 1 April 2010	2,386
Donated as at 1 April 2010	40
Total at 1st April 2010	**2,426**

12.1 Property, plant and equipment 2010/11

2010/11:	Land	Buildings excluding dwellings	Dwellings	Assets under construct and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2010	**31,215**	**522,735**	**9**	**18,885**	**133,115**	**160**	**8,475**	**18,221**	**732,815**
Additions purchased	0	6,290	0	6,043	3,011	0	595	58	15,997
Additions donated	0	0	0	0	74	0	0	7	81
Reclassifications	0	11,083	0	(11,357)	400	0	0	0	126
Disposals	0	0	0	0	(25)	0	0	(12)	(37)
At 31 March 2011	**31,215**	**540,108**	**9**	**13,571**	**136,575**	**160**	**9,070**	**18,274**	**748,982**
Accumulated depreciation as at 1 April 2010	**0**	**209,334**	**9**	**0**	**83,077**	**146**	**6,003**	**13,702**	**312,271**
Provided during the year	0	8,859	0	0	11,951	7	919	1,027	22,763
Depreciation at 31 March 2011	**0**	**218,193**	**9**	**0**	**95,028**	**153**	**6,922**	**14,729**	**335,034**

12.2 Property, plant and equipment 2009/10

2009/10:	Land	Buildings excluding dwellings	Dwellings	Assets under construct and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	**39,505**	**237,706**	**13**	**1,960**	**102,474**	**156**	**8,181**	**16,397**	**406,392**
Additions purchased	0	290,780	0	16,875	18,859	0	316	1,589	328,419
Additions donated	0	12	0	0	10,716	0	0	0	10,728
Impairments	(1,425)	(4,906)	0	0	0	0	0	0	(6,331)
Reclassifications	0	(49)	0	44	22	0	(22)	16	11
Revaluation surpluses	135	(808)	0	6	2,549	4	0	330	2,216
Transferred to disposal group as asset held for sale	(7,000)	0	0	0	0	0	0	0	(7,000)
Disposals	0	0	(4)	0	(1,505)	0	0	(111)	(1,620)
At 31 March 2010	**31,215**	**522,735**	**9**	**18,885**	**133,115**	**160**	**8,475**	**18,221**	**732,815**
Accumulated depreciation as at 1 April 2009	**0**	**9,355**	**3**	**0**	**75,160**	**133**	**4,637**	**12,510**	**101,798**
Provided during the period	0	16,181	10	0	7,566	10	1,366	1,069	26,202
Impairments recognised in operating expenses	0	183,798	0	0	0	0	0	0	183,798
Revaluation surpluses	0	0	0	0	1,856	3	0	234	2,093
Disposals	0	0	(4)	0	(1,505)	0	0	(111)	(1,620)
Depreciation at 31 March 2010	**0**	**209,334**	**9**	**0**	**83,077**	**146**	**6,003**	**13,702**	**312,271**

12.3 Property, Plant and Equipment Financing

	Land	Buildings excluding dwellings	Dwellings	Assets under construct and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value - 31 March 2011									
Owned	30,990	43,433	0	13,571	33,615	7	2,128	3,505	127,249
Finance lease (PFI)	0	277,316	0	0	0	0	0	0	277,316
Donated	225	1,166	0	0	7,932	0	20	40	9,383
NBV Total at 31 March 2011	**31,215**	**321,915**	**0**	**13,571**	**41,547**	**7**	**2,148**	**3,545**	**413,948**
Net book value - 31 March 2010									
Owned	30,990	31,260	0	18,847	41,766	13	2,472	4,493	129,841
Finance lease (PFI)	0	278,002	0	0	0	0	0	0	278,002
Donated	225	4,139	0	38	8,272	1	0	26	12,701
NBV total value - 31 March 2010	**31,215**	**313,401**	**0**	**18,885**	**50,038**	**14**	**2,472**	**4,519**	**420,544**

13 Intangible assets acquired by grant funding

	Software licences
	£000
Carrying amount at 1 April 2010	25
Carrying amount at 1 April 2011	**19**

14.1 Economic life of Intangible assets

	Minimum life Years	Maximum life Years
Intangible assets purchased		
Software	3	7

14.2 Economic life of property, plant and equipment

	Minimum life Years	Maximum life Years
Buildings (excluding dwellings)	1	90
Plant and machinery	5	10
Transport equipment	5	7
Information technology	5	5
Furniture and fittings	2	10

15.1 Analysis of property, plant and equipment 31 March 2010

	Land	Buildings excluding dwellings	Dwellings	Assets under construct and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Net book value									
Protected assets at 31 March 2010	31,215	313,401	0	0	0	0	0	344,616	
Unprotected assets at 31 March 2010	0	0	18,885	50,038	14	2,472	4,519	75,928	127,249
Total at 31 March 2010	**31,215**	**313,401**	**18,885**	**50,038**	**14**	**2,472**	**4,519**	**420,544**	**277,316**

15.2 Analysis of property, plant and equipment 31 March 2011

	Land	Buildings excluding dwellings	Dwellings	Assets under construct and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Net book value									
Protected assets at 31 March 2011	31,215	321,915	0	0	0	0	0	353,130	
Unprotected assets at 31 March 2011	0	0	13,571	41,547	7	2,148	3,545	60,818	127,249
Total at 31 March 2011	**31,215**	**321,915**	**13,571**	**41,547**	**7**	**2,148**	**3,545**	**413,948**	**277,316**

16. Investments

The Trust did not hold any investments in either 2010/11 or 2009/10.

17. Associates and joint controlled operations

The Trust did not have any assets or liabilities in respect of associates and joint controlled operations in either 2010/11 or 2009/10.

18. Non-current assets for sale and assets in disposal groups 2010/11

As at the 31 March 2011 the Trust held one non-current asset for sale in the value of £7m in respect of the Land at the Royal Manchester Children's Hospital, Pendlebury.

The Trust has not been exposed to liabilities in respect of disposal groups in either 2010/11 or 2009/10.

19. Other assets

The Trust did not hold any other assets at either 31 March 2011 or 31 March 2010.

20. Other Financial Assets

The Trust did not have any other financial assets at 31 March 2011 or 31 March 2010.

21. Inventories

21.1. Inventories

	31 March 2011 £000	31 March 2010 £000
Materials	**8,710**	9,409
Total	**8,710**	9,409

21.2 Inventories recognised in expenses

	2010/11 £000	2009/10 £000
Inventories recognised as an expense in the period	**81,866**	74,831
Write-down of inventories recognised as an expense	**126**	483
Total	**81,992**	75,314

22. Trade and other receivables

	31 March 2011 £000	31 March 2010 £000
Current		
NHS receivables	**16,824**	19,277
Other receivables with related parties	**339**	0
Provision for the impairment of receivables	**(1,529)**	(520)
Prepayments	**2,604**	2,316
Accrued income	**3,236**	3,134
PDC receivables	**430**	717
Other trade receivables	**13,979**	13,651
Total current trade and other receivables	**35,883**	38,575

	31 March 2011 £000	31 March 2010 £000
Non-current		
Provision for the impairment of receivables	**(190)**	(119)
Accrued income	**1,958**	1,852
Total non-current trade and other receivables	**1,768**	1,733

23.1 Provision for impairment of receivables (bad debt provision)

	31 March 2011 £000	31 March 2010 £000
At 1 April	**639**	935
Increase in provision	**1,080**	0
Amounts utilised	**0**	0
Unused amounts reversed	**0**	(296)
At 31 March	**1,719**	639

23.2 Analysis of impaired receivables

	31 March 2011 £000	31 March 2010 £000
Ageing of impaired receivables (bad debt provision)		
By up to three months	**9**	2
By three to six months	**106**	24
By more than six months	**1,604**	613
Total	**1,719**	639

Ageing of non-impaired receivables past their due date		
By up to three months	18,522	17,155
By three to six months	2,104	2,703
By more than six months	2,078	2,249
Total	22,704	22,107

24.1 Finance lease receivables

The Trust did not have any obligations under finance leases in either 2010/11 or 2009/10, except for the Trust's PFI scheme which is covered at note 37, and therefore no receivables in this category were due.

25. Cash and cash equivalents

	31 March 2011 £000	31 March 2010 £000
Balance at 1 April	29,693	32,539
Net change in year	5,538	(2,846)
Balance at 31 March	**35,231**	29,693
Made up of		
Commercial banks and cash in hand	135	60
Cash with the Government Banking Service	35,096	29,633
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**35,231**	29,693
Bank overdraft	0	0
Cash and cash equivalents as in statement of cash flows	**35,231**	29,693
Third party assets held by the NHS Foundation Trust	**12**	11

26.1 Trade and other payables

	31 March 2011 £000	31 March 2010 £000
Current		
Receipts in advance	**14,315**	9,521
NHS payables	**6,122**	8,412
Amounts due to other related parties	**7,520**	6,754
Trade payables - capital	**1,309**	3,659
Trade payables and accruals	**28,844**	28,864
Total current trade and other payables	**58,110**	57,210

	Financial liabilities 31 March 2011 £000	Financial liabilities 31 March 2010 £000
Non-current		
Receipts in advance	**919**	1,116
Other payables	**3,098**	3,598
Total non-current trade and other payables	**4,017**	4,714

27. Borrowings

	31 March 2011 £000	31 March 2010 £000
Current		
Loans from:		
Foundation Trust Financing Facility	**2,224**	2,224
Obligations under Private Finance Initiative contracts	**6,656**	6,001
Total	**8,880**	8,225

	31 March 2011 £000	31 March 2010 £000
Non-current		
Loans from:		
Foundation Trust Financing Facility	**36,552**	37,776
Obligations under Private Finance Initiative contracts	**333,910**	340,566
Total	**370,462**	378,342

The Trust borrowed a further £1m during 2010/11 through the Foundation Trust Financing Facility in order to fund capital investment in respect of the Critical Care Development.

28. Prudential borrowing limit

	31 March 2011 £000	31 March 2010 £000
Total long term borrowing limit set by Monitor	**406,600**	390,160
Working capital facility agreed by Monitor	**40,000**	25,000
Total prudential borrowing limit	**446,600**	415,160
Long term borrowing at 1 April	**378,342**	83,230
Net actual borrowing in year - long term	**(7,880)**	295,112
Long term borrowing at 31 March	**370,462**	378,342
Working capital borrowing at 31 March	**0**	0

The Trust is required to comply and remain within a Prudential Borrowing Limit, as set by Monitor. Following the introduction of IFRS, Monitor has amended its compliance framework to cover Trusts with and without PFI schemes by way of a two tier system. Therefore, as the Trust has a PFI scheme it is measured against Monitors' Tier 2 limits, as set out below.

This is made up of two elements:

- the maximum cumulative amount of long-term borrowing. This is set by reference to ratio tests set out in Monitor's Prudential Borrowing Code.
- the amount of any working capital facility approved by Monitor, as set out in the table above.

The ratio tests used to determine the maximum long term borrowing limit and the Trust's performance against them is set out below:

	Tier 2 Limits	Plan 2010/11	Actual 2010/11
Minimum Dividend Cover	>1 x	19.0	**n/a**
Minimum Interest Cover	>2 x	2.6	**2.3**
Minimum Debt Service Cover	>1.5 x	1.9	**1.7**
Maximum Debt Service to Revenue	<10%	4.5%	**4.5%**

29. Other liabilities

	31 March 2011 £000	31 March 2010 £000
Current		
Deferred grants	**610**	441
Total	**610**	441

	31 March 2011 £000	31 March 2010 £000
Non-current		
Deferred grants	**4,712**	6,387
Total	**4,712**	6,387

30. Other Financial Liabilities

The Trust did not have any other financial liabilities at 31 March 2011 or 31 March 2010.

31.1 Provisions for liabilities and charges

	Current		Non-current	
	31 March 2011 £000	31 March 2010 £000	**31 March 2011 £000**	31 March 2010 £000
Pensions relating to former directors	**9**	9	**110**	119
Pensions relating to other staff	**156**	156	**1,815**	1,961
Other legal claims	**77**	64	**150**	240
Payroll provisions	**8,775**	4,199	**0**	0
Other	**4,298**	3,275	**810**	634
Total	**13,315**	7,703	**2,885**	2,954

31.2 Provisions for liabilities and charges analysis

	Pensions relating to former directors	Pensions relating to other staff	Legal claims	Payroll provisions	Other	Total
	£000	£000	£000	£000	£000	£000
As at 1 April 2010	**128**	**2,117**	**304**	**4,199**	**3,909**	**10,657**
Change in discount rate	0	(47)	0	0	(29)	(76)
Arising during the year	0	0	0	5,166	4,294	9,460
Used during the year	(9)	(156)	(77)	0	(3,084)	(3,326)
Reversed unused	0	0	0	(590)	0	(590)
Unwinding of discount	0	57	0	0	18	75
At 31 March 2011	**119**	**1,971**	**227**	**8,775**	**5,108**	**16,200**
Expected timing of cash flows:						
- not later than 1 year	9	156	77	8,775	4,298	13,315
- later than 1 year and not later than 5 years	35	624	150	0	204	1,013
- later than 5 years	75	1,191	0	0	606	1,872
Total	**119**	**1,971**	**227**	**8,775**	**5,108**	**16,200**

Other provisions are made in respect of a number of unrelated liabilities. The Trust has taken professional advice and used its best estimates in arriving at the provisions. These include provision for potential litigation under commercial contracts and provisions for permanent injury benefits.

31.3 Clinical Negligence Liabilities

Included in the provisions of the NHS Litigation Authority at 31 March 2011 is £69,937k in respect of clinical negligence liabilities of the Trust (31 March 2010 £73,735k).

32. Contingent liabilities and assets

32.1 Contingent liabilities

	31 March 2011	31 March 2010
	£000	£000
Gross value of contingent liabilities	**(129)**	(137)
Amounts recoverable against liabilities	**0**	0
Net value of contingent liabilities	**(129)**	(137)

For each provision included in note 31.2 where a probability of settlement factor is applied to estimate the value of the provision, the difference between the estimated total liability and the amount included in provisions is reported as a contingent liability.

32.2 Contingent assets

The Trust held no contingent assets at the 31 March 2011 (31 March 2010 nil).

33.1 Revaluation Reserve 2010/11

	Total revaluation reserve	Revaluation reserve - intangibles	Revaluation reserve - property, plant and equipment
	£000	£000	£000
Reserves at 1 April 2010	28,219	0	28,219
Prior period adjustment	0	0	0
Reserves at 1 April 2010 restated	**28,219**	**0**	**28,219**
Reserves at 31 March 2011	**28,219**	**0**	**28,219**

33.2 Revaluation Reserve 2009/10

	Total revaluation reserve	Revaluation reserve - intangibles	Revaluation reserve - property, plant and equipment
	£000	£000	£000
Reserves at 1 April 2009	26,801	0	26,801
Prior period adjustment	0	0	0
Reserves at 1 April 2009 restated	**26,801**	**0**	**26,801**
Impairments	(1,425)	0	(1,425)
Other reserve movements	2,843	0	2,843
Reserves at 31 March 2010	**28,219**	**0**	**28,219**

34. Related party transactions

Central Manchester University Hospitals NHS Foundation Trust is a public interest body authorised by Monitor - the Independent Regulator for NHS Foundation Trusts.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Central Manchester University Hospitals NHS Foundation Trust.

The Trust has a significant number of transactions with the University of Manchester during the year, and these are deemed to be at arms length.

The Department of Health is regarded as a related party. During the year the Trust has had a significant number of material transactions (£6m) with the Department.

Additionally, the Trust has had a significant number of material transactions with other entities for which the Department is regarded as the parent Department. These entities, with net income/expenditure greater than £5m, are listed overleaf.

The transactions and balances for 2010/11 were:-

	Net Income/(Expenditure)		Net Receivables/(Payables)	
	2010/11	2009/10	**2010/11**	2009/10
	£000s	£000s	**£000s**	£000s
Manchester PCT	**191,796**	202,955	**2,520**	5,506
Western Cheshire PCT	**147,849**	151,671	**1,984**	729
Stockport PCT	**47,300**	16,870	**616**	562
North West Strategic Health Authority	**45,492**	44,950	**72**	88
Trafford PCT	**24,583**	21,122	**733**	884
London Strategic Health Authority	**23,027**	22,589	**(431)**	2,264
Salford PCT	**20,096**	19,322	**243**	(208)
Tameside and Glossop PCT	**19,681**	18,451	**47**	(129)
Bury PCT	**9,195**	40,290	**48**	402
Oldham PCT	**8,642**	8,329	**65**	914
Bolton PCT	**8,414**	7,062	**130**	102
Heywood, Middleton and Rochdale PCT	**7,390**	7,818	**60**	(111)
Ashton, Leigh and Wigan PCT	**6,858**	6,592	**355**	(74)
Central and Eastern Cheshire PCT	**6,791**	3	**109**	0

The Trust has also received revenue and capital payments from its charitable funds, Central Manchester University Hospitals NHS Foundation Trust Charity (registration number 1049274). The Trust, as a body corporate, is the Trustee of the Charity. Copies of the accounts of the Charitable Funds can be obtained from the Trust's administration by contacting the Director of Corporate Services on 0161 276 6262.

In addition, the Trust has had a number of material transactions with other Government Departments and other Central and Local Government bodies, with the greatest volume relating to HM Revenue and Customs.

35. Contractual capital commitments

Commitments under capital expenditure contracts at 31 March 2011 were £2,757k (31 March 2010 £1,562k).

36. Finance lease obligations

The Trust did not have any obligations under finance leases in either 2010/11 or 2009/10, except for the Trust's PFI scheme which is covered at note 37.

37. Private Finance Initiative contracts

37.1 Total obligations for on-statement of financial position PFI contracts due:

	31 March 2011 £000	31 March 2010 £000
Gross PFI liabilities	**745,631**	772,022
Of which liabilities are due:		
Not later than one year	**26,688**	26,392
Later than one year, not later than five years	**101,545**	104,035
Later than five years	**617,398**	641,595
Less finance charges allocated to future periods	**(405,065)**	(425,455)
Net PFI liabilities	**340,566**	346,567
Net PFI obligation		
Not later than one year	**6,656**	6,001
Later than one year, not later than five years	**25,414**	26,358
Later than five years	**308,496**	314,208

37.2 On-statement of financial position PFI commitments

The Trust is committed to making the following payments for the service element of on-Statement of Financial Position PFI obligations:

	31 March 2011 Total £000	31 March 2010 Total £000
Within one year	**26,316**	25,433
2nd to 5th years (inclusive)	**114,717**	110,870
Later than 5 years	**1,341,913**	1,372,076
Total	**1,482,946**	1,508,379

38. PFI schemes deemed to be off balance sheet.

The Trust had no PFI schemes deemed to be off-Statement of Financial Position as at 31 March 2011.

39. Events following the Statement of Financial Position date

With effect from 1 April 2011 certain elements of NHS Manchester's Community Services have transferred to the Trust. The total impact on the Trust has been to increase both income and expenditure by £55m.

40. Financial Instruments

40.1 Financial assets by category

	Loans and receivables £000	Total £000
Trade and other receivables not including non-financial assets	**34,617**	**34,617**
Cash and cash equivalents	**35,231**	**35,231**
Total at 31 March 2011	**69,848**	**69,848**
Trade and other receivables not including non-financial assets	37,275	37,275
Cash and cash equivalents	29,693	29,693
Total at 31 March 2010	66,968	66,968

40.2 Financial liabilities by category

	Other financial liabilities £000	Total £000
Borrowings not including finance leases and PFI obligations	**38,776**	**38,776**
Obligations under PFI contracts	**340,566**	**340,566**
Trade and other payables not including non-financial liabilities	**39,813**	**39,813**
Provisions under contract	**16,200**	**16,200**
Total at 31 March 2011	**435,355**	**435,355**
Borrowings not including finance leases and PFI obligations	40,000	40,000
Obligations under PFI contracts	346,567	346,567
Trade and other payables not including non-financial liabilities	44,533	44,533
Provisions under contract	10,657	10,657
Total at 31 March 2010	441,757	441,757

40.3 Fair values of financial assets at 31 March 2011

As at 31 March 2011, and 31 March 2010, the Trust did not hold any financial assets that required a fair value valuation.

40.4 Fair values of financial liabilities at 31 March

Fair values at 31 March 2011	Book value £000	Fair value £000
Non current trade and other payables excluding non financial liabilities	**3,098**	**3,098**
Provisions under contract	**16,200**	**16,200**
Loans	**38,776**	**38,776**
Total 31 March 2011	**58,074**	**58,074**

Fair values at 31 March 2010	Book value £000	Fair value £000
Non current trade and other payables excluding non financial liabilities	**3,598**	**3,598**
Provisions under contract	**10,657**	**10,657**
Loans	**40,000**	**40,000**
Total 31 March 2010	**54,255**	**54,255**

41. Defined benefit obligations

The Trust did not hold any on-Statement of Financial Position defined benefit schemes during the financial period.

42. Losses and Special Payments

There were 239 cases of losses and special payments totalling £749k paid during the year to 31 March 2011 (year to 31 March 2010 152 cases totalling £547k).

Central Manchester University Hospitals
NHS Foundation Trust

WE WOULD LIKE TO THANK EVERYONE WHO HAS CONTRIBUTED TO PRODUCING THIS ANNUAL REPORT.

For further information contact:
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For further information about the organisation visit our website:

www.cmft.nhs.uk