Central Manchester University Hospitals
NHS Foundation Trust

Annual Report and accounts 2011/12

Central Manchester University Hospitals NHS Foundation Trust
Annual Report and Accounts – 2011/12.

Presented to parliament pursuant to Schedule 7,
Paragraph 25 (4) of the National Health Service Act 2006.

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 key organisational priorities, 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

Contents

Chairman and Chief Executive's Introduction

Welcome to our fourth 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.

As a healthcare organisation we have three main objectives – Patient safety and clinical quality; Patient and staff experience and productivity and efficiency. These are always at the heart of everything we do.

We pride ourselves in ensuring that we deliver the best possible care and treatment to our patients not only as a local hospital but as a specialist centre in so many clinical fields.

The official opening of our new hospitals by Her Majesty the Queen and His Royal Highness The Duke of Edinburgh was an exceptionally exciting time and a historic occasion for the organisation. We were incredibly honoured to have been chosen as part of the Diamond Jubilee celebrations. The day was most certainly a highlight in our careers and we were pleased that so many staff were able to take part. Our new hospitals are a shining example of the NHS at its very best.

We are an organisation which is committed to adapting to new challenges so that we are best placed to ensure that we have a positive future in store. In April 2012 we acquired the three hospitals based in Trafford and in April 2011 we became responsible for managing 45 community based services.

We are also working in partnership with other hospitals to support them so that they can provide local services safely and which are sustainable.

We are also developing our specialist services and we are in a strong position to do this because we have our fantastic new hospitals which brings together the best clinical expertise in state-of-the-art facilities.

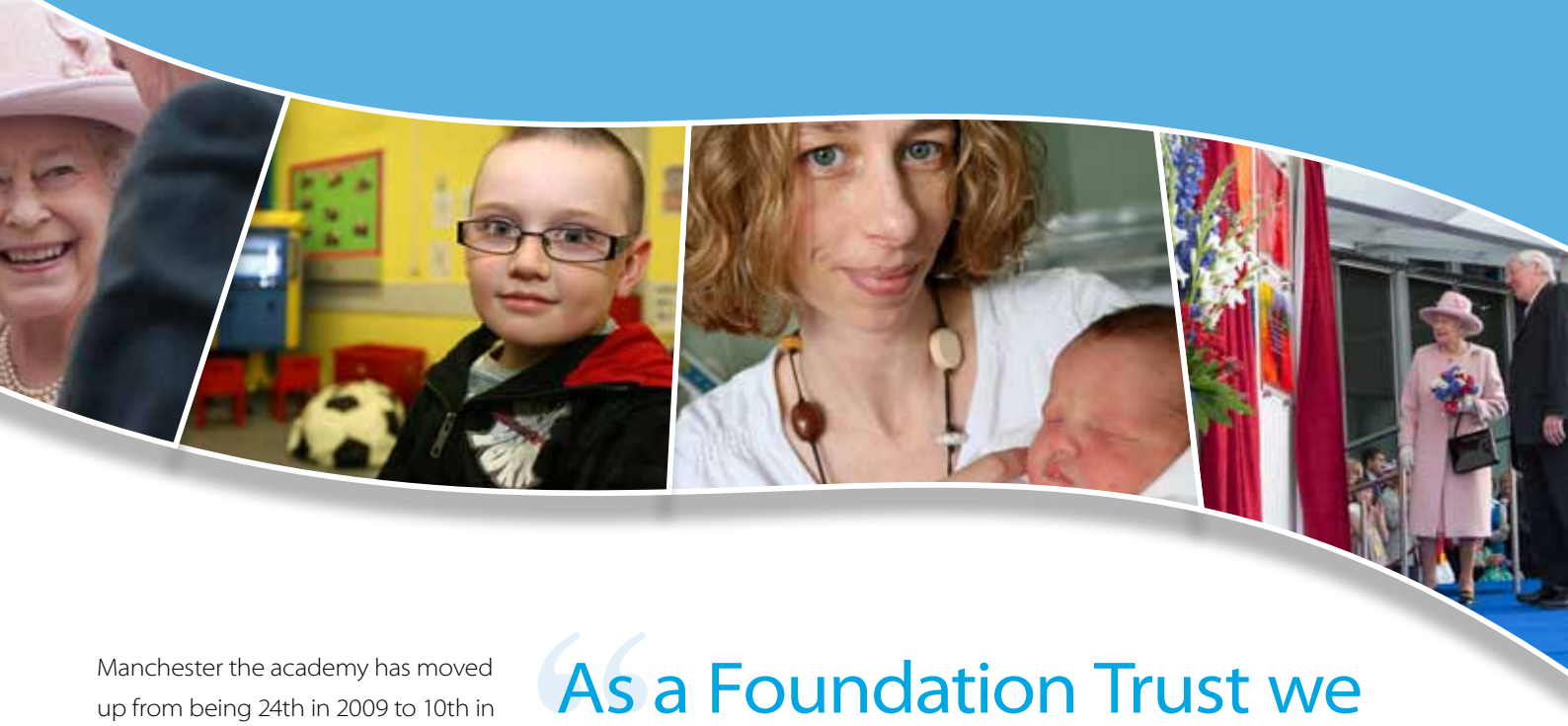
Clinical research is the cornerstone of first-class healthcare and we are proud of our extensive research portfolio. We are currently undertaking 789 research studies. With excellent facilities and internationally renowned researchers, we are gaining a global reputation for pioneering research in many areas. 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.

We are a proud to be a partner in the Manchester Academic Health Sciences Centre, led by Professor Ian Jacobs. Together with The University of Manchester and our local NHS partners we continue to work to bring benefits to patients through research, education and innovation.

Our Quality Campaign 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.

Another major project to support patient experience has been the introduction of the Ward Accreditation scheme. Wards are assessed on a large number of indicators and are awarded either White, Bronze, Silver or Gold standard. It has proved incredibly successful and we intend to develop this scheme further over the coming months.

We are lead sponsors of the Manchester Health Academy. The new building was officially opened in May 2011 by Olympian Jonathan Edwards. The academy has achieved amazing success since its launch. The latest OFSTED report from January 2012 classed it as 'securely satisfactory' and recent figures have shown that we now have full admissions and out off all the secondary schools and academies in



Manchester the academy has moved up from being 24th in 2009 to 10th in 2012 based on which schools parents would prefer to send their children.

Recently we have undertaken a large scale staff engagement project called 'Voices'. We gathered feedback from over 400 members of staff through focus groups and online suggestions. Our aim was to understand what staff thought worked well and in which areas improvements could be made to enhance staff experience. Various ideas and actions are currently in the process of being implemented.

As a Foundation Trust we are directly accountable to our members, local population, communities, partners and other organisations with whom we work. As a Member of this organisation, you have a very real opportunity, through your elected representatives to shape our future.

It is important to remember that even in a publically funded service such as ours, charitable funding needs to play a major part in our activities. A separate report is available which details all our charitable activities and we would like to thank all our supporters who fundraise in so many different ways. Our charity events during the year have included The Great Manchester Run; Big T Break and Be Seen in Green Day. This May saw the opening of a new £7.5 million Ronald McDonald House on site which provides accommodation for up to 60 families at a time.

> "As a Foundation Trust we are directly accountable to our members, local population, communities, partners and other organisations with whom we work."

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 you can also follow us on Facebook and Twitter.

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

Mike Deegan
Chief Executive

Peter W Mount CBE
Chairman

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. 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

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
- Trafford Hospitals *(from 1st April 2012)*
- Research & Innovation
- Corporate.

We are made up of the following hospitals:

Manchester Royal Eye Hospital (MREH) was established in 1814 and today is one of the largest teaching eye hospitals in Europe and one of only two dedicated eye hospitals in the country. Globally acknowledged as a centre of excellence, the Eye Hospital is renowned for its pioneering work in all aspects of ophthalmology, including the Emergency Eye Centre, Acute Referral Centre, Ophthalmic Imaging, Ultrasound Unit, Electrodiagnosis, Laser Unit, Optometry, Orthoptics, Manchester Eye Bank, Ocular Prosthetics and the bionic eye implant trial.

Manchester Royal Infirmary (MRI) was founded in 1752 in a small 12-bedded house in the city centre. We are now a large teaching hospital and a specialist regional centre for kidney and pancreas transplants, cardiology and cardiothoracic surgery. We have boasted many medical breakthroughs, including, the first hospital in the UK to undertake 4,000 kidney transplants, the first to have undertaken1,000 cochlear implants and more recently the first in the UK to use a standalone 3D system for prostate cancer surgery.

Royal Manchester Children's Hospital (RMCH) provides specialist healthcare services for children and young people. We see 185,000 patients each year across a range of specialties including oncology, haematology, bone marrow transplant, burns, genetics, and orthopaedics. With 371 beds it is the largest single-site children's hospital in the UK.

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 and babies 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 dental 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.

Trafford Hospitals: From 1st April 2012 the three hospitals (Trafford General, Altrincham and Stretford Memorial) are now under the management of our organisation following a successful acquisition process. Services include general surgery and medicine; children's services; cardiology; orthopaedics; audiology; elderly care; dermatology; respiratory; and Ear, nose and throat.

Quality Accounts 2011 - 2012

Part 1 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 this 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 key priorities which are:-

- Patient Safety and Clinical Quality
- Patient and Staff Experience
- Productivity and Efficiency

Our quality strategy underpins everything we do and enables us to set targets and monitor their impact. In addition to the National clinical targets, we have developed a range of indicators covering the three domains of patient safety, clinical effectiveness and patient experience. We have continued to participate in NHS North West's Advancing Quality Programme, which measures performance across a range of five clinical conditions:-

- Acute Myocardial Infarction
- Coronary Artery Bypass Grafting
- Hip and Knee Replacements
- Heart Failure
- Community Acquired Pneumonia

We have continued to encourage a culture within all our hospitals where staff feel recognised and supported but also where poor performance is challenged and managed appropriately. This year we introduced the ward accreditation programme, where all 57 of our inpatient wards have been accredited. We plan to roll out this programme to non-ward areas in 2012/13. Our 'change one thing' initiative has continued to encourage staff to contribute to the quality agenda, by raising issues which will improve the patient and staff experience within the Trust.

QUALITY CAMPAIGN
IMPROVING PATIENT EXPERIENCE

A significant focus has been placed on monitoring patients in the acute phase of their illness through the monitoring of the early warning scores. This has produced noticeable success in recognising deterioration in these patients early. In addition, emergency bleep meetings have been instigated and these too have proved successful in analysing the triggers for arrest situations.

This quality report will detail the key achievements and a summary of progress across a range of indicators. Each indicator is described, not only in respect of improvements achieved during the year, but also the identification of further improvements required during 2012/13.

Finally, we are pleased to celebrate the incredible performance in reducing the number of healthcare associated infections, with only four incidents of MRSA bacteraemia reported to the Department of Health for the year 2011/12. This is the third year running that the Trust has achieved less than ten incidents and represents excellent progress. The same success also applies to the numbers of reports for clostridium difficile infection, where the Trust has been 17% under the target number. There is no room for complacency, however, as the target will always be to achieve zero avoidable infections.

I confirm that to the best of my knowledge the information contained within this report is accurate.

Statement from Medical Director

We set out in 2011/12 with new hospitals, new services and a challenging programme of improvements to care. Patient safety and clinical quality remain absolutely at the top of the organisational agenda and the focus of my work this year has been to ensure that we continue to deliver safe, high quality care that meets and exceeds the needs and expectations of our patients.

I reported last year that in addition to the many hospital services provided, we were preparing for the integration of Community Services as part of a national transformation project. We are already using this new partnership to improve the care patients receive and working well together to provide the same high quality service as we do in our hospitals.

We set out at the beginning of this year with a demanding work programme in which I set some ambitious targets for improvement; I am delighted to report that we were able to achieve almost everything we set out to do. The Trust Quality Account sets out all of these achievements in detail but here are some of the headlines:

- We continue to work on our Hospital Standardised Mortality Ratio (HSMR) and our end of year figure is 97.3. This is a nationally reported measure in which the figure 100 represents the expected number of deaths for a range of conditions based on several risk factors. Therefore any figure above 100 means the hospital has had more deaths than expected and below 100, less deaths than expected. Towards the end of the year the Trust received data on the new Summary Hospital Mortality Indicator, (SHMI) another measure relating to deaths both in and out of hospital. Both of these measures are used, with other clinical outcome information, to enable us to consistently improve the quality of care delivered and we will continue to do this in 2012/13.
- We have continued our significantly improved performance on the risk assessment of patients for venous thromboembolism, sometimes referred to as VTE. The Trust has continued to meet the national standard of 90% of all appropriate patients receiving this assessment.
- The Trust was assessed against the National Health Service Litigation Authority Risk Management Standards for acute and maternity services and was awarded level 3, the highest level that can be achieved. This is an independent assessment of the management of risk and patient safety in the organisation.
- We have undertaken a scheme of work to reduce the number of hospital acquired pressure ulcers and this has brought about considerable reduction in the numbers of those graded at level 4 and 5
- We have committed to reducing the number of falls that happen whilst patients are in our care. As a result we have seen the number of falls decrease by 195 compared to the previous year
- The Care Quality Commission is the regulatory body which oversee the quality and safety of care across England and Wales. They have registered the Trust to provide services with no conditions applied. They are in regular contact with the Trust and in 2011/12 have assured themselves, our patients and the organisation that we are providing a safe, high quality service.
- Patient safety is a primary concern for the organisation and, as many other hospitals have done, we set targets in respect of reducing harm from patient safety incidents such as medication errors and falls. I am delighted to report success in this area with a 20% reduction in the number of serious harm events.
- The report into standards at

the Mid Staffordshire NHS Trust provided Trusts with many lessons. I oversaw the development of a detailed action plan in response to that report and am pleased to report that its completion was reported to the Board of Directors during 2011/12. Any new lessons from the public enquiry will be reviewed and implemented with Executive oversight throughout.

I am sure 2012/13 will continue to present many challenges and I will be working with our staff to again deliver improvements to standards across all areas. I am particularly delighted to welcome colleagues from Trafford Hospitals who joined us on April 1st and look forward to working with them all this year and in the future.

We have again agreed a detailed and challenging work programme which will focus on many areas including:

- further improvements to patient safety
- working with organisations such as the Health Foundation to make sure we deliver the best clinical outcomes
- continued improvements against nationally and locally agreed goals such as venous thromboembolism, mortality figures and hospital acquired infection
- improvements to the medical undergraduate experience of training here in the Trust
- developments to patient, public and staff information on patient safety, clinical outcomes and quality of care
- ensuring the Trust and all of our Medical Staff are prepared for the new arrangements for medical revalidation.

I would like to take this opportunity to thank Trust 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

A year of Improvement – Focus on the Year 2011/12

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

Key Achievements

- Maintained performance of 90% all appropriate patients risk assessed for venous thromboembolism
- Reduced serious harm events for the second year running
- Established a Clinical Effectiveness Scrutiny Committee at which Board members scrutinise clinical quality in the same way they do performance and finance
- Improved on the number of staff reporting incidents
- Reduction in cardiac arrest calls
- Successfully accredited all wards using the quality framework assessment
- Risk assessments undertaken for all NPSA 'never events' to ensure we are preventing their occurrence
- No serious medication errors this year
- Increased by 20% the number of patients at end of life cared for on our end of life pathway
- Trained all new Doctors in our prescribing policy
- Achieved Level 3 accreditation across all acute services and maternity care from the NHSLA who assess risk management and patient safety.
- Received praise from the CQC on the quality of a number of our services
- Introduced the Leadership Walk Rounds to clinical support as well as clinical areas
- Implemented a programme of review for all deaths
- Trained more staff in Patient Safety (Human Factors) techniques
- Improved our referral rates for organ donation
- Met our targets on MRSA and Clostridium Difficile rate reduction

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.

Our priorities for improvement in 11/12 and summary of progress:

We have used a series of images to demonstrate progress

- ✓ - indicating where targets set have been improved
- – - where targets have been held similar to those of last year
- ✗ - where targets set have not been achieved

Safety	**2010/11**	**2011/12**
Venous Thromboembolism Risk Assessment (VTE) (page 17)	✓	✓
The Acutely Unwell Patient (page 17)	✓	✓
Reduction in harm from falls (page 20)	✓	✓
Reduction of 'serious harm' (page 22)	✓	✓
High Risk Medication Errors (page 24)	✗	✓
Reducing Pressure Ulcers (page 26)	✓	✓
Clinical Effectiveness	**2010/11**	**2011/12**
Mortality (page 28)	✓	–
Infection Prevention (page 28)	✓	✓
Stroke Care (page 30)	✓	–
Reliable Care (page 31)	✓	✗
Urgent Care (page 32)	✓	✓
Patient Experience	**2010/11**	**2011/12**
Improving Quality Programme (page 38)	✓	✓
Leadership Walk Rounds (page 39)	✓	✓
Commissioning for Quality and Innovation CQUINS (National Priorities) (page 39)	✓	✓
Organ Donation (page 40)	✓	✓
End of Life Care (page 40)	✓	✓
Provision of Same Sex Accommodation (page 42)	✓	✓

Part 2 - Priorities for Improvement and Statements of Assurance from the Board

What do we want to improve?

Patient Experience Measures

Each year the Trust participates in a number of Patient Experience surveys one of which is the National Inpatient Survey. We have worked hard to increase the number of patients who complete the survey and this has resulted in a marked increase in our returns. The feedback from the survey helps us to focus our improvement work.

However, the Trust recognises that this is a relatively small sample of patients (less than 400). And in 2009 electronic real time patient feedback devices were introduced to clinical wards and departments. These allow patients to feedback their opinions on the quality of their care and overall experience using electronic devices that collate the information wirelessly and provide a consolidated response to the ward managers on a monthly return. The questions asked are based on the ones from the national inpatient survey.

These results are included in the monthly Quality Care Dashboard along with the results of the Quality Care Rounds completed monthly by ward managers. Ward staff are expected to identify specific issues and implement improvements at a local level using the skills gained as part of our Improving Quality Programme.

The use of our patient experience tracker devices has significantly improved during 2011/12 with almost 15,000 inpatients completing the survey compared to 5,200 in 2010/11.

Clinical Quality Indicators (CQUIN)

As part of the National CQUIN programme, 5 questions have been selected based on the national picture of little or no change over the life span of the survey. In 2011, based on our patients' responses to these questions, income of circa £600,000 was achieved however for this year there has not been the same level of performance resulting in a loss of income of circa £350,000.

In 2012 the same questions will be focused on as part of our ongoing quality improvement programme and these are as follows:

Patient Experience Question	2010/11	2011/12	Status
Were you involved as much as you wanted to be in decisions about your care and treatment	89%	86%	✗
Did you find someone on the hospital staff to talk to about your worries and fears?	80%	77%	✗
Were you given enough privacy when discussing your condition and treatment?	89%	93%	✓
Did a member of staff tell you about medication side effects and what to watch for when you went home?	63%	56%	✗
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	75%	70%	✗

Whilst the respondents to the national inpatient survey have provided feedback which demonstrates a level of dissatisfaction with four of these areas the feedback we have from the patient tracker devices does present evidence of greater satisfaction.

This is particularly noticeable in relation to the following questions where scores have increased by 10% from April 11 to Mar 12:

- Did a member of staff tell you about medication side effects and what to watch out for when you went home?

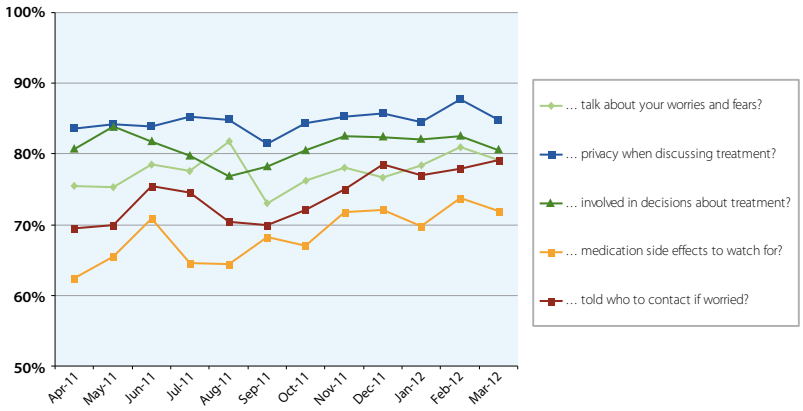
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

This can be linked to improvement work undertaken in year related to the implementation of a new medication discharge checklist. Further work in relation to improving information giving at discharge is planned for 2012/13 as part of Brilliant Basics Quarter 3 'Leaving Our Care'.

The questions related to communication:

- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?

CQUIN question results from Patient Experience Trackers 2011/12



Scores are expected to improve further in 2012/13 following the implementation of Patient Focus Rounding across all ward areas. This involves nursing staff completing an intentional round to check on patient needs at least every two hours. Focused improvement work is planned in Brilliant Basics Quarter 4 'Care and Compassion' and through the development of 'patient passports' and shared care 'contracting documents' linked to age or condition specific needs.

We were pleased that the privacy question score improved in the in-patient survey results:

- Were you given enough privacy when discussing your condition and treatment?

This correlates with the improvements seen in the Trust Quality Care Round data in relation to whether 'do not enter' signs are used on all closed curtains and doors. Compliance to this standard has remained between 85-95% since August 2012

Integration of Community Services

In our Quality Account last year we reported on the proposed transfer of community services to our Trust. On 1st April 2011, 45 adult and children community services with over 1000 staff, transferred to the Trust and became part of the Division of Medicine and Community Services. The transfer of community services

was part of the previous government's plan to reorganise and split the commissioner and provider functions of Primary Care Trusts. On the whole this has been an administrative change and patients who receive community health services are unlikely to have experienced changes in the way these services are provided. Community services continue to be based at health centres and clinics.

The change is aimed at improving services in the longer term. These services provide a wide range of specialist care across the city for example, District Nursing, Podiatry, Physiotherapy, Health Visiting, School Nursing, Community Children's Nursing to name a few. The transfer of community services is providing exciting opportunities for the Trust and for our patients in terms of improving the patient experience through the provision of better joined up care both in hospital and in a community setting, close to home.

The transfer of services has, on the whole, been achieved successfully. The views of staff, before and after the transfer, were sought in both the adult and children directorates. Overall, the feeling has been positive, although it is a continuous process to ensure the staff feel that they are part of an integrated acute and community organisation.

Improving Community Services

Over the last 12 months a number of service improvements have been initiated with community services. A review of the Health Visiting service importantly recognised the need to increase the number of health visitors in the city. The increase in the workforce will ensure the service is managing their workload safely and will provide additional opportunities to develop and modernise the service to the high standard expected by patients and staff.

The community service for Intermediate care has been reviewed and as a result, three important projects have emerged. The first project will improve the support patients receive who have had a fall but wish to stay safely at home. The second project is improving the management of patients with Chronic Obstructive Airways Disease. The third project is enabling patients to make informed choices about the end of life. All of these projects involve the Trust working together with other local Health and Social Care agencies to ensure that resources are always used as efficiently and effectively as possible.

Statements of assurance from the Board

The Board of Directors of Central Manchester University Hospitals NHS Foundation Trust 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 e.g. the Clinical Effectiveness Committee and the Risk Management Committee. During 2010/11 the Trust provided and/or sub-contracted the provision of all services set out as Mandatory Services under the Terms of Authorisation.

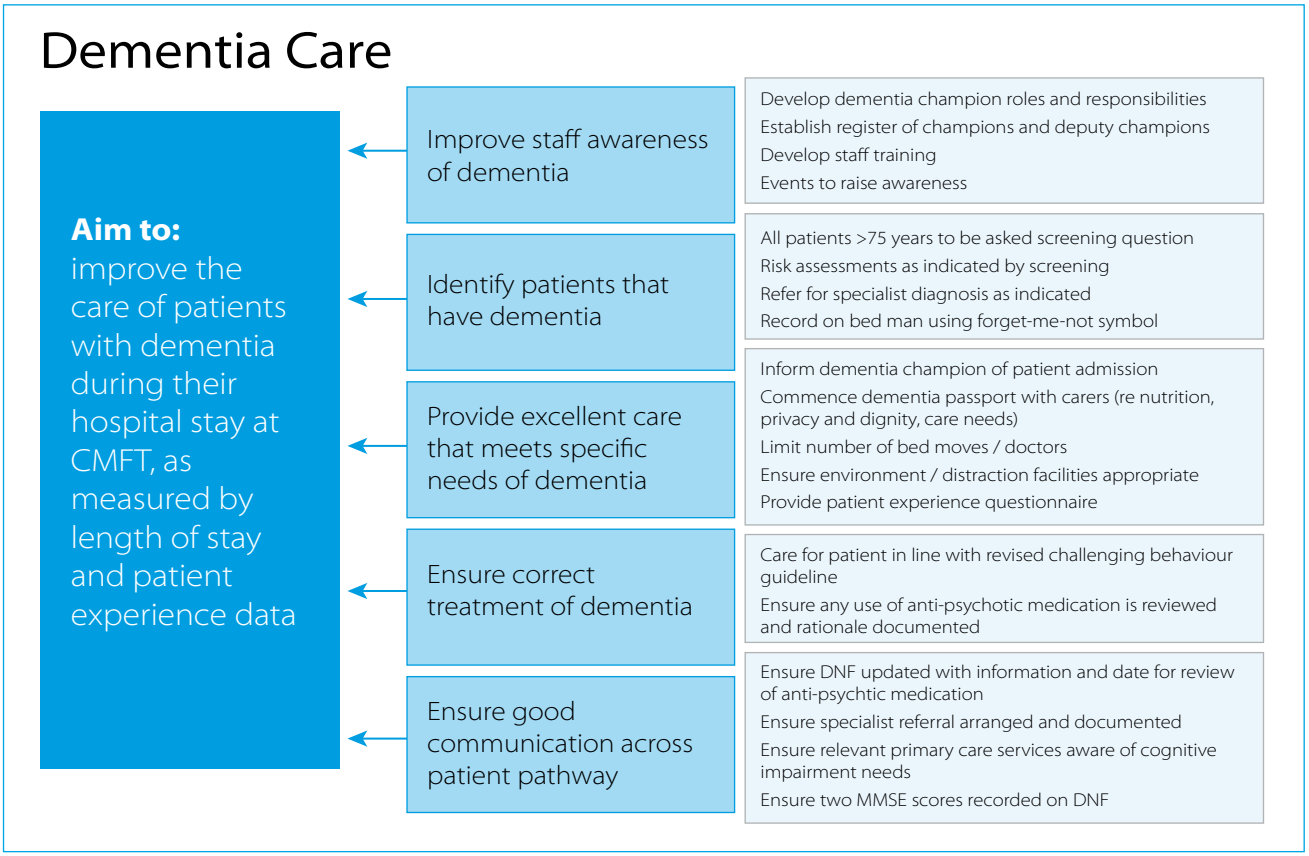
The Central Manchester University Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these NHS services. The information presented in the Intelligent Board Report covers a wide range of performance indicators for safety, clinical effectiveness, 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 Work 2012/2013

During 2012/13 in addition to those previous areas of focus the Trust has decided to work on three key areas to improve patient safety, clinical effectiveness and clinical quality. The Trust has chosen these three particular areas as they are currently of national focus and improvements will benefit large numbers of patients. The three are:

1. Dementia Care

Improving the care of patients in hospital who have dementia is one of our priorities. The national focus on this has provided a welcome spotlight to the work we have commenced and will continue throughout the year. We have chosen to do this to improve the experience of those patients in our care that have dementia and is based on local and national feedback from patients and their carers. The work plan below sets out what we aim to do in a driver diagram explaining our overall aim and how we expect to deliver outcomes. This is a challenging programme of work and one which we are working closely on with our commissioners, patients and staff.



2. Harm Free Care

Safety is a fundamental aspect of high quality, responsive and accessible patient care. We know that national and international research estimates that one in ten patients admitted to hospital will be involved in an error (ranging from very minor incidents to patient deaths) and that around 50% of these events could have been avoided. This year we want to go even further in our work on improving safety by taking a really proactive approach to reducing four particular harms that patients may experience. We have committed to the national campaign which aims to reduce the harm from pressure ulcers, falls, urinary catheter infections and Venous Thromboembolism (VTE). We will share our data on these harms with other NHS organisations so that we can compare our improvement work and share learning.

We are also working on electronic systems for patient risk assessment and VTE will be a priority.

Harm Free Care

Aim to: ensure harm free care for patients at CMFT (>95%), as measured by safety thermometer

Improve awareness of harm free care	Develop IQP module Link to Brilliant Basics Align to everyday work via SBAR handover SLWR feedback and patient story to board meeting
Recuce occurence of falls	Falls risk assessment within 12 hours of admission Falls care plan in place if at risk RCA following fall in older person Record on bed man - and handover as part of SBAR
Reduce incidence of grade 2-4 pressure ulcers	Risk assessment completed within 6 hours Pressure ulcer care plan if at risk RCA following any pressure ulcer graded 2-4 Record on bed man - and handover as part of SBAR
Reduce incidence of catheter acquired urinary tract infections	Risk assessment completed at time of insertion of catheter RCA for any incidence of CAUTI Record on bed man - and handover as part of SBAR
Reduce incidence of Venous Thrombo Embolism	Risk assessment on all adults at admission Prophylaxis given if indicated Record on bed man - and handover as part of SBAR

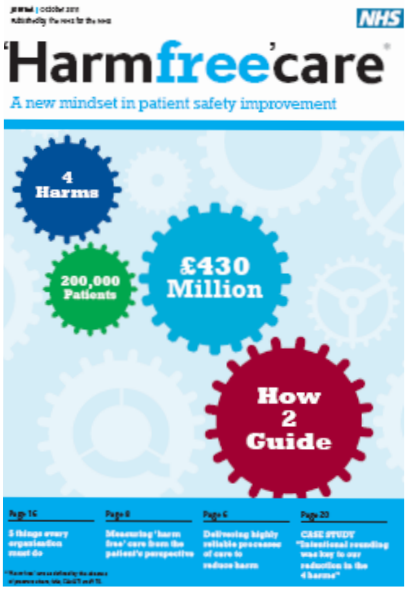
3. Mortality

What: Evidence high quality care through reduction of HSMR and SHMI. HSMR and SHMI are national measures of hospital mortality which, reviewed against other information, can be an indicator of quality of care. The national average is adjusted annually to a figure of 100; any score above 100 indicates the possibility of more deaths than expected, below, fewer deaths than expected.

How much: HSMR and SHMI of below 100 after re-basing. (Current HSMR 97.3, SHMI 106).

By When: March 2014

Action Planned: The Trust has set up a Mortality Review Committee and all services in the organisation now review deaths on a regular basis. The Trust will be undertaking a piece of work over the year to improve record keeping and accuracy of Coding (this has been shown to improve the accuracy of HSMR and SHMI in reflecting quality of care). There are numerous other clinical quality improvement projects, such as Harm Free Care below, that are also expected to contribute to this aim.



Quality Improvement Projects – What we set out to do in 2011/12 and what we achieved

Patient Safety

Venous Thromboembolism (VTE)

The organisation has worked hard to maintain the achievement of 90% of all appropriate patients being assessed for their risk of developing a VTE. We are delighted to report that we achieved this for the full year. This year we will be working to maintain that standard and reduce significantly the incidence of VTE as part of our 'Harm Free Care' programme of work.

What Maintain 90% performance on risk assessment

How much Minimum of 90%

By When During 11/12

Outcome At least 90% of appropriate patients risk assessed every month

Progress ✓

Our work on VTE risk assessment provides us with an excellent foundation to build on our success and deliver a reduction in the incidence of VTE – this will be one of our aims in 2012-Trust2013

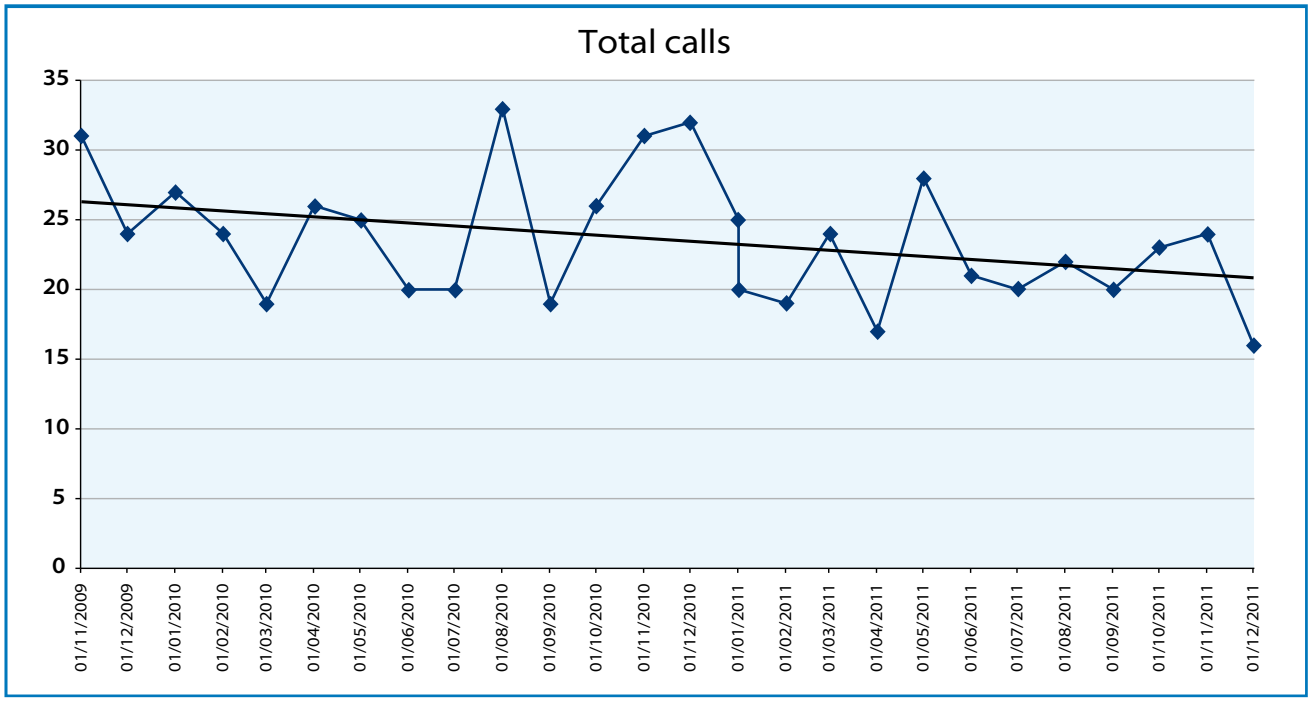
The Acutely Unwell Patient

Reduction in Cardiac Arrest Calls

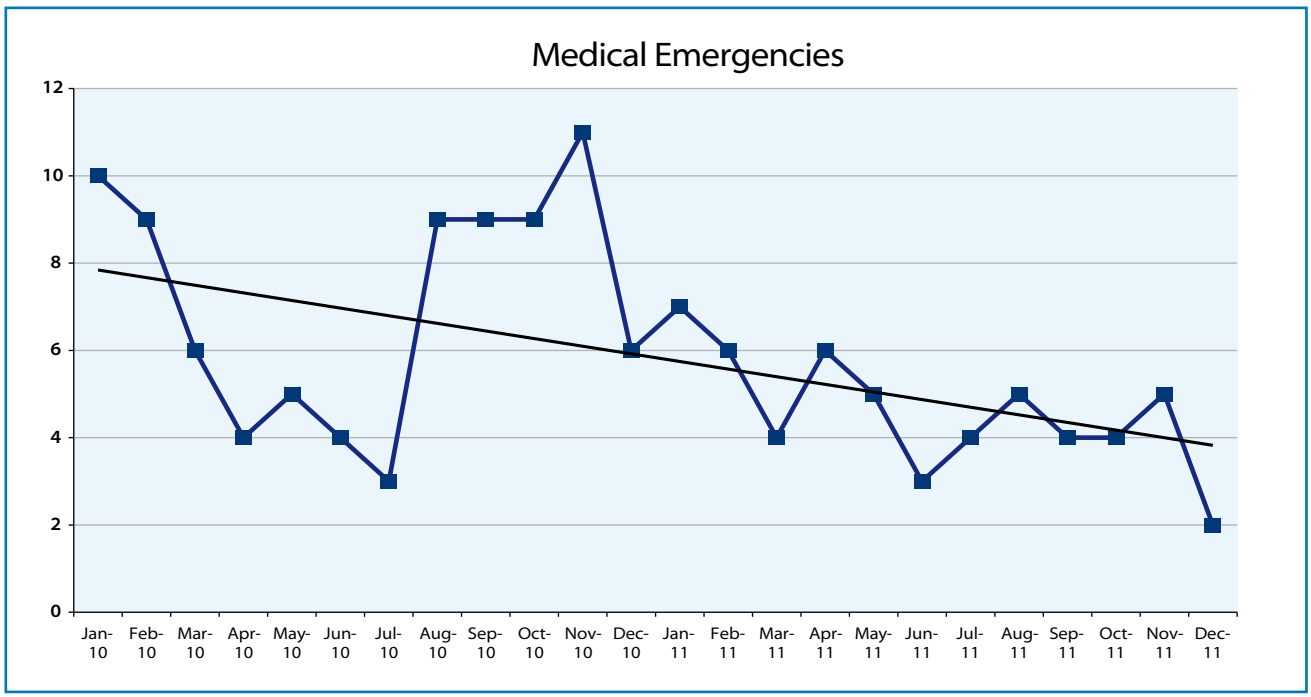
✓ The analysis of all emergency bleeps and high level incidents relating to recognition and response of deterioration in a patient's condition continues at the Trust Emergency Bleep Meetings. This involves a collaborative approach from the multidisciplinary teams within each Division of CMFT, led by the Chief Nurse. This process has enabled a greater understanding of the causes of patient deterioration. Through the sharing of this information, resources and education have been focused to improve patient safety.

As the process has demonstrated essential learning and process change, it has now widened its area of focus and includes grade 3 incidents as well as previously agreed grade 4 to 5 relating to delayed recognition and response. All details of the cases are fed back to the wards for action, outcome and feedback to the teams.

The analysis of the data collated by the Acute Care Team relating to emergency bleep calls and high level incidents (relating to acute deterioration) has been analysed and there has been a relative risk reduction 30% total emergency bleep calls.

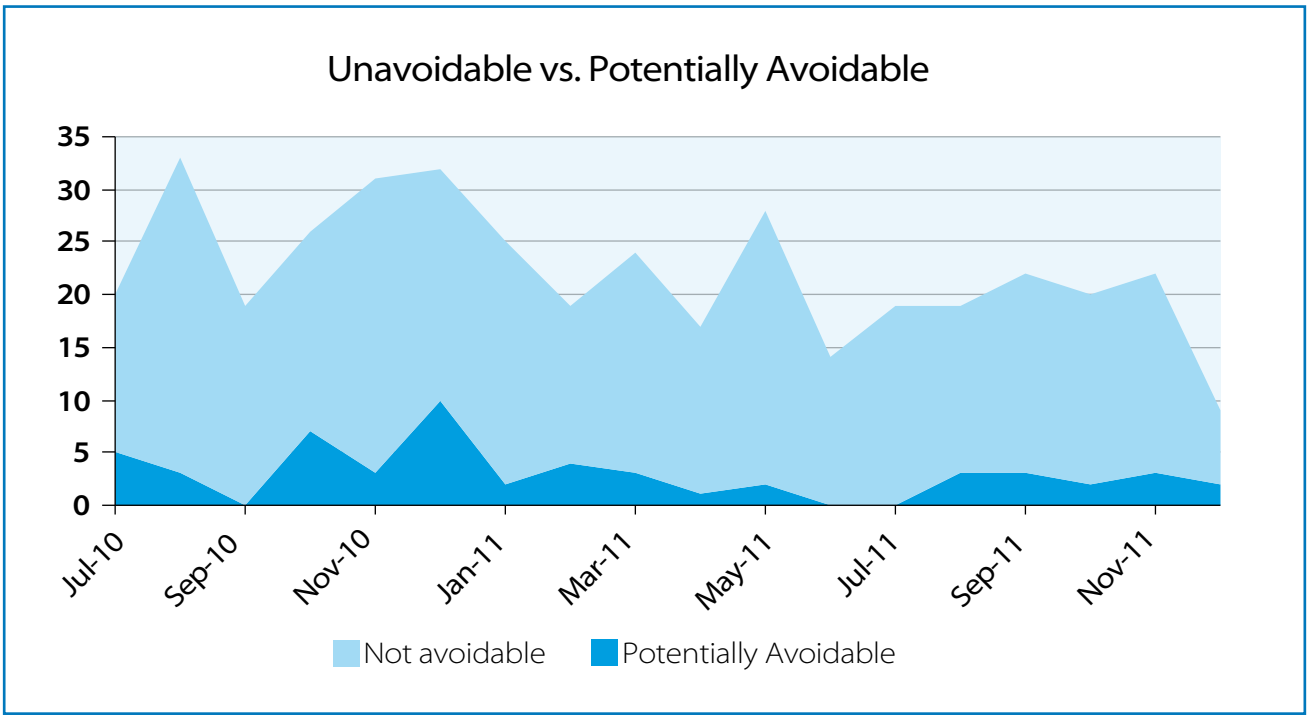


With the biggest reduction within medical emergency calls reduced by over 55%

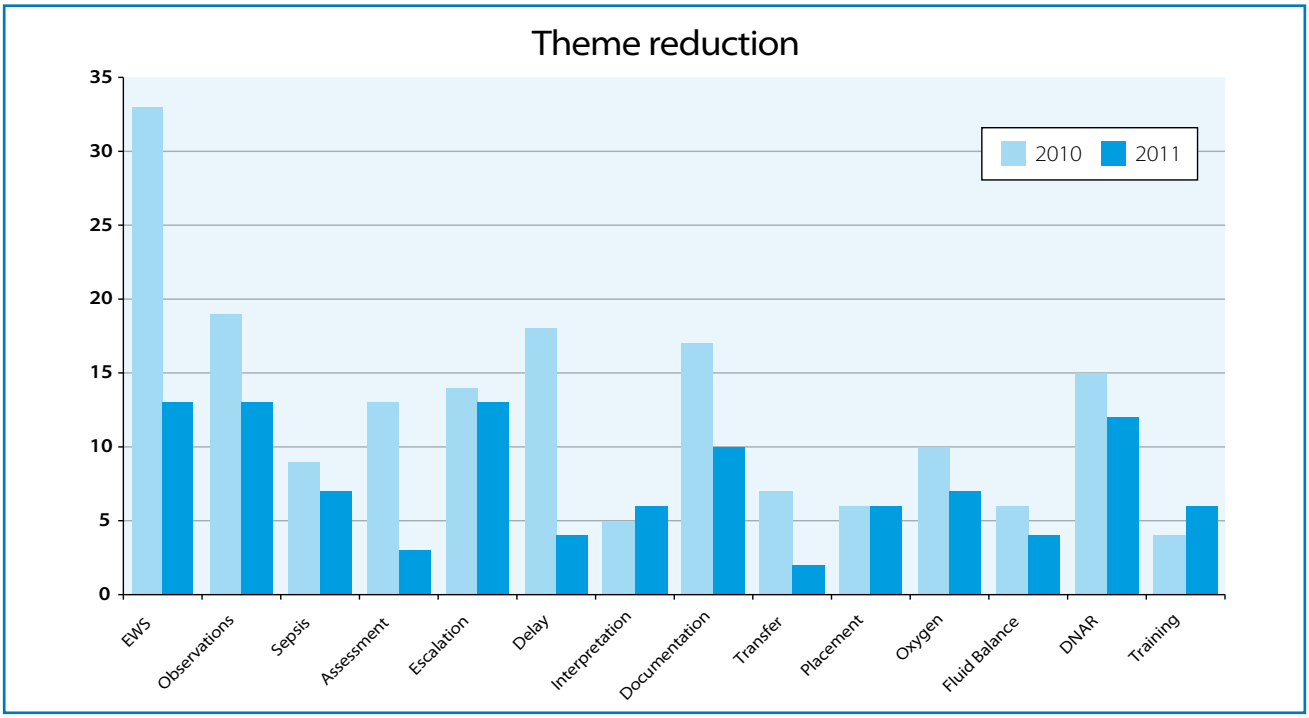


Once a case has been presented at the meeting and the parent team analyses the incident is potentially avoidable, the vision was that as training, policy alterations and any other changes occurred, these potentially avoidable incidents would reduce.

This has occurred and particularly in some of the Divisions there have been significant reductions, in other areas work is continuing to improve this.



One of the most effective outcomes of the meeting is the identification of themes, which are used to direct training, policy and future practice. Over the last 2 years there have been themes completely removed, whilst others have significantly reduced, for example with the implementation of Patientrack, the issues surrounding EWS have significantly reduced. For those that are still highlighted at the meeting, training, review and work streams continue to review and identify methods of improvement.



Acute Illness Management Course (AIMS) / Ill Medical Patients Acute Care and Treatment (IMPACT)

The acute care training has been a vital part of the patient safety programme in the Trust, ensuring that ward clinical staff are empowered, skilled, competent and confident in the management of the acutely ill patient.

The training consists of a number of skills sets and courses, with a standard drawn up to ensure that in each ward, on each shift, staff are able to manage acute deterioration.

The courses include;

- The Acute Illness Management Course (AIM), a 1 day course providing skills in recognition and response - this course is assessed and all Junior Doctors attend this before coming into practice in the Trust.

  The course begun in 2002 and since that time 2006 learners have attended.

- 28 AIM Study days have been taught throughout 2011 and in 2011, 441 staff attended the course. This included nurses, midwives and junior doctors.

- The Acute Care Study Day (ACSD), a 1 day course to enhance acute care skills, including the Prescribing Group Directive, a tool to enable nurses to administer normal saline 0.9% in acutely dehydrated patients. We are aiming to have a nurse on every shift who has these additional skills. We want to do this by the end of the year. The course begun in 2009 and 200 Staff have completed. In 2011, 96 nurses have completed the ACSD with 11 ACSD Days delivered.

- Sepsis Study Day a 1 day course based on the survive sepsis initiative, this has run since 2008 with 319 learners attending over that time.

- Manchester Acute Care Course (MACC), a new 2 day course that has been developed last year following identified learning needs from the Emergency Bleep Meetings. This course runs for Consultants, middle and junior grade Doctors from the Surgical and Gynaecological specialties. The course uses simulation to enable human factors as well as clinical skills to be developed.

The acute care and Outreach team also deliver acute care training to Junior Doctors on a monthly basis on all topics from ECGs to oxygen delivery, respiratory failure to ABG analysis.

Simulation is used across the Trust to ensure skills are maintained and practiced safely, this is an area of training we are looking to develop further across the year.

Reduction in harm from falls

What To reduce the serious harm caused to patients as a result of falls

How much To reduce overall the number of falls by 10% by March 2012

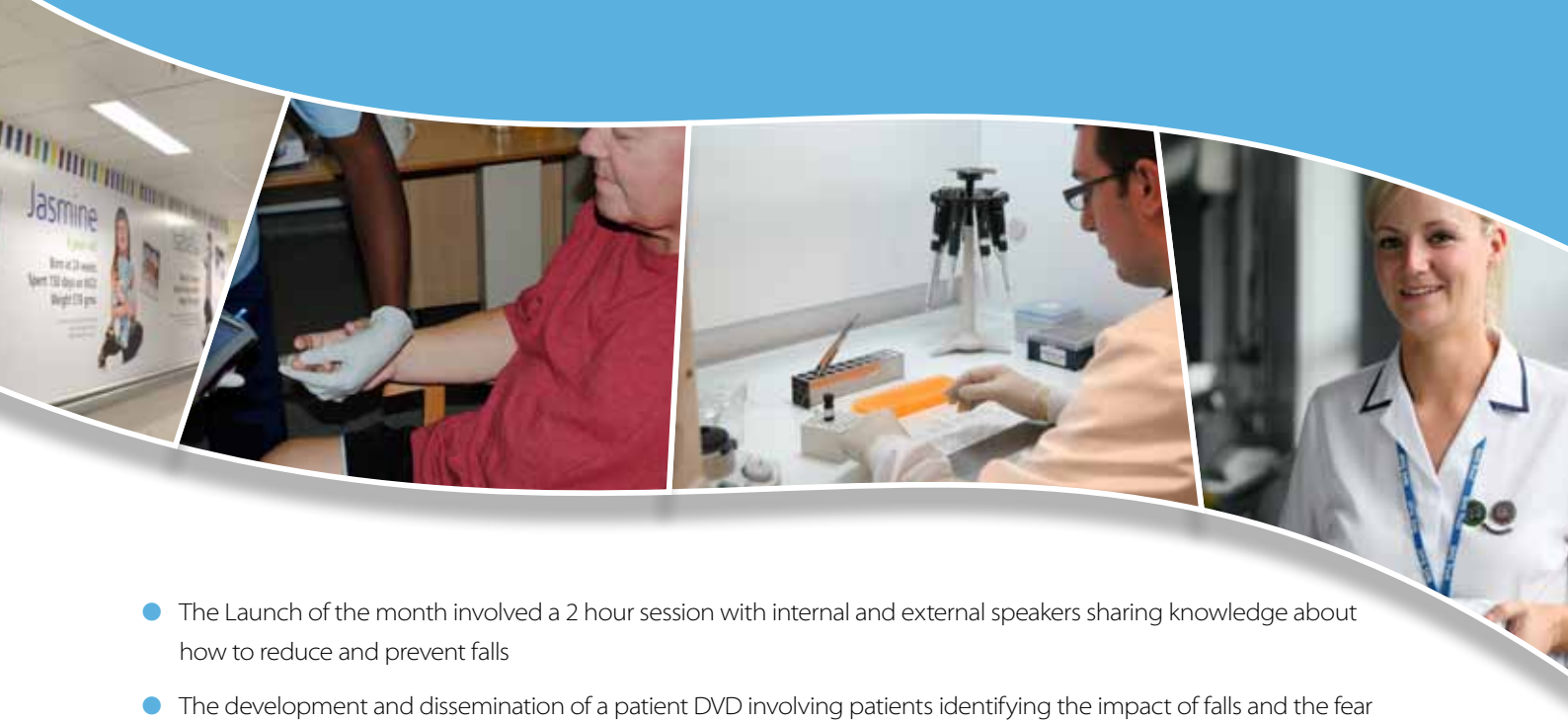
By When March 2012

Outcome Average falls per month have reduced by 11% in 11/12 compared to 10/11 and 79% reduction in moderate to severe actual harm falls. This is a reduction of 195 falls from previous year.

Progress ✓

Work on falls reduction for this year has included:

- As part of the Trust Brilliant Basics events, Falls was identified as a key priority for the month of June 2011, to coincide with the national Falls Awareness week in June.



- The Launch of the month involved a 2 hour session with internal and external speakers sharing knowledge about how to reduce and prevent falls
- The development and dissemination of a patient DVD involving patients identifying the impact of falls and the fear of falling

- Trust wide road-shows scheduled and undertaken, as part of the National Falls Awareness Week (20-24th June 2011) around the Trust to improve patient and staff knowledge relating to falls and falls prevention
- The development of an e-learning package to educate staff on the risk of falls and the measures to employ to reduce the risk of patients falling
- The development of a falls knowledge and skills competency framework for all grades of clinical staff
- Falls risk assessment tool, which is completed for over 9% of patients within 6 hours of their admission
- Analysis of the effectiveness of the Trust's Falls Risk Assessment Tool, which demonstrated that the assessment tool was 98% sensitive to predicting a patient who would actually fall
- The identification of non-slip hospital issue patient slippers, which are now the minimum provision supplied by the hospital for those patients who do not have appropriate footwear of their own
- Wards own their data in the form of quality dashboards which are refreshed monthly and displayed in each clinical area, information from the dashboard indicates that over 99.9% of staff can identify actions to reduce and prevent falls.

Further Improvements Identified

- Roll out of the NPSA essential care after falls advice as a simple to follow flow chart for front line staff. The advice includes the care required if patients have suspected head injuries or fractures
- Identification of areas with a high number of inpatient falls to receive intensive training
- Review of the outcomes of the roll out of 'Patient Focused Rounding'*

In 2012/13 the Trust has taken the decision to revise its falls grading methodology. Trusts across the country do differ in the severity grades applied to different types of falls sustained by patients. Following work by our Falls Team following up patients who fell and sustained a fractured neck of femur it has been decided to grade any fall resulting in a fractured neck of femur as at least a level 4. This will change the figures for the Trust in the future but we believe it more accurately reflects the level of harm.

Preventable Harm

An increase in the number of patient safety incidents reported (Reporting Culture)

What Increase the number of patient safety incidents reported

**Patient Focused Rounding or Intentional Rounding encourages ward teams to check on all patients at as a minimum 2 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.*

How much Minimum of 10%

By When During 11/12

Outcome Average number of patient safety incidents reported has increased by 63% from 695 per month in 10/11 to 1130 per month in 11/12.

Progress ✓

Work has been undertaken to ensure incidents are correctly identified as patient safety incidents and with Divisions in encouraging reporting. This work has been successful in increasing the number of incidents reported as demonstrated by the data published by the NPSA which has moved us to the top 25% of reporters for our cluster group of hospitals during the first 6 months of 2011/12. The details of reporting are included in the table and graph below which demonstrate the increased reporting levels since 2005.

Financial Year	Total Incidents	NPSA reported Incidents
2005-06	5506	2379
2006-07	8946	4155
2007-08	10868	4698
2008-09	11346	6394
2009-10	13800	8344
2010-11	16610	8340
2011-12	16784	13556

Further Improvements Identified

We will continue this work through 2012/13 aiming to increase reporting year on year by a minimum of 5%.

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 10%

By When During 11/12

Outcome Average number of serious harm by month decreased by 20% - from an average of 2.25 to 1.8 per month

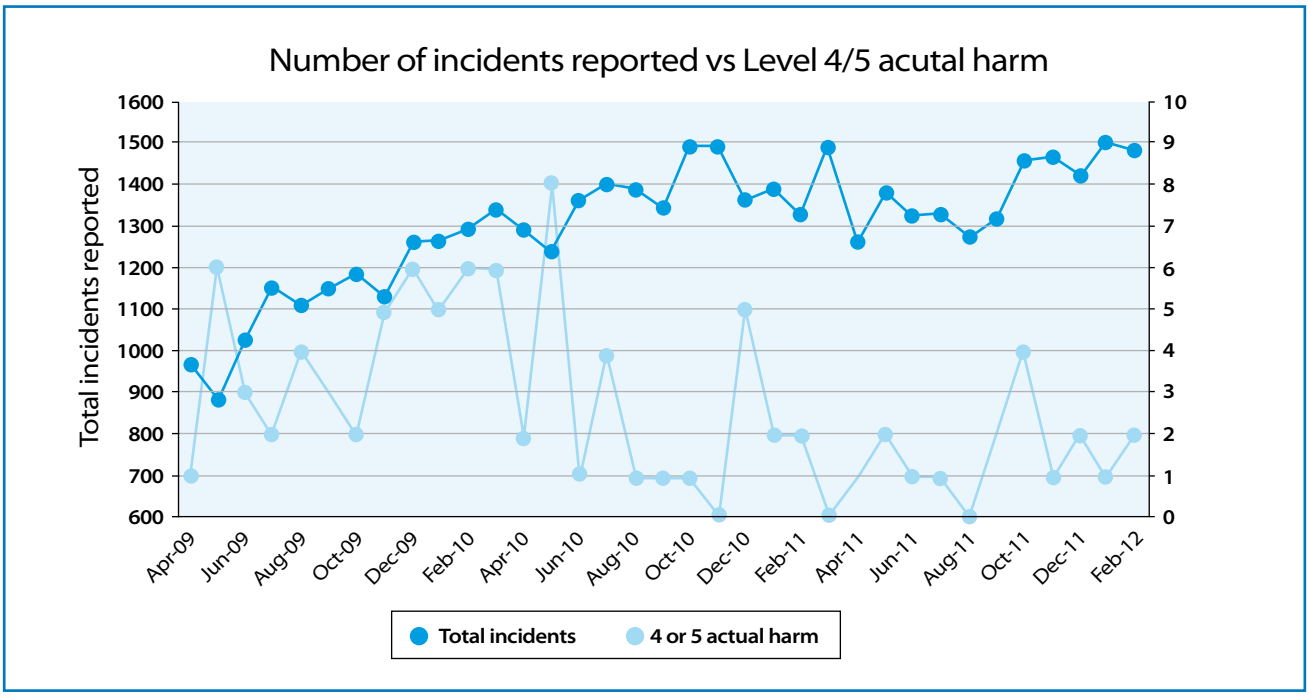
NB. This data is correct at April 2012. As incidents are investigated, their severity grading can change and will be reported in the 2012/13 Quality Account.

Progress ✓

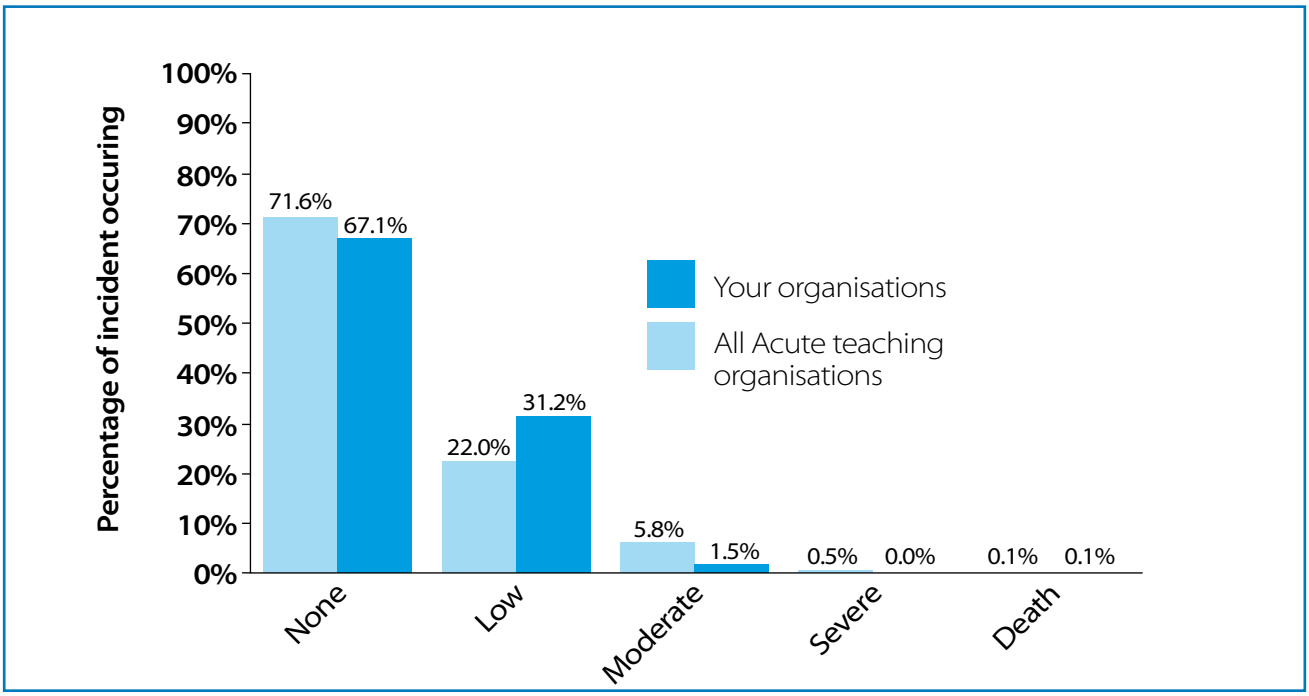
A number of patient safety initiatives have taken place during the year and the combined effort of these indicate a 20% reduction in those incidents reported as serious harm.

Further Improvements Identified

We will continue this work through 2012/13 aiming to reduce these incidents year on year by a minimum of 10%. Next year this information will need to be broken down slightly differently to take into account the new Trafford Division and the changes to the reporting of harm from falls.



The chart below, provided by the National Patient Safety Agency, shows the position in relation to serious harm in comparison nationally with similar organisations



Never Events

A 'Never Event' is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented. There are 25 National 'Never Events' for 2011/12. The Trust has a number of risk assessments and preventative measures in place to prevent these occurring which has resulted in no occurrences during the year.

Being Open

Communicating honestly and sympathetically with patients and their families when things go wrong is a vital component in dealing effectively with errors or mistakes in their care. The Trust policy is that following any incident resulting in harm, information should be given to the patient or relative/carer regarding the incident, the investigation findings and any corrective actions that are being put in to place. For all serious incidents, the formal investigation report should be shared with the patient or relatives/carers. During 2011/12 there was a 20% reduction in level 4/5 (the most serious) actual harm incident investigations completed and 'Being Open' was instigated in all of these.

Fair and Just Culture

In order for an organisation to learn and improve, staff must be happy to report when things go wrong.

At CMFT, we have seen incident reporting increase year on year. Increasing numbers of staff have reported in the Staff Survey that they are happy to report incidents and feel fairly treated when things go wrong.

The National Patient Safety Agency reports indicate that we are in the top 25% of all Trusts for the numbers of incidents reported and yet we are seeing incidents of serious harm reducing.

High Risk Medication Errors

Medication Safety

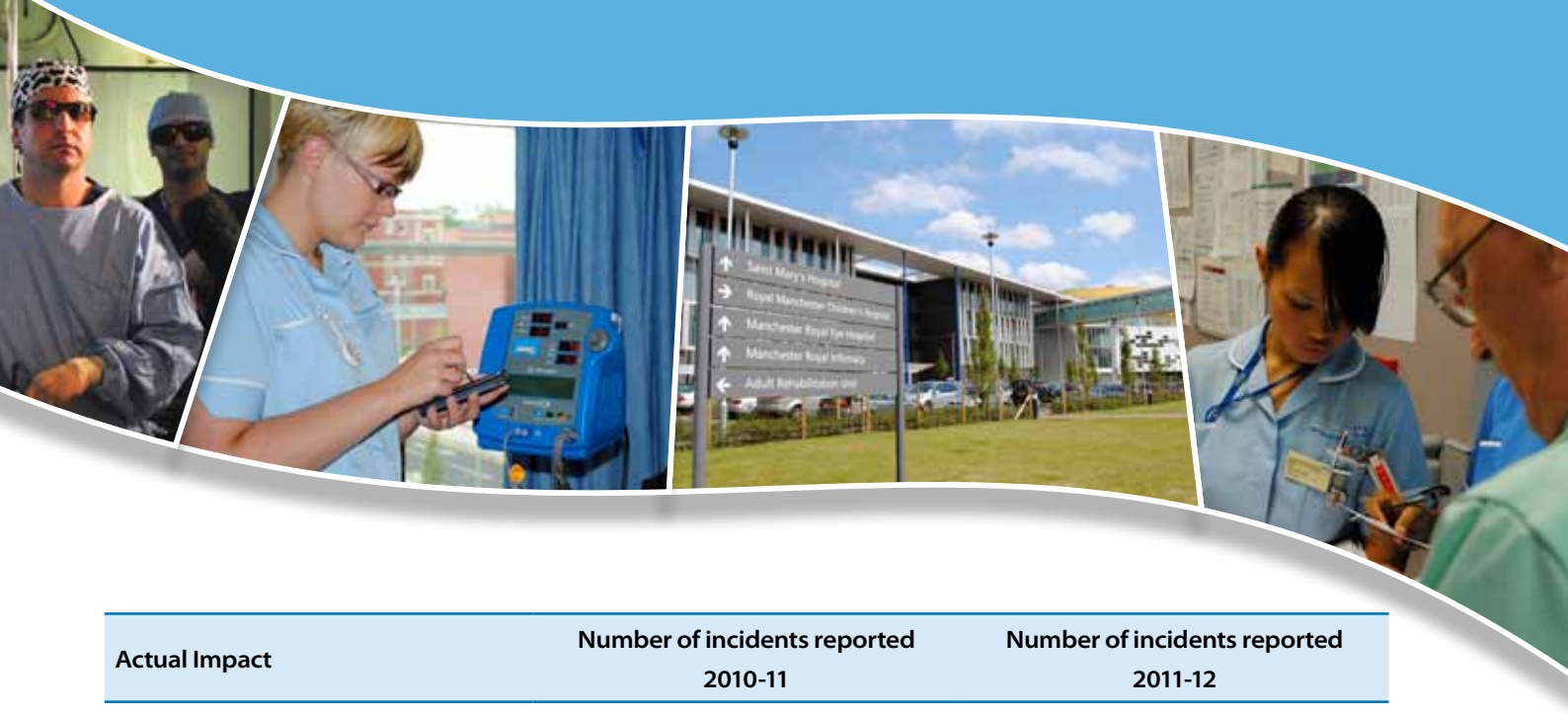
Medication is a high risk area with medication errors being one of the highest reported incidents nationally. We set out to do a great deal of work this year and detail below some of the many achievements by our clinical teams.

Medication safety incidents account for 14% of all incidents reported in the Trust, compared to a figure of 13% nationally. The slight increase is thought to be due to the better reporting culture which exists within the Trust.

What	To continue to improve reporting rates and reduce serious harm from medication errors by 10% each year
How much	To reduce serious harm from medication errors by 10% March 2012
By When	March 2012
Outcome	There have been no serious harm (level 4/5) incidents in 11/12 and moderate harm (level 3) has been reduced by 90% despite an increase in incidents reported of 5%
Progress	✓

The increase in reported medication related patient safety incidents is a sign that there is a fair and open culture within our services so that staff can learn from things that go wrong. Evidence shows that as reporting levels rise serious incidents begin to decline and this has been the case in medication related incidents as well as incidents overall. In addition

- There has been a reduction in incident reports for specific medication safety themes in 2011 including opiates, Midazolam, 10x dosing errors, and surgical antibiotic prophylaxis.
- Use of Flumazenil injection in the Trust has fallen by 30% in 2011. Flumazenil use is a marker of excessive Midazolam dosing.



Actual Impact	Number of incidents reported 2010-11	Number of incidents reported 2011-12
1 Near miss \ No Harm	873	1388
2 Slight	706	415
3 Moderate	158	16
4 Severe	0	0
5 Catastrophic	0	0
Total	1737	1819
Average per month	145	152

Work on medication harm reduction for this year has included

- Trust-wide circulation of a Medicines Safety Dashboard monitoring numbers of incidents with specific high risk medicines and key incident themes the report highlights specific risk reduction strategies
- Introduction of Green Medication Bags for patients to reduce prescribing errors and reduce omissions by improving transfer of medication
- Introduction of a Medication Discharge Checklist to ensure patients have comprehensive information about their medication on discharge
- Availability of a Pharmacy Medicines Helpline to improve patient's access to information about their medicines after discharge
- Focus on common, specialty specific, serious prescribing errors - prescribing errors audits completed, speciality action plans developed and actions underway
- Increased use of pre-prepared intravenous drugs to minimise the risk of preparation and administration errors
- Vancomycin Best Practice Campaign and introduction of therapeutic drug monitoring (TDM) management plans
- Introduction of pre-printed stickers for the prescribing of aminophylline and phenytoin intravenous loading dose regimes
- Continued Mandatory Trust Medicines Safety Training
- Continued Prescribing Competency Assessment Tests
- Further expansion of the ward-based clinical pharmacy service.

Further Improvements Identified for 2012/13

- Trust-wide Campaign on Safe Administration of Medicines
- Trust-wide Medicines Safety Alerts on Penicillin, Insulin, Opiates and Anticoagulants

- Integrated Care pilot project to improve communication about medication at the transfer of care into the community and reduce the risk of unintended changes in medication
- Introduction of an E-learning module on Medicines Reconciliation
- Development of Pharmaceutical Care Standards for High Risk Medicines
- Actions to increase prescribers' awareness of, and access to, Trust Prescribing Guidelines
- Safe Medicines Practice in Theatres Workshops
- Actions to further reduce the incidence of 10x dosing errors in Paediatrics
- Development of an Electronic Prescribing strategy for the Trust.

Prescribing Assessment

Prescribing of medication is one of the most common interventions undertaken during a patient's hospital stay. Whilst medicines can produce great clinical benefit, there is also the potential for them to cause significant harm. Prescribing is a high risk area, which is highly significant for the Trust in striving to improve patient safety. Evidence regarding medication errors from the EPIC study (Dec 9 2009: GMC) suggests that all grades of medical staff are implicated in prescribing errors.

Foundation year doctors undertake a Deanery led prescribing assessment before they begin their first post. Core and Specialist trainees are evaluated using a Trust-developed baseline prescribing competency assessment. The assessment, which has been in place since August 2010, is intended to signpost areas of training and development for candidates to further their prescribing expertise. It also provides assurance to the Trust that its intake of doctors has reached a satisfactory level of prescribing competency at the start of their employment with us. There has been a reduction of level and 4 and 5 prescribing incidents since the introduction of the assessment.

The Trust is now working to develop prescribing assessments focussed at specific speciality level and to transfer the paper-based system to an e-learning platform.

Reducing Pressure Ulcers

What Overall continued reduction of grade 2, 3 and 4 pressure ulcers.

How much Overall reduction on 10/11

By When March 2012

Outcome There has been a 56% reduction in grade 4 hospital acquired pressure ulcers and a 34.7% reduction in grade 2, 3 hospital acquired pressure ulcers.

Progress 

Work on pressure ulcer harm reduction for this year has included:

- Introduction of an Integrated Care Pathway for management of patient identified at risk of pressure ulcer development. This document enables accurate pressure ulcer risk identification and provides evidence based guidance on skin care.
- Education – Preventing Pressure Ulcers training programme 110 key staff attended in 2011/12.
- Ward based training has been provided in areas that have identified that specific improvements are required – including roll out of pressure ulcer grading and prevention, the use of mattresses and other pressure relieving equipment.
- Bespoke training days for student nurses.
- Participation in Brilliant Basics – Over 150 staff/members of the public attended, giving us the opportunity to discuss pressure ulcer prevention.

- Worked in Partnership with 'Your Turn' – a national campaign to heighten awareness within health care settings and in the public domain in relation to skin care and pressure ulcer prevention.
- Raising awareness – (as part of this work the team secured the winning poster at the Trusts 2011 CARM fair – which is a celebration of improvement work).
- Focus on community services as they joined CMFT. This has enabled a focus on the prevention of pressure ulcers in the community and to work collaboratively with district nurse teams and other community health professionals.

Further Improvements Identified

Pressure Ulcer Policy to be launched in 2012.

Other Patient Safety Information

Patient Safety Training

We aim for all staff members to undertake this training course at least once regardless of seniority or discipline. All groups of staff from Board Members to Students have attended over the years that it has been running. This course is mandatory for Consultants and Ward Managers who are our senior leaders in the organisation. Well over 1000 staff have attended, 270 of them in 2011/12.

The aims of this training course are to:

- reduce the rate and severity of clinical error and to improve patient safety
- promote awareness of factors which reduce human performance in complex working environments
- show staff how to recognise and respond to error inducing situations
- Improve communication and team working skills.

This year we expanded the faculty and now have a team of eight regularly involved, four of these are Consultant staff. We have also revised and updated the content of the course. Staff feedback throughout the year has been consistently excellent with staff enjoying the activities on the day.

Patient Safety Alerts

Patient safety alerts come into the organisation via the Patient Safety and Risk Management Department and are managed in a systematic way to ensure that we do everything we can in a timely way in response to these alerts.

National Patient Safety Agency Alerts	Detail	Compliant
NPSA/2010/RRR017	The transfusion of blood and blood components in an emergency	Y
NPSA/2010/RRR018	Preventing fatalities from medication loading doses	Y
NPSA/2011/RRR001	Essential Care after and inpatient Fall	Y
NPSA/2010/RRR019	Safer Ambulatory Syringe Drivers	Y
NPSA/2011/PSA002	Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants	Y

Learning from Experience

The Trust continues to share 'lessons learned' in its regular publication of the same name.

Clinical Effectiveness

Mortality

In recent months the Dr. Foster Hospital Guide 2011 has been released. This year is the tenth year of publication. The report intends to shine a spotlight of a number of aspects of patient safety, quality and variability in outcomes. One of the key focuses for this year is on mortality and the introduction of Standardised Hospital Mortality Index (SHMI).

Four mortality measures are included in the hospital guide: HSMR, SHMI, rates of death following surgery and death in low risk conditions. SHMI is a new method by which to assess mortality levels within Trusts. It has been introduced, in part, to overcome some of the debates around the basis on which the Hospital Standardised Mortality Ratio (HSMR) is calculated. It is not intended to be a replacement for HSMR and will be reported alongside it on public websites like NHS Choices.

The key differences between HSMR and SHMI are:

- SHMI includes all deaths, while HSMR includes only a basket of 56 diagnoses (around 85% of deaths)
- SHMI includes post-discharge deaths while HSMR is only in-hospital deaths.
- HSMR is adjusted for more factors than SMHI such as palliative care and case mix. The amount of Coding for palliative care is particularly significant in overall HSMR scores, as in some Trusts over a quarter of cases are so coded.

It is of critical importance to appreciate that information about mortality comes from many different additional sources. These sources include internal mechanisms such as our Emergency Bleep Review Meeting and processes, clinical incidents, high level investigations, complaints analysis and clinical audit and mortality review. In addition there are many external comparators apart from Dr Foster data. These are national audits, confidential enquiries and in particular the contribution of adult and children's critical care to national data sets.

CMFT has improved its HSMR over recent years and is currently 97.3, which is exactly average. The current SHMI score is 106, also within the expected range and well within confidence intervals. A retrospective calculation of SHMI also indicates that this is less than it would have been in previous years.

For the other two published indicators, the deaths in low risk conditions is very low at 0.29 (published range 0.27 - 1.99) as is deaths after surgery at 82 (published range 29 -163).

We are working hard to understand all of our clinical outcomes, including mortality. Clinical teams are reviewing the information on a regular basis throughout the year and a group of senior clinicians, nurses and information staff meet regularly to discuss themes identified.

Our aim in the next few years will be to reduce both our HSMR and SHMI scores to below the national average.

Infection Prevention

Clostridium Difficile Infection (CDI)

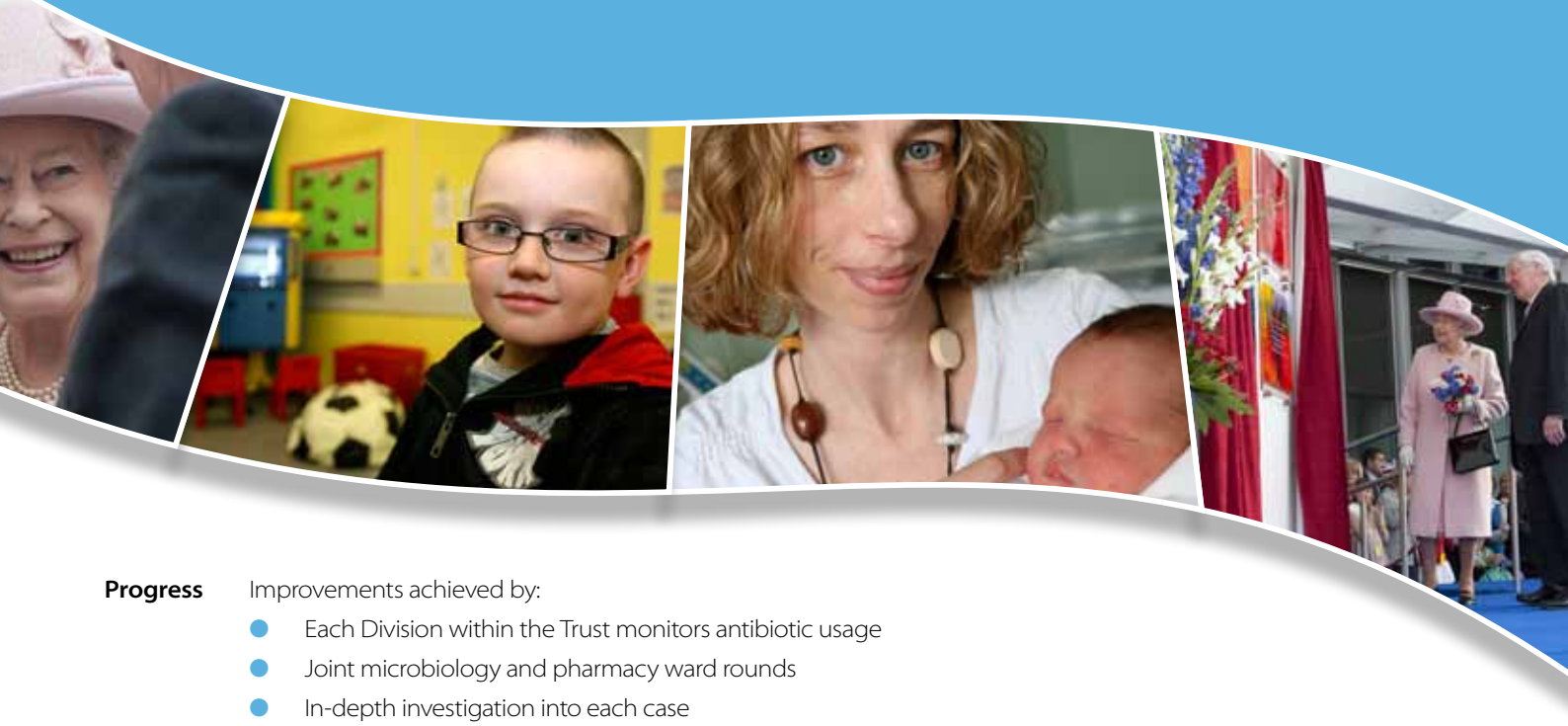
CDI causes serious illness and outbreaks among hospital patients. Usually it affects the elderly, the debilitated and patients who have had antibiotic treatment (DH 2010).

What To reduce the number of cases of CDI within the Trust

How much No more than 96 cases

By when 31 March 2012

Outcome To date, 68 cases resulting in a 64% reduction from previous year



Progress Improvements achieved by:

- Each Division within the Trust monitors antibiotic usage
- Joint microbiology and pharmacy ward rounds
- In-depth investigation into each case
- Identification of lessons learnt and action planning

Further Improvements Identified

- Partnership working with the PCT to develop tools to improve healthcare economy working and patient outcome

Methicillin Resistant Staphylococcus Aureus (MRSA)

What To reduce the number of cases of MRSA bacteraemia (bloodstream infections) within the Trust

How much No more than 6 cases

By when 31 March 2012

Outcome 3 cases resulting in a 43% reduction on previous year

Progress ✓

Improvements achieved by:

- Development of responsibility cascaded into the Divisions who have devised local prioritised initiatives to make further improvements. For example:-
  - 'Commitment to infection control' sign up in adult critical care
  - 'Re-energising campaign' within the Division of surgery
  - 'High risk assessment tool' within the Division of medicine and community services
- Development of patient information leaflets on the use of MRSA decolonisation treatment.

Further Improvements

- Ongoing collaborative working between the Infection Prevention and Control team and the Divisions.

Surgical Site Infection – Coronary Artery By-Pass Surgery

What To reduce surgical site wound infections in patients who have had Coronary Artery By-Pass Surgery (CABG)

How much To reduce the number of infections to lower than the national benchmark which is currently 4.5%

By when March 2012

Outcome We did a spot check on one Quarter data which indicated we had achieved 2.25%

Progress ✓

The focus of this programme is to measure the numbers of patients developing a surgical site wound infection following Coronary Artery By-Pass Surgery (CABG). The data is used to measure the effect of interventions implemented to reduce the risk of surgical site infection.

The Trust began voluntary participation in the national programme for surveillance of surgical site infections amongst

patients undergoing this type of surgery in January 2009. Information is collected and submitted to the Health Protection Agency for at least one quarter of every year. As this is a national programme, the results from our performance can be benchmarked against other similar centres across the country that are also participating in the scheme.

For the Quarter of April – June 2011, the Trust achieved an incidence of 2.25% for Surgical Site infection amongst patients who had coronary artery by-pass surgery. The national benchmark is 4.5%. This success has been achieved through the implementation of a series of interventions overseen by a multi-disciplinary group including cardiac surgeons and nurses as well as members of the Infection Prevention and Control Team.

Further Improvements Identified

In 2012/13, we plan to undertake regular monitoring, include post-discharge patients in surveillance and continue the improvements in performance.

Infection control in the community

Arrangements have been put into place for the provision of an infection control service for community based services. Work undertaken so far includes:-

- An Assurance framework assessment based on the Health and Social Care Act 2008
- Site visit assessments of key services (including Intermediate Care, Dental Services and The Foot Hospital)
- Focus groups conducted to ascertain infection control priorities
- Review of key policies to ensure community relevance.

Further Improvements

- Roll out of ANTT training and assessment
- Review of the community audit programme.

Stroke Care

What To support patients on discharge following a stroke, a minimum of 50% of eligible patients discharged home with input from the Early Supported Discharge Service. This involved the hospital teams continuing to work with patients on their rehabilitation goals in their own homes for a period of time following discharge from hospital.

When March 2012

Outcome ✓ In Quarter 4, 68% of eligible patients were discharged with the support of ESD.

Further Improvements Identified: Over the course of the next year we aim to continue this work by increasing the number of patients admitted directly to the stroke unit by expanding the hours at which this takes place.

During 2011/12, we started to directly admit stroke patients to the Stroke Unit from the Emergency Department ensuring timely access for patients to the specialist stroke service.

The current Sentinel Audit (the main bi-annual audit of stroke services nationally) is to be replaced in April 2012 by the Sentinel Stroke National Audit Programme which will monitor stroke performance on a more regular basis and inform future service developments both locally and nationally.

There have also been a number of Care Quality Indicators (Commissioning for Quality Innovation Schemes [CQUINS]) designed around our stroke services. For 2012/13, our work will focus on the rapid assessment of patients on arrival at the Emergency Department; ensuring that patients are seen in clinic within six weeks following discharge from hospital and

revising our discharge processes in conjunction with our partners in Primary Care to ensure a more seamless handover of care on discharge.

We aim to continue this work by increasing the number of patients admitted directly to the stroke unit ensuring timely access for patients to the specialist stroke service. We plan to have a minimum of 40% of patients discharged home with input from the Early Supported Discharge Service. The current Sentinel Audit is to be replaced in April 2012 by the Sentinel Stroke National Audit Programme (SSNAP) which will monitor stroke performance and inform future service developments. Our aim will be to set targets for Trust performance in line with national expectation. We are working with the Stroke network and the Royal College of Physicians to understand how these new performance measures will be applied.

In respect of ESD, we aim to meet the national standard of 40% for ¬all Stroke patients discharged.

Reliable Care

The Trust is 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. The indicators below ore projected figures for 2011/12. The Trust has improved on its performance in heart failure. In year improvements have also been made in stroke and hip and knee replace, and pneumonia and we are projecting improved performance next year. However the full year figure did not meet the required standard to demonstrate the improvements made.

More challenging targets and a need to embed processes more fully led to some deterioration in performance and this has been reflected in our full year figures. We have set out below action to address these going forward and expect improvements in 2012/13.

What To improve the quality of care received by patients with:

Acute Myocardial Infarction	✓
Coronary Artery Bypass Grafting	✓
Heart Failure	✓
Community Acquired Pneumonia	✗
Hip and Knee Replacement	✗
Stroke	✗

How much To demonstrate year on year improvement

By When By end of March 2012

Outcome Improvements achieved in three indicators but deterioration in three

Progress ✗

Improvements Achieved

- Performance in Coronary Artery Bypass Grafting has been consistently high
- Performance in heart failure has improved significantly
- Hip and knee replacement performance has improved in the last 6 months of the year and this will be demonstrated in the full year results for 12/13
- A care bundle has been developed for community acquired pneumonia and this is expected to improve care for those patients

Further Improvements Identified

- To achieve scores which are in the top 25% when benchmarked against other organisations across all Advancing Quality categories for 2012/13

Urgent Care

What To ensure that patients attending the A/E Department are seen and treated, discharged or admitted within four hours

How much To achieve this standard for 95% of patients each Quarter and for the year.

Outcome ✓ Achieved standard for 3 out of 4 Quarters and achieved 95.4% for the year.

Improvements Achieved

System and process improvements have been identified across the following areas:

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

Further Improvements Identified for 2012/13

In order to facilitate an improved patient experience through the urgent care system, the Trust will be continuing to make improvements across all areas of the Clinical Quality Indicators but specifically focussing on the following three key priorities:

- The further development of a rapid assessment and treatment model for the Emergency Department at MRI in order to ensure that patients are seen by a Senior Doctor as early as possible after they arrive within the Emergency Department
- The Development of an Observational Medicine Unit which will be run by the Emergency Physicians and the Acute Care Physicians and will be for patients who are ambulatory or require a short length of stay
- Restructuring of the medical workforce to ensure that Senior Consultant presence on the wards and within the Emergency Department can be increased. This will help to ensure patients do not stay in hospital any longer than is absolutely necessary and also provide better continuity of care.

Other Clinical Effectiveness Information

Care Bundles

In 2010, CMFT became one of 8 Trusts in the North West taking part in a two year Reducing Mortality programme of work led by AQuA, the North West Quality Observatory. The use of care bundles, which identify those key aspects of care that significantly influence positive clinical outcomes and patient experience, was recommended. Bundles are condition specific and are developed by a multi-disciplinary team. They are brief (contained within a side of A4) and are produced in the format of a large label which is stuck into the patient's clinical notes where the bundle is followed and signed off by those clinical staff responsible for the care aspects listed.

Two care bundles in respect of patients presenting with an acute abdomen (pre-operative and intra/post-operative) have been developed and have been in use for most of the year. The condition was selected because it carries a high complication and mortality risk and accounts for a high use of Intensive Care beds. The pathway on which it is based has been included in a 2011 Report from the DH and Royal College of Surgeons on the Peri-operative care of the high risk surgical patient.

An endovascular care bundle has also been developed and ones for Community Acquired Pneumonia and the Management of the Child with Complex needs are in development.

Learning from Clinical Audit to improve care

National Audit

During 2011/12, Central Manchester University Hospitals NHS Foundation 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 Audit is divided into two main categories: snapshot audits (including patient data over a short, pre-determined period) for example the Sentinel Stroke Audit, Paediatric Asthma Audit and those audits where data on every patient with a particular condition or undergoing specific treatment is included, for example the Cancer audits and the National Hip Fracture Database.

A total of 48 audits are listed on the HQIP database for inclusion in Quality Accounts. There are a number in which CMFT does not participate as the service is not provided in the Trust. Examples of these are adult mental health disorders and liver transplantation. A list of the National Audits in which the Trust participates is shown below.

Title:	Participated ✓/✗	Type of Audit:	Target:	Number entered:
Peri-natal and neonatal				
Perinatal Audit	✓	Every death between 24 weeks gestation and 28 days	All applicable	Data entered via the MPMM portal. Report due mid-summer 2012
Neonatal Intensive and Special Care	✓	Every patient	All applicable	On-going data collection
Children's				
Paediatric pneumonia [BTS]	✓	Snapshot	All applicable	47/82 [57%] (18 sets of case notes not available for audit purposes)
Paediatric asthma [BTS]	✓	Snapshot	All applicable	30/32 [94%] (2 sets of case notes not available for audit purposes)
Pain Management [College of Emergency Medicine	✓	Snapshot	All applicable	50 [100%] cases submitted
Childhood Epilepsy [RCPH Childhood Epilepsy Audit]	✓	Snapshot	All applicable	37 [100%]

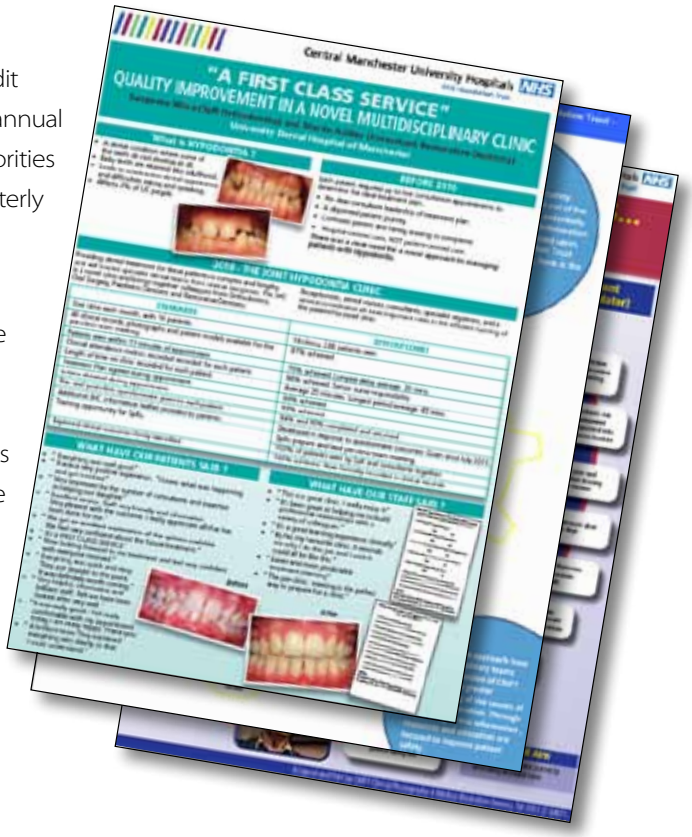
Paediatric Intensive Care [PICANet]	✓	Every patient	All applicable	579 [100%] Continuous data collection of all PICU patients (data April 11 to Present date)
Diabetes [RCPH National Paediatric Diabetes Audit	✓	Snapshot	All applicable	226 [100%]
Acute Care				
Emergency use of oxygen [BTS]	✓	Snapshot	All applicable	**39 [100%]**
Adult community acquired pneumonia [BTS]	✓	Snapshot	All applicable	Data collection closes 31.05.2012
Non invasive ventilation adults [BTS]	✓	Snapshot	All applicable	Data collection closes 31.05.2012
Cardiac Arrest [National Cardiac Arrest Audit]	✓	All patients	All applicable	Data collection closes 31.3. 2012
Severe sepsis and septic shock [College of Emergency Medicine]	✓	Snapshot	30	**30 [100%]**
Adult Critical Care [ICNARC CMPD]	✓	All patients	All applicable	**685 [100%]**
Potential donor audit (NHS Blood & Transplant)	✓	All patients	All applicable	Data collection closes 31.3. 2012
Seizure management (National Audit of Seizure Management)	✗			Insufficient local resources to allow participation
Long term conditions				
Diabetes (National Adult Diabetes Audit)	✓	All patients	All applicable	**~2500 patients [100%]**
Heavy menstrual bleeding (RCOG National Audit of HMB)	✓	Snapshot patient Questionnaire	All women presenting for the 1st time with the complaint	**28** patients chose to participate
Chronic pain (National Pain Audit) (Paediatrics)	✓	Snapshot	All Applicable	**16 [100%]** New patients attending the chronic pain clinic
Ulcerative colitis & Crohn's disease (UK IBD Audit)	✓	Snapshot	40 patients: 20 UC and 20 CD patients	**20** UC and **20** CD patients **[100%]**
Parkinson's disease (National Parkinson's Audit)	✗			Not permitted to participate following registration deadline
Adult asthma (British Thoracic Society)	✓	Snapshot	All Applicable	**38 [100%]**
Bronchiectasis (British Thoracic Society)	✓	Snapshot	All Applicable	**64 [100%]**

Elective procedures				
Hip, knee and ankle replacements (National Joint Registry)	✓	Every patient	All applicable	Total for 2011 = **332 [100%]** (144 hip, 188 knee, 0 ankle)
Elective surgery (National PROMs Programme)	✓	Selected patients	328	**181** to date Data collection closes 31.3.2012
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	✗			Not undertaken in this Trust
Liver transplantation (NHSBT UK Transplant Registry)	✗			Not undertaken in this Trust
Coronary angioplasty (NICOR Adult cardiac interventions audit)	✓	Every patient	All applicable	Data collection closes 31.5.2012
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	✓	Every patient	All applicable	Total for 2011 = **87** 1st April – present = **59 [68%]**
Carotid interventions (Carotid Intervention Audit)	✓	Every patient	All applicable	**77 [100%]**
CABG and valvular surgery (Adult cardiac surgery audit)	✓	Every patient	All applicable	Data collection closes 31.5.2012
Cardiovascular disease				
Acute Myocardial infarction & other ACS (MINAP)	✓	Every patient	All applicable	Data collection closes 31.5.2012
Heart failure (Heart Failure Audit)	✓	Every patient	All applicable	Data collection closes 31.5.2012
Acute stroke (SINAP)	✓	Every patient	All applicable	Data collection closes 31.3.2012
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	✓	Every patient	All applicable	Data collection closes 3.05.2012
Renal disease				
Renal replacement therapy (Renal Registry)	✓	Every patient	All applicable	Data collection closes 31.3.2012
Renal transplantation (NHSBT UK Transplant Registry)	✓	Every patient	All applicable	**235** patients
Cancer				
Lung cancer (National Lung Cancer Audit)	✓	Every patient	All applicable	Data collection closes 30.06.2012
Bowel cancer (National Bowel Cancer Audit Programme)	✓	Every patient	135	**132 [98%]** (3 sets of case notes not available for audit purposes)
Head & Neck cancer (DAHNO) *(Patients excluded are thyroid cases and those patients that do not meet all of the mandatory field requirements)*	✓	Every patient	99	**36 [37%]** Issues with resources and MAXIMs so due to time constraints had to use web-portal.

Oesophago-gastric cancer (National)-G Cancer Audit)	✓	Every patient	All applicable	**114/210 (54%)**
Trauma				
Hip fracture (National Hip Fracture Database)	✓	Every patient	All applicable	**179 [100%]**
Severe trauma (Trauma Audit & Research Network)	✓	Snapshot	All applicable	Results not due until June 2012 – on target for 65%+ data completeness
Psychological conditions				
Prescribing in mental health services (POMH)	✗			Not undertaken in this Trust
Schizophrenia (National Schizophrenia Audit)	✗			Not undertaken in this Trust
Blood transfusion				
Bedside transfusion (National Comparative Audit of Blood Transfusion)	✓	Snapshot	70	**73 [100%+]** patients
Medical use of blood (National Comparative Audit of Blood Transfusion)	✓	Snapshot	All applicable	**88 [100%]** patients
End of life				
Care of the dying in hospital (NCDAH)	✓	Snapshot	All applicable	**30 [100%]** patients

Local Audit

The Trust undertakes 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 and Divisional Clinical Effectiveness Committees.



All audits are deemed incomplete until an action plan in response to audit findings has been detailed. This year, a number of Trust wide audits have required the development of individual action plans for each area, examples of this are the Divisional action plans in response to the Record Keeping Policy and Early Warning Score [Recognising the Deteriorating Patient] audits. Thus all audits are reviewed and actions completed to ensure improvement based on the audit outcome.

Examples of those improvements or good assurance against standards include:

- Administration of Medication Observation Audit [Re-audit]

- Re-audit of inappropriate use of physiotherapy on-call service
- Effectiveness of Mircrosuction Clinic Appointments.

Each year, national and local audit work is show cased at the Trust annual Clinical Audit and Risk Management [CARM] Fair. This year the fair took place in April and over 160 poster presentations were displayed. Every year prizes are awarded to those posters presenting audit work which has significantly improved safety or quality of care, this year the prizes went to the following titles:

- Reducing pressure ulcers one year on
- A first class service (Dental Division)
- Working together to reduce cardiac and respiratory arrests in the Trust one year on.

NICE Guidance

NICE guidance and assurance that the Trust is compliant, or taking steps towards compliance, forms an integral part of our clinical audit calendar.

NICE guidance, including Clinical Guidelines and Interventional Procedure Guidelines are disseminated to representatives of the Trust's eight clinical Divisions upon issue. The representatives discuss the applicability of the guidance within their Divisions and respond. Where the remit of a specific guideline is thought to apply within a Division's clinical services an appropriate clinician within the relevant speciality is asked to respond to the guidance. The Trust position is that we aim to be compliant with all NICE guidance wherever possible.

Responses to guidance citing compliance are recorded as such on the Trust's NICE database. For assurance purposes, this information is used to provide a list of guidance applicable to each Division which is reviewed by clinicians, clinical effectiveness teams and the clinical audit department when formulating their annual clinical audit programme. Each clinical audit programme is regularly monitored throughout the year to monitor the progress of these projects. In this way, assurance for NICE guidance is embedded through the Trust audit programme.

There is a five year rolling programme to cover all applicable NICE guidance.

Responses to guidance citing partial compliance are confirmed and verified with Divisions and referred to the Clinical Practice Committee, a sub-committee of the Trust's Clinical Effectiveness Committee. This committee takes appropriate action, led by the committee chair in order to establish the nature of the partial compliance, categorise it and request suitable actions to resolve the

The committee receives a report on the status of NICE guidance issued by Division and reviews all guidance which has been referred to the committee as partially compliant.

National Confidential Enquiries

There were five 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 2012/13, we will continue to improve data completeness for these types of studies via a revised continuous monitoring system, to ensure improved data submission rates in 2012/13.

NCEPOD Study	Eligible	Participated	% Submission	Status
Perioperative care	Yes	Yes	100%	Complete
Surgery in Children	Yes	Yes	65%	Complete
Cardiac Arrest	Yes	Yes	40%	Complete
Bariatric Surgery	Yes	Yes	On-going	On-going
Alcohol Related Liver Disease (ARLD)	Yes	Yes	On-going	On-going

We have received and reviewed the reports of two of these studies in 2010/11 (Perioperative Care and Surgery in Children) and intend to review all applicable recommendations relating to these studies as appropriate throughout 2012/13.

In addition, the Trust is also continuing to evaluate recommendations released in two previous NCEPOD studies published in 2010; a summary of the work that has resulted from these recommendations is shown below.

- **Parenteral Nutrition** – this has become the main focus of the Trust's Nutrition Steering Group, and the following actions have been undertaken:
  - annual audit of parenteral nutrition
  - risk assessments carried out in response to non-compliance/disagreement with the NCEPOD recommendations
  - ward surveys on the views of nurses and consultants on parenteral nutrition and nutrition support
- **Care of the Elderly who have Surgery** - two multi-disciplinary working groups have been established in order to focus on the pathways of acute abdomen and fractured neck of femur patients; work is currently underway in both groups to improve the patient journey, experience and outcomes for individuals treated for these conditions.

Patient Experience

Improving Quality Programme

What To roll out sustainable quality improvements across all clinical areas within CMFT

How much 100% day case areas

By when End Sept 2011

Outcome

14 week programme delivered across all agreed day case areas
3 master classes for matrons and lead nurses held
Master classes for matrons and lead nurses

Progress ✓

The Improving Quality Programme aims to achieve a level of standardisation across CMFT, with appropriate levels of flexibility built in to each standard to ensure changes are appropriately applied to all clinical areas.

The 14 week programme is structured using master classes and action learning for Ward champions. This supports the implementation of the Improving Quality data board, standardisation of colour coding stock in non-patient areas, embedding the use of multi-disciplinary status at a glance boards and ensuring the use of SBAR and core huddles for nursing shift handovers.

In addition, the programme starts to embed knowledge and skill in agreed improvement methodologies, thus ensuring a level of capability for continuous improvement across the organisation.

Improvements achieved

Based on the agreed day case areas (n=7):

- Completed 14 week programme (approximately **140 staff** involved) **100%**
- Improving quality data board established **100%**
- Colour code standards implemented in non-patient areas **100%**
- Status at a glance boards established as part of daily work **100%**
- SBAR and Core Huddle implemented for shift handovers **100%**
- Assessed as achieving bronze, silver or gold **100%**

All areas subsequently transitioned to full ward accreditation for on-going monitoring

Additional Improving Quality sessions were held including half day master classes for matrons and lead nurses. Through these sessions, another **160 staff** were taught the core tools and methodologies for continuous improvement.

Activity clocks have been completed to analyse the percentage time spent by registered nurses on direct care. Based on the ward and day case areas (n= 58) that reported in January 2012 (86 % returned):

- Registered nurses spend at least 50% of the time providing direct care in **92% wards**
- Non-registered nurses spend at least 50% of the time providing direct care in **75% wards**

Further improvements identified

- To continue roll out of 14 week programme and Trust wide standards to Trafford wards and Emergency Departments.
- To support Trust wide improvement work and the delivery of key objectives set nationally, regionally or locally by developing master classes in the IQP methodology and Trust wide standards that are rolled out in line with the Brilliant Basics calendar.

Leadership Walk Rounds

The Board of Directors has committed to undertaking Senior Leadership Walk Rounds in all of our clinical wards and departments, the feedback from patients during these is overwhelmingly positive with a high level of satisfaction expressed with both care and services received. The walk rounds have continued in 2011/2012 and have also included our non clinical departments. These have proved to be very successful with staff reporting feeling very positive about having a regular opportunity to meet with members of the Board. A programme for the Walk Rounds has been developed for the coming year which includes all of the corporate support services, as well as continuing to meet with staff and patients as part of the clinical walk rounds.

Commissioning for Quality and Innovation (CQUIN)

A proportion of Central Manchester University Hospitals NHS Foundation Trust income in 2011/12 was conditional upon achieving quality improvements and innovation goals agreed between Central Manchester University Hospital NHS Foundation Trust and any person or body they entered into a contract agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation Scheme payment framework. Further details of the agreed goals for 2011/12 and for the following 12 month period are available online at www.cmft.nhs.uk.

In 2011/12 we received a total of £6.2M from a total of £7.2M in income for the achievement of our CQUIN goals.

Organ Donation ✓

Over the past year, the option for organ donation has become a normal part of end of life care within the Accident and Emergency Department, Adult and Paediatric Intensive Care Units. More families are offered the option to donate their loved ones' organs in the tragic event of their death.

The feedback given by parents whose children have donated is that they have found comfort in knowing their child has been able to help others after they have sadly died.

The Trust has a Medical and Nursing lead for organ donation and, some time ago, established a committee to raise awareness and coordinate improvements to donation rates. This has been done by providing education and information to staff on how to approach and support families through this decision making process.

The Trust has succeeded in its aim of improving organ donation referrals during 2011/12. We aim to continue this work in 2012/13 and to also improve tissue donation rates.

End of Life Care

What To improve the quality of care our patients and their loved ones experience at the end of life. To increase awareness and compliance with usage of the Integrated Care of the Dying Adult Pathway (ICP) and promote use of the ICP as a best practice supportive tool in all expected deaths.

To produce a policy for Care after death leading a cultural, organisation-wide change in the affording of dignity to the deceased persons in their final journey through the Trust.

To surpass a 60% success rate that all in-patient expected deaths are supported by the pathway.

How Use of the electronic patienttrack early warning score (EWS) system to track patients whom have had their EWS suspended due to commencement of the ICP and end of life presentation. This enables the End of Life Care Team to track patients in real time and target that ward / area to offer additional support to patient, carers and audit the ICP completion.

By When March 2012

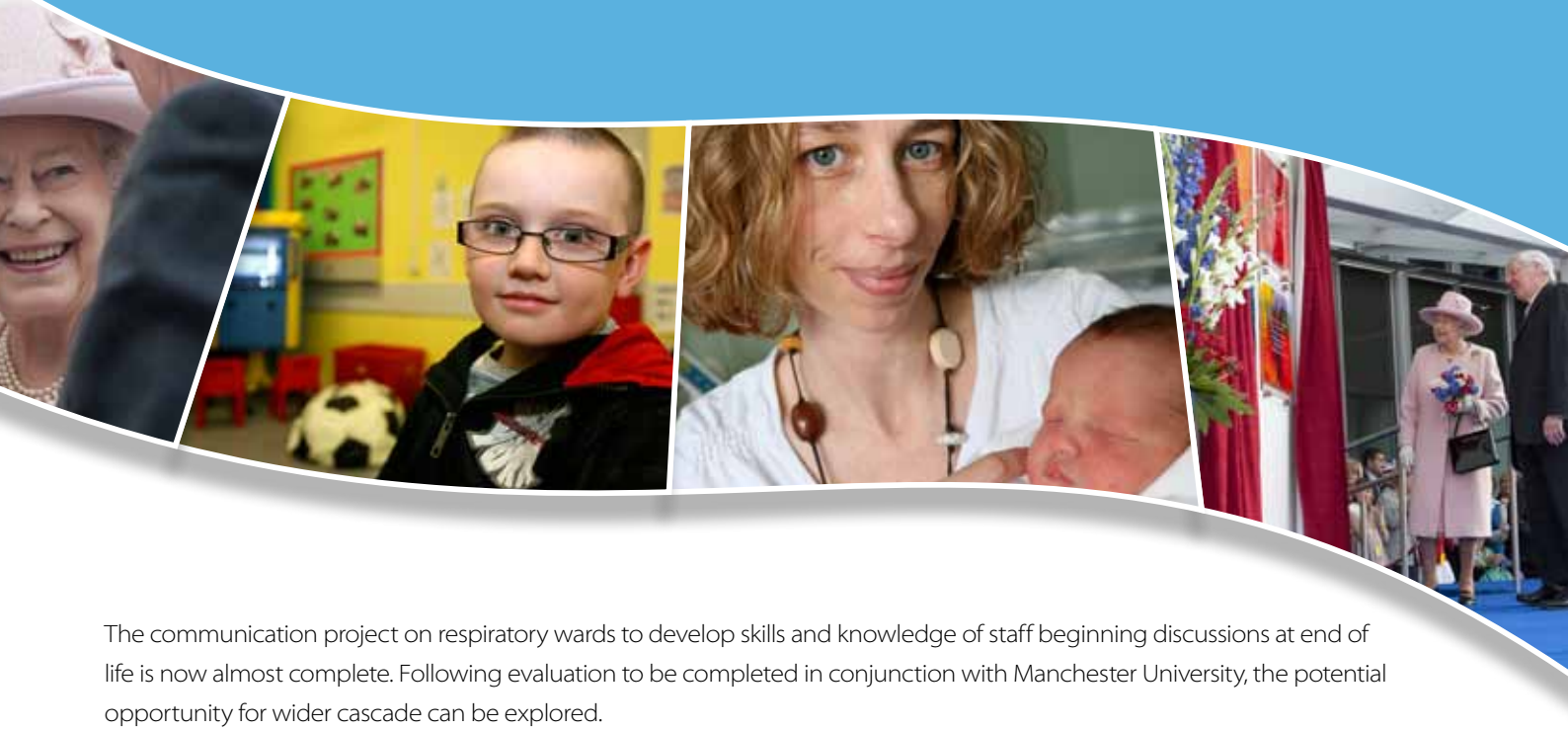
Outcome Achieved 76% by the end of the year

Progress ✓

2011/12 saw a strategic drive to focus improved end of life care ensuring that the use of the Care of the Dying Adult Pathway was implemented in all adult in-patient areas. This was supported by the appointment of two End of Life Care facilitator nurses to underpin and support the care delivered on the Trust adult wards.

The Palliative Care and End of Life team has led the revision and implementation of Version 12 of the Liverpool End of Life Care Pathway which provides the multi-disciplinary team with a framework for evidence based best practice standards of care to improve the experience at end of life for patients and relatives. This was reviewed followed by a consultation with all staff groups and constructive feedback was sought on how best to deliver the pathway, engaging the whole team making the document user friendly. The launch and review of the pathway is reported through the Trust's End of Life Steering Group

Work began last year in the production of the Trust Care of the Deceased Person (Adult) policy, following the 2011 National guidance. The Trust policy was ratified in December 2011 and the launch with an educational strategy began on the 1st of February 2012.



The communication project on respiratory wards to develop skills and knowledge of staff beginning discussions at end of life is now almost complete. Following evaluation to be completed in conjunction with Manchester University, the potential opportunity for wider cascade can be explored.

The Specialist Palliative Care team undertook a project supported by the Patient and Public Involvement team, seeking feedback on the service as part of their clinical effectiveness work. Facilitated feedback from relatives and carers was undertaken with the aim of delivering service improvements. To further support this, staff user feedback was also initiated at the same time with 73 respondents. This information has been used to carry forward a number of work streams including the formation of a working party looking at how we communicate at end of life with Non-English speaking service users.

Improvements Achieved

- Implementation of updated Integrated Care of the Dying Adult Pathway (ICP) adapted from Version 12 Liverpool Care of Dying Pathway
- Increase in the use of End of Life Pathway by 20% in 6 months.
- 84% of patients being cared for on the End of Life Pathway have had preferred place of care identified
- The End of Life Care team project managed and supported the conversion of the syringe drivers regularly used with medication at end of life. The new syringe drivers are available across the Trust and community services
- May 2011 saw a successful Trust wide support to the National Dying Matters Campaign display stands in the main atrium's of the Trust afforded the opportunity for the topic of 'Dying Matters' to be discussed openly following the national agenda
- During this event the EOL team visited residents at a local Nursing Home undertaking artwork featuring tea pots. The aim being a cup of tea can help open discussion when entering a conversation about what end of life meant to the residents
- September 2011 saw the EOL Brilliant Basics campaign events focussed raising EOL awareness and educational issues to over 600 Trust staff
- The Trust submitted data to the National Care of the Dying Audit 3rd round

Further Improvements Identified

- Spring 2012 audit of end of life pathway to reflect feedback from users following the revision
- Project report produced with renal patients to improve discussions with patients in terms of end of life/limitations of treatment
- Work with the Manchester Eye bank to increase awareness and opportunity for corneal donation
- Upgrade to the facilities for the viewing of the deceased person, as a follow-on to the launch of the Care of the Deceased Person (adult) policy
- Work streams in the Emergency Department and Critical Care areas supporting implementation and review of the pathway specific to those areas

Provision of Same Sex Accommodation

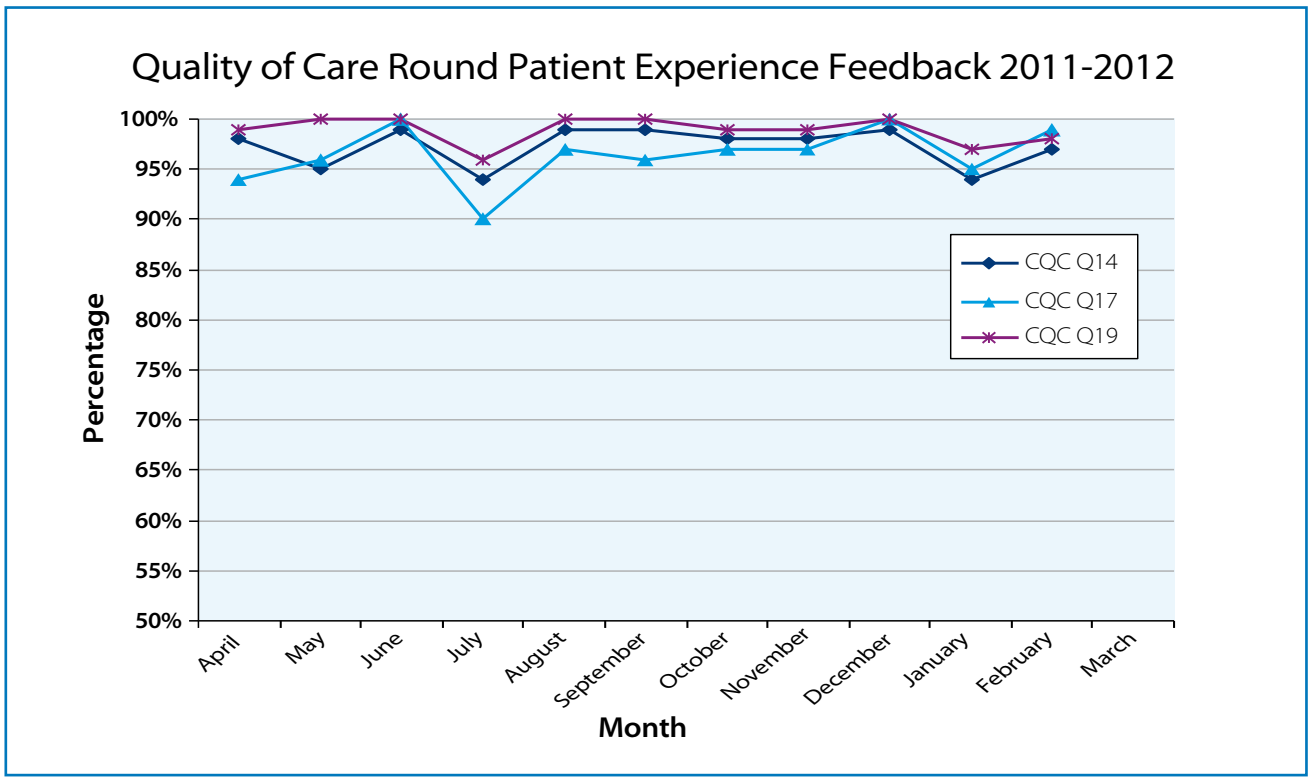
The Trust has undertaken a significant amount work over the past 2 years in order to enable the requirements in relation to the same sex accommodation guidelines. This work enabled the Trust in March 2011 to declare compliance with the virtual elimination of mixed sex accommodation.

The Trust has moved to single sex wards where possible and has put in place a range of operational changes that eliminate mixed sex accommodation and address specific dignity issues across the services

The Trust has 66% of the clinical areas as single sex wards, with the remaining clinical areas providing single sex bays with dedicated single sex bathroom and toilet facilities.

Since June 2009, patient experience has been measured on a monthly basis via the Ward Managers Quality of Care ward round process using pre determined Department of Health questionnaires

These audits have demonstrated an improvement in patient perceptions in terms of same sex accommodation and privacy and dignity. The data from April 2011 to date shows that 95% of patients surveyed believed that that they had not shared a room or bathroom with a member of the opposite sex. Where patients had identified that they had experienced mixing this was within critical care environments.



Other Patient Experience Information

Brilliant Basics

Brilliant Basics captures a number of initiatives launched under the Trust Quality Campaign to measure the quality of care from a patient's perspective. Each month sees a different focus from the Brilliant Basics Team, involving talks, e-Shots and the distribution of the latest research evidence. CMFT researchers have contributed to Brilliant Basics, illustrating how Nursing, Midwifery and Allied Health Professionals research in Manchester contributes directly to the provision of evidence-

based services at the Trust. For instance, June 2011 saw a focus on Falls Prevention, with Professor Chris Todd from the School of Nursing, Midwifery and Social Work at The University of Manchester presenting the latest research evidence.

The Brilliant Basics Calendar 2011/2012 was developed following feedback from Ward Managers and team leaders to assist staff to improve the 'fundamentals of care'. The concept was specifically developed to address the following objectives:

- Align changes/feedback to national/local events/audits
- Reduce poster 'blindness' and change 'exhaustion'
- Promote and ensure delivery of CNO High Impact Interventions
- Assist all staff to understand their role in delivering safe, effective and quality care
- Provide clear consistent message
- Provide constructive feedback from patient stories, incidents and complaints

A review of the Brilliant Basic Calendar process for 2011/12 has indicated that there have been a number of successes achieved aligned to planned objectives:

- Greater individual awareness of what matters to our patients
- Greater ownership for improving the fundamentals of care
- Staff feeling less overwhelmed with guideline/policy changes as these have been aligned to the monthly topic
- Integration of literature reviews with the monthly topic
- Staff feeling enabled to make changes within their area

Feedback from the review indicated that the concept of Brilliant Basics Calendar should be continued in 2012/13.

Therefore the concept will continue during 2012/13, but the following key changes will be implemented:

- To base the calendar on a quarterly format providing 3 months for each topic
- Promotion of the topics through team events such as displays and seminars
- Topics to align with other improvement work such as IQP and staff experience work
- Utilise available resources to provide an evaluation framework for the Brilliant Basics Calendar
- To promote the concept of brilliant basics wider than the nursing and midwifery workforce
- To establish quarterly kick-off events to celebrate achievements from each Division and launch the new topic

A number of mechanisms have been used to establish the overarching topics for the 2012/13 calendar. These include the preliminary results of the 2011 in-patient survey, Quality of Care ward round themes, CQUIN requirements for new financial year and feedback from senior nursing and midwifery staff.

The topics for 2012/13 will be:

- April-June 2012 — Communication
- July-September 2012 — Harm Free Care
- October-December 2012 — Leaving our Care
- January-March 2013 — Care & Compassion

Equality Performance Improvement Toolkit (EPIT) and Equality Delivery System (EDS)

In accordance with national requirements, the Trust has submitted to NHS North West, its self assessment report on progress towards excellence in the 5 goals for equality of outcomes for everyone. That includes both patients and staff, regardless of their gender, race, disability, sexual orientation, transgender background, religion or belief, age or social background. In January 2012, the EPIT system was replaced by the Equality Delivery System (EDS) and the Trust is currently developing its Plan and Strategy to take this forward.

Ward Accreditations

What To develop and complete formal nursing accreditations across all clinical areas within CMFT

How much 100% inpatient wards and day case areas

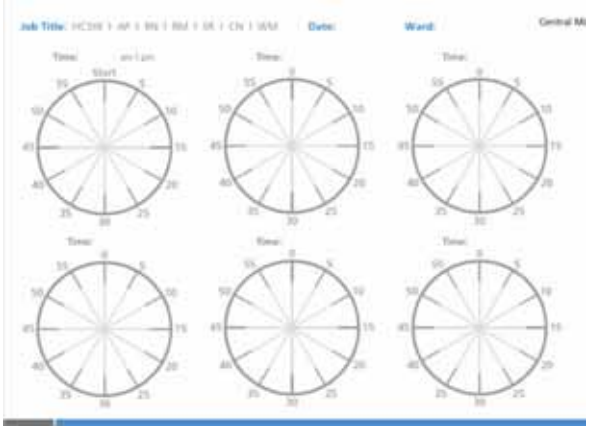
By when End Jan 2012

Outcome All inpatient and day case areas formally accredited as bronze, silver or gold

Any areas identified as white assessed as safe or unsafe with appropriate supportive actions being agreed and completed within agreed timescales

Progress ✓

The ward accreditation process aims to achieve a level of assurance for the Trust Board of Directors that wards are consistently delivering high quality care across four categories:



- Culture of continuous improvement, including leadership, team culture and use of evidence based practice
- Environment of care, including infection control an safety standards
- Communication about and with patients, including team communication, documentation and patient perceptions
- Nursing processes, this category is specified year on year with medications and meals being the focus for 2011/12

The ward accreditation process has been developed to last 4 hours for each ward area. A team, comprising of one of the senior nursing team, a member of the service improvement team and the relevant head of nursing, complete a review of the ward data then spend time in the ward area, observing practice and gathering views from staff and patients. The team analyse the findings by triangulating the on the day observations, staff and patient feedback and trends over time seen in the data. This leads to a formal scoring of a number of standards resulting in an overall result of bronze, silver or gold. If any standard does not meet the Trust agreed minimum standard the ward is identified as white and a package of support is provided to ensure all relevant actions are completed in a sustainable way. Wards that achieve gold are celebrated through the 'We Are Proud of You' award scheme.

Improvements achieved

Based on the inpatient wards and day case areas (n=56):

- Completed accreditation process 100%
- Achieved bronze, silver or gold (with 12 wards achieving Gold) 89%

- Identified as white and safe (n=6) 11%
- Identified as white and unsafe (n=0) 0%
- White wards on target with support package and action plan (n=6) 100%

Data collated from the ward quality dashboards demonstrated improvements of at least 10% resulting in scores of >90% in a number of specific areas including:

- Use of Trust wide standardised communication tools
- Trust risk assessments completed and documented within agreed timescale
- Ensuring safe medications – drug fridge locked
- Improving meals – offering all patients hand wipes

Further improvements identified

- To further develop and complete 2nd accreditation on all ward and day case areas at central site
- To complete diagnostic version for baseline position of all Trafford wards

Measurement and Assurance

External Regulation

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 registered with no conditions.

The Care Quality Commission has not taken enforcement action against the Trust during 2011/12.

Central Manchester University Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The Trust continues to be registered with the Care Quality Commission and works closely with them on maintaining high quality services. This year they visited a number of areas of the Trust including our Short Break Service for adults with a Learning Disability. The CQC found that the service was meeting all standards that they reviewed and set out below is an example of the type of comments made in their report.

"We observed the care provided to people using the service. All the staff we observed engaged very well with people using the service. Staff appeared to have positive and warm relationships with people using the service. Staff were very respectful of people, saying please and thank you to them and giving them choices, for example about what to eat and how to spend their time. People's choices were respected and staff supported them to be as independent as possible. Staff appeared to know people well and they were aware of how each person communicated, for example hand gestures and other non-verbal forms of communication. This enabled people to be as involved as possible in their care. Staff encouraged people to maintain their dignity." **February 2012**

With the recent distressing news of poor quality care being delivered in some services for vulnerable adults in other parts of the country we are proud to be delivering this standard of care in our own services.

They also visited the Manchester Royal Infirmary to review the management of nutrition and staff training, both were found to meet the required standards.

"We saw evidence in the records that everyone had a nutritional assessment using the Malnutrition Universal Screening Tool (MUST) when they were admitted and at regular intervals throughout their stay. Where people were identified as being at risk of malnutrition they had a care plan in place to meet their nutritional needs. We saw evidence in the records that these people were referred promptly to a dietician, they were prescribed nutritional supplements and their food intake and weight was closely monitored. We also saw evidence that people were reviewed quickly by a doctor if their weight changed unexpectedly. Records of nutritional care were complete and up to date. On all the wards we visited the nursing staff performed hourly rounds which included checking whether people needed mouth care and asking if people would like a drink. Fluid balance charts were completed where people had been identified as being at risk of dehydration."

We were also extremely proud to announce the achievement of National Health Service Litigation Authority (NHSLA) assessment at level 3 for both our General and Maternity services. The NHSLA undertakes rigorous and detailed assessment of the organisational management of safety across all aspects of service delivery. This includes clinical care, staff training and risk management arrangements. Level 3 is the highest level of achievement that a Trust can attain and we are one of only a small number to have this for both General and Maternity Services. This recognises an immense amount of hard work over the last few years by both frontline clinical staff and the various support teams to improve safety and quality.

The Trust Clinical Standards Committee continues to oversee the management of external regulatory compliance and performance assessment.

Research and Innovation

Research and innovation is at the forefront of each of our five hospitals and is the cornerstone of first-class healthcare. In 2011 we have continued to strengthen our research resources through the National Institute for Health Research Manchester Biomedical Research Centre (BRC), with our main academic partner The University of Manchester.

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

Excellence in research

In partnership with The University of Manchester, we have been chosen by NIHR to run one of only three Musculoskeletal Biomedical Research Units (BRUs) in the UK. The highly regarded Manchester Musculoskeletal Research Group successfully applied for just under £5m to set up a nationally recognised BRU, which will become operational from the 1st April 2012. On top of the awarded funding from NIHR, the Department of Health has also agreed to provide a capital investment of £1.27m towards state-of-the-art equipment for the unit.

The research team, led by Professor Deborah Symmons, will pioneer new methods of assessing early response to treatment in adults and children with MSK disease, new ways or preventing rheumatoid arthritis and its complications, new therapies for arthritis and new resources for patients to help them achieve the best response to treatment.

Improving our research figures

During 2011/12:

8126	patients receiving NHS services, provided or sub-contracted by the Trust in 2011/12, were recruited to participate in research approved by a research ethics committee
£14.5m	of external research funding was awarded to researchers working within the Trust
789	clinical research studies were underway, of which
46	were in the follow-up stages
286	new studies were approved, of which
242	were approved within 30 working days
147	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
147	Research Passports were processed, allowing external researchers access to our facilities

The next generation of researchers

We are dedicated in developing the next generation of researchers through the NIHR Manchester BRC Academy for Training and Education. In October 2011 the BRC awarded six one year clinical research fellowships to young researchers in a variety of areas including endocrinology, paediatrics and maternal and fetal health. These awards are in addition to the previous 19 fellowships the Training Academy has awarded to researchers since 2008. Three of these fellows went on to be awarded prestigious external fellowships from the Medical Research Council in 2011.

Research in numbers

4mm	is the size of a new stent device used at the MRI in the first four operations in the UK to repair abdominal aortic aneurysms. The stent is designed to enable a much broader group of patients to benefit from minimally invasive surgery
8	global first recruits to trials at the Children's Clinical Research Facility (CCRF) based in the Royal Manchester Children's Hospital. The facility has had overwhelming success and has doubled its nursing team since 2009
10	years ago the Wellcome Trust Clinical Research Facility opened itsdoors, since then
450	clinical trials have taken place at the facility
700	patients will benefit each year from a new genetic testing service for patients with inherited blindness, developed by BRC Director Professor Black and colleagues
5000	samples were banked by the BRC Biobank in its first year of operation

Innovation

We continue to drive innovation within the NHS, with the renal team at Manchester Royal Infirmary becoming one of the first winners of the NHS Innovation Challenge Prizes. The team was awarded funding for their redesign of existing dialysis provisions in hospitals. Their innovation not only means that some patients can now choose home haemodialysis, but is projected to make an annual saving of approximately £1m based on 70 patients receiving home dialysis.

Manchester Former Royal Eye Hospital

Manchester currently sits in one of the UK's top three biomedical clusters, which is set to be utilised through the redevelopment of the Former Royal Eye Hospital. The site will provide an international centre for companies working in

healthcare research and increase collaboration opportunities. Encouraging more innovation into the NHS will lead to improved care and treatment for our patients.

Information on the Quality of Data

Central Manchester University Hospital NHS Foundation Trust submitted records during 2011/12 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number
  Admitted patient care: 97%
  Accident & Emergency: 80%
  Outpatients: 97.9%
- which included the patient's valid General Practitioner Registration Code
  Admitted patient care: 100%
  Accident & Emergency: 100%
  Outpatients: 100%

The Trust information Governance Assessment Report overall score for 2011/12 was 84% which is a 4% increase on 10/11. Although we are pleased with the increase in score the Trust can still improve on its completeness of information governance training and there are plans to make this mandatory for all staff in 12/13.

Central Manchester University Hospitals Foundation Trust will be taking the following actions to improve data quality:

- restructuring the Data Quality Department to better align to the hospital services and administrative functions
- development and implementation of a new set of data quality reports
- developing and improving the system training across the organisation
- improving the extraction of information from IT systems (community services)

Central Manchester University Hospital NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the accuracy rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical code) are;

- Primary procedure 91.5%
- Secondary procedure: 89.2%
- Primary diagnoses: 87.6%
- Secondary diagnoses: 85.9%

These results were from a sample size of 206 FCEs. 100 of these were from a random sample and the rest from General Surgery. These errors were primarily non coder errors which relate to errors in the documentation. There is a detailed work programme in place which looks to continue our improvements in data collection and clinical coding. These results should not be extrapolated further than the actual sample audited.

Update on Our People

Improving capability and qualifications of staff

A revised strategy for learning and development sets out a number of objectives to assist in the development of a cohesive, sustainable approach to workforce development, promoting lifelong learning that supports and makes explicit the Trust's commitment to equipping all staff with the skills, knowledge and attitudes required to deliver and improve services. The Trust is working to develop and sustain a culture and an environment where learning is recognised and celebrated as being fundamental to its success; not in isolation but also in relation to our patients, service users, clients, carers and partners. The Trust's training requirement is regularly reviewed to ensure interventions are offered in line with the Trust's Vision and Key Priorities and offerings are continually evaluated in order to improve the provision of service that is of the highest quality, fit for purpose, value for money and which demonstrates a positive return on investment.

The mandatory training agenda is continuously reviewed to ensure that it meets the necessary legislative requirements, best practice and dovetails with the Core Skills framework, to support and influence continual improvements in quality, safety and understanding of relevant responsibilities. By bringing in the use of a learning management system that is part of the Trust's personnel system, improvements have been seen in the efficiency and accuracy of recording training requirements and completions, and managers can access the system directly to ensure the training and development of their teams is up to date and can address any shortfalls.

The use of e-learning is being promoted introducing national content and developing local packages, providing a blended learning approach that gives staff the opportunity to train without spending significantly more time in a class room environment resulting in a positive effect on productivity and efficiency. Numeracy and Literacy programmes that were offered in a classroom setting are now available via e-learning for greater flexibility and support effective communication and reduced errors, such as in relation to drug calculations.

To ensure that we are able to deliver the changes required to provide high quality health care, it is crucial that our support staff are prepared and equipped with the necessary qualifications, skills and competencies to perform effectively within their roles. The Trust has implemented new apprenticeship programmes for support staff which will ultimately improve the quality and provision of our current education programmes ensuring staff working within support roles are fit for purpose. The Organisational Development and Training department has now become an accredited centre to deliver level two and three 'apprenticeship' programmes within healthcare support and healthcare science as part of a suite of qualifications available through the qualifications and credit framework. The programmes are offered to both existing staff and new employees. The apprenticeship programmes replace the old National Vocational Qualifications and incorporate three key elements which include a Qualification Credit Framework diploma, Business and Technology Education Council certificate and functional skills qualification. Generally level two apprenticeships take 12 months to complete and a level three will take 18 months. Ultimately, by offering these programmes, the organisation will benefit in many ways, such as, by offering apprenticeships we are able to become a competitive employer of choice for jobs seekers; attract high quality recruits and improve the skills and productivity of existing staff; increases staff morale and retention.

Leadership

Through our leaders, we aim to support the Quality Strategy to improve the patient experience, with the ultimate aim of enabling managers to operate in a complex demanding service, which meets the demands of ever increasing customer expectations, an ageing population and the negative health impacts of economic instability. Managers clearly face many challenges in delivering financial targets whilst managing staff and leading services and people.

In order to develop the leadership and management capacity and capability required, the Leadership and Management Strategy has been developed focusing on developing leaders and managers through various methods to increase personal effectiveness and enhance service delivery and team effectiveness. We aim to enhance the leadership and management skills for staff at all levels by offering a range of accredited programmes; National Leadership and Management Competency Framework and the NHS Leadership Framework (LF) as aspirational models.

An Institute of Leadership and Management (ILM) Level 5 Certificate in Management is offered in house. This is a 12 month programme aimed at Band 7 middle managers and above; successful candidates achieve an accredited qualification, whilst enhancing their managerial, and leadership, skills and expertise. Delegates are also required to work on a service improvement project which is designed to meet the Trust objectives specifically in relation to improving quality of care and cost efficiency savings.

An ILM Level 5 Certificate in Leadership commenced in October 2011, offered as part of the newly appointed consultants 12 month development programme. A Clinical Directors programme is now being developed; this will be offered to all existing Clinical Directors across the Divisions and will entail a series of master classes, workshops, psychometric test and participation within an action learning set.

Our current Key Skills for Managers programme, designed to support first line managers who may need to develop skills, knowledge and awareness to be an effective people manager is being reviewed and will be aligned with an accredited qualification, ILM Level 3 Award. This eight week course will be offered Trust wide and will be targeting Band 6 and below who hold managerial responsibility of others and will provide them with an insight into the functions, knowledge and skills required to be able to work effectively within a managerial role at their level.

The Leadership Framework 360 degree review is incorporated as standard as part of all our leadership programmes and facilitation of feedback reports in conducted internally giving leaders valuable self-awareness and feedback in order to continually drive for improvement.

Supporting Staff

Staff Support Services include occupational health which has recently been reviewed and the referral process brought online to improve the quality of the service and to reduce waiting times for staff. Preventive interventions aimed at reducing organisational causes of stress, include stress risk assessments and facilitated team work to address risks, coaching and guidance for managers about managing staff issues and psychological support and mediation for teams undertaking complex work or dealing with distressing incidents. Over the past year the service has increased the range of training and communication about workplace stress, and handling conflict; providing a range of programmes and bespoke workshops. These focus on helping staff and managers develop the skills to cope positively with workplace pressures. The service continues to provide counselling and psychological interventions to support employees on a self referral basis.

Staff Benefits & Incentives

In order to increase motivation and productivity, a range of staff benefits have been promoted to support staff such as childcare vouchers and an on-site nursery. Salary Sacrifice Schemes support staff in accessing the nursery and transport

including car parking and cycle to work combined with interest free travel loans and reduced cost coach and bus tickets. A new buying and selling of annual leave policy has been introduced to provide staff with flexible working options.

Recruiting and Retaining our People

Recruitment processes have been quality assessed this year with a new online recruitment system introduced in order to increase the speed of the recruitment process. A predictive recruitment tool has been developed to predict where nursing vacancies are likely to occur and how many nurses will need to be recruited. The process for group recruitment has been redesigned and implemented particularly for staff nurses and clinical support workers, along with work to standardise information, letters, forms and promotional materials.

Customer Service

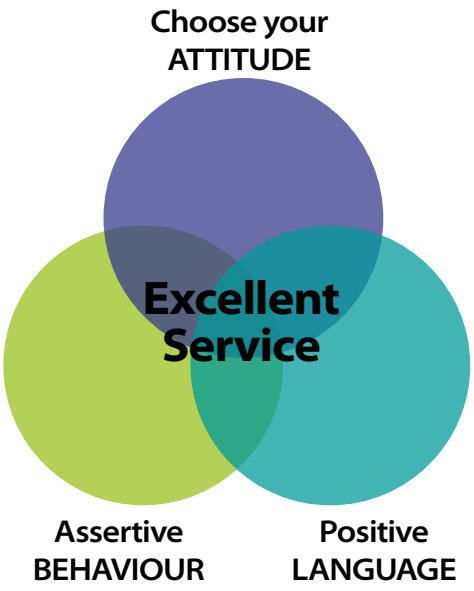
In support of the Trust wide Quality Campaign and supporting the NHS Values of Dignity and Respect, the CMFT Customer Service programme and Customer Service NVQ programmes launched across the Trust wide, following successful pilot programmes in the Dental Hospital.

The Customer Service programme puts Patients at the heart of everything that we do, but also broadens care to include their families, friends, visitors, communities – and each other. Departments, teams, suppliers, contractors, individuals all must work effectively together to deliver the best quality care for patients and extend care, compassion and respect to each other in the process.

The programme is underpinned by the NHS values of respect and dignity, commitment to quality of care, compassion, improving lives, working together for patients and everyone counts. The Trust programme aims to support staff in the ability, motivation and opportunity to enhance the service that we offer to customers. Groups create a vision of their ideal, best possible hospital and look at the barriers to excellent service delivery and how we can ensure the quality of service provision matches our aspirations. The course explores the skill of superior service by looking at three overlapping circles of service; choose your attitude, assertive behaviour and positive language to support staff to make a difference to the customers that they meet each and every day. Film clips are used to explore what excellent service, respect and dignity look and feel like and the impact of when that care is missing. Patients also attended the pilot programmes to share their real life experiences of service.

We offer a course aimed at staff and also offer a course tailored specifically to those with management responsibilities. This course covers the similar elements but learners are also prompted to coach, support and encourage their team members, to recognise excellent service and to develop improved performance and practices. Staff are supported to devise tangible action plans of how they personally can demonstrate their commitment to putting the customer first.

Principles, knowledge and skills are consolidated and embedded through the opportunity for staff to undertake accredited qualifications in order to recognise the skills they have developed and the standards of service they attain, along with Customer Service standards led by the surgical Division being rolled out across the Trust. The qualifications are being updated in line with the new National Qualification Credit Framework that has replaced National Vocational Qualifications.



Staff Recognition – We're Proud of You awards

The annual "We're Proud of You Awards" recognise the fantastic achievements of our staff. Every day our colleagues and teams go above and beyond the call of duty and these Awards allow us to acknowledge their outstanding contributions. All employees and volunteers at the Trust are eligible for the Awards and winners and those highly commended receive trophies, framed certificates to display in their work areas and Trust-wide recognition. Award categories include: Partnership and Involvement, Innovation, Improvement and Efficiency, Equality, Diversity and Dignity, Unsung Hero and Inspirational Role Model and many nominations represent quality improvements and development.

Achievements are celebrated within departments with a member of the Executive Team, accompanied by Trust governors and trade union representatives presenting the award to individuals and teams. Winners and those highly commended are invited to attend an annual gala dinner to celebrate their accomplishments, which was this year held at Gorton Monastery, thanks to much appreciated sponsorship from the staff lottery, Sodexo, Catalyst and Hill Dickinson. Wards who had achieved 'Gold' status as part of the Improving Quality Programme were also presented with certificates by the Executive team in their ward areas and took part in the celebrations at the Gala dinner, being presented with wall plaques to display at the entrance to their wards by the Chairman.

This recognition scheme has helped to ensure achievements are showcased and celebrated and dedication and hard work is appreciated.

Summary of performance - NHS staff survey

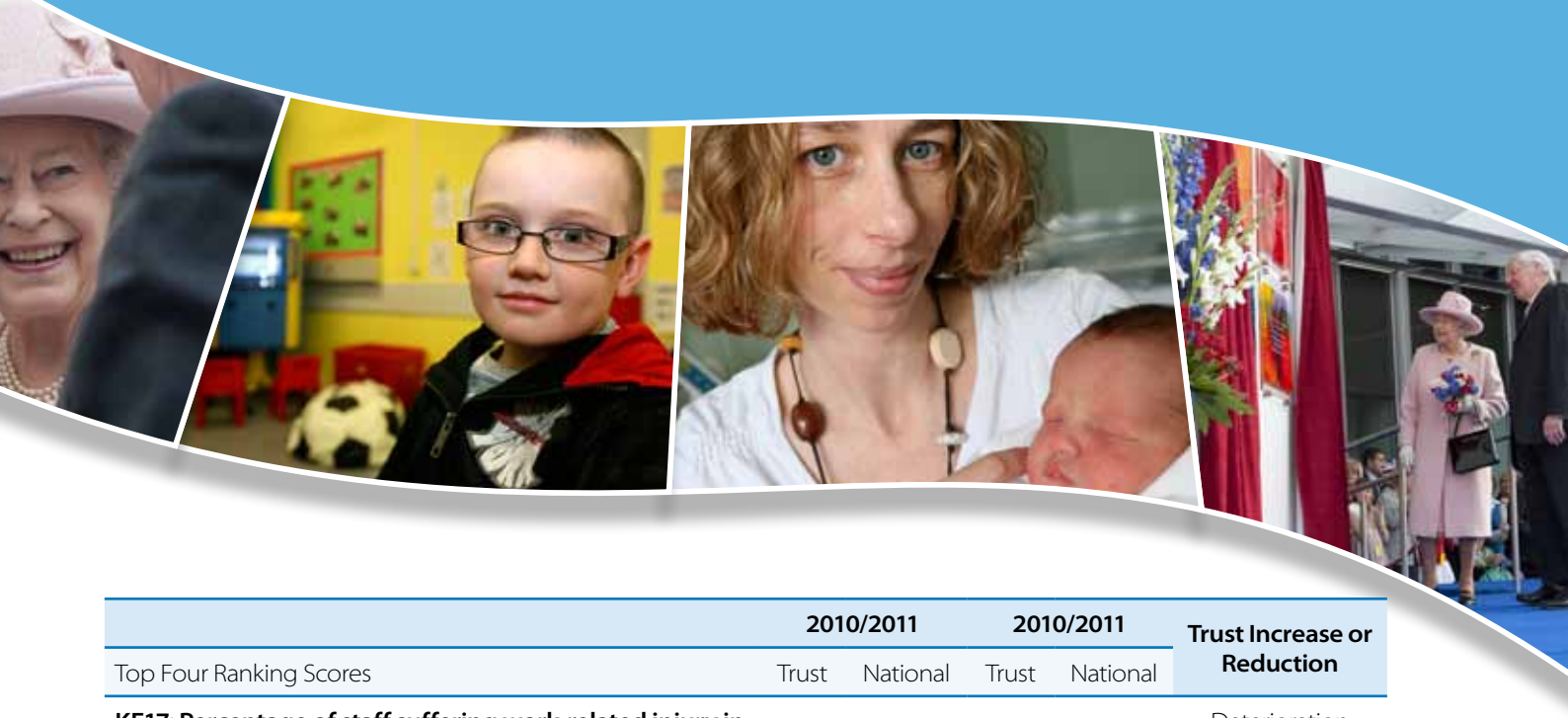
The response rate for the census results in 2011 has deteriorated slightly from last year which furthers the need for real engagement of staff to understand their reluctance to participate in the survey.

However, despite a challenging year for the Trust and a period of great transition for many staff, the overall picture of results has remained largely the same. Great strides have been taken in staff appraisals and e-learning continues to grow rapidly as a key method of training and development. The table below details the areas in which we are above and below average compared to other acute Trusts.

Sample Data

	2010/2011		2011/2012		Trust Increase or Reduction
Response Rate	Trust	National Average	Trust	National Average	
	43%	54%	37%	52%	-6%

	2010/2011		2010/2011		Trust Increase or Reduction
Top Four Ranking Scores	Trust	National	Trust	National	
KF21: Percentage of staff reporting errors, near misses or incidents witnessed in the last month (the higher the score the better)	99%	95%	99%	96%	No Change
KF14. Percentage of staff appraised with personal development plans in last 12 months (the higher the score the better)	63%	66%	78%	68%	Improvement +15%



Top Four Ranking Scores	2010/2011 Trust	2010/2011 National	2010/2011 Trust	2010/2011 National	Trust Increase or Reduction
KF17: Percentage of staff suffering work-related injury in the last 12 months (the lower the score the better)	11%	16%	13%	16%	Deterioration +2%
KF12. Percentage of staff appraised in last 12 months (the higher the score the better)	70%	78%	88%	81%	Improvement +18%

Bottom 4 Ranking Scores	2010/2011 Trust	2010/2011 National	2010/2011 Trust	2010/2011 National	Trust Improvement or Deterioration
KF19: Percentage of staff saying hand washing materials are always available (the higher the score the better)	40%	67%	48%	66%	Improvement +8%
KF29. Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell (the lower the score the better)	30%	26%	33%	26%	Deterioration +3%
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)	63%	74%	66%	74%	Improvement +3%
KF27. Perceptions of effective action from employer towards violence and harassment (the higher the score the better)	3.58	3.56	3.43	3.58	Deterioration -0.15

Voices Project

The Voices project was commissioned by the Board of Directors, sponsored by the Chairman and Non-Executive Directors to consider a radical approach to improve staff engagement and staff perception of wellbeing following the results of the 2010 staff survey. A working group was convened by the Chairman who commissioned a Trust wide programme entitled Voices. This resulted in 18 focus groups along with a consultation undertaken both online and using postcards involving a cross section of over 400 staff across all bands, Divisions and staff groups including medical staff.

Detailed results have been categorised according to themes, pulling out elements that staff felt most positive about, those they were dissatisfied with and those they most wanted to change. The key themes that emerged were:

- Leadership style and culture
- Staffing and patient care
- Facilities and resources
- Policies and processes
- Communication and change

Addressing these factors is expected to lead to improvements in staff engagement, motivation and job satisfaction. Action plans are in development and implementation of changes is expected imminently.

Part 3 Other Information

Performance of Trust against Selected Metrics

Achievements against key national priorities and National Core Standards

	2009/10	2010/11	2011/12	Status
Patient Safety Measures				
Improvement in VTE risk assessments carried out	**15.5%**	**90.1%**	**90%**	✓
Reduction in hospital acquired grade 3 or 4 pressure sores	**30 (Sept-Feb)**	**7 (Sept-Feb)**	**7 (Sept-Feb)**	✓
Reduction in serious patient safety incidents resulting in actual harm (those graded at level 4 or 5)	**49**	**29**	**15** (7 pending grade)	✓
Clinical Outcome Measures				
Reduce hospital standardised mortality ratio (HSMR)	**94.3**	**91.5**	**97.3**	−
Reduce the number of potentially avoidable cardiac arrests outside of critical care areas	**-**	**135** Actual cardiac arrest	**146***	✓
Improve stroke care Sentinel Audit composite score	May 2008 60%	March 2011 87%	Not due in 11/12	-
Patient Experience Measures				
Increase overall satisfaction expressed with pain management	-	76.14%	74.06%	✗
Increase overall satisfaction expressed with fluids and nutrition provided	-	71.73%	72.66%	✓
Increase overall satisfaction with the cleanliness of the ward or department	-	77.60%	75.96%	✗

**There has been an increase in bed days used and this figure actually represents a decrease in numbers of cardiac arrests per patient bed day. There has been an overall reduction in medical emergency calls.*

Achievements against key national priorities and National Core Standards

Definition	Indicator	2008/09	2009/10	2010/11	Target 2011/12	2011/12
Intelligent Board Report	C Difficile	242	179	106	96	82
Intelligent Board Report	MRSA	17	8	7	6	4
2008/09 Q4 2009/10 Full Year 2010/11 Apr-Dec * 2011/12 Full Year	Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	99.0%	94.1%	92.6%	93.0%	94.4%
2008/09 Q4 2009/10 Full Year 2010/11 Apr-Dec * 2011/12 Full Year	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%	98.8%
2008/09 Q4 2009/10 Full Year 2010/11 Apr-Dec * 2011/12 Full Year*	Maximum 31 days from decision to treat to start of subsequent treatment	n/a	100.0%	98.1%	96.0%	99.5%
2008/09 Q4 2009/10 Full Year 2010/11 Apr-Dec * 2011/12 Full Year	Maximum waiting time of 62 days from urgent referral to treatment for all cancers	88.0%	88.1%	82.0%	85.0%	87.2%
2008/09 Q4 2009/10 Full Year 2010/11 Apr-Dec * 2011/12 Full Year	Maximum waiting time of 62 days from screening programme	n/a	n/a	74.7%	90.0%	93.6%
Intelligent Board Report	18 weeks maximum wait from point of referral to treatment (non admitted patients)	98%	98%	97%	95%	96.7%
Intelligent Board Report	18 weeks maximum wait from point of referral to treatment (admitted patients)	91%	92%	88%	90%	93.6%
QMAE - reported	Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	97%	98%	96%	95%	95%

Feedback from Stakeholders

Manchester Local Involvement Network

Manchester LINk has developed a positive and ongoing working relationship with key staff at Central Manchester University Hospitals NHS Foundation Trust (CMFT), regular liaison meetings are held with the organisations Chief Nurse and Deputy Director of Nursing.

Manchester LINk conducted a series of Enter and View visits at the Medical Assessment Units during 2011 /12 and would like to thank CMFT for their cooperation and responses to the subsequent report and recommendations that were published.

The 2011 /12 Quality Accounts developed by CMFT remain clear, concise and provide an effective overall picture of the current status of the Trust and the areas that it wishes to improve for the benefit of its patients.

Manchester LINk were presented with a draft version of the Quality Accounts in April 2012 alongside an explanation of how the Accounts were compiled. Manchester LINk is satisfied that the Quality Account appropriately focuses on

- Patient safety
- Patient experience
- Clinical effectiveness

Manchester LINk are satisfied that CMFT had set itself some very challenging targets for 2011 /12, some of which it was unable to meet. However, we are impressed and satisfied with the explanations provided for not being able to reach the targets and also the honesty in which this was delivered.

Further, we are equally satisfied with the targets CMFT has set itself for 2012/13. We endeavour to continue working together in a positive manner.

The LINk urges the Trust to continue to work on a more reader-friendly version of the Quality Account, using the insights and techniques developed by such bodies as the Plain English Foundation - we believe this would be an addition to the report, and would be well worth putting resources into it, given the increasing cl imate of accountability to patients and public of NHS Trusts.

Michael Kelly
Chair of the Manchester LI Nk Steering Group
May 2012

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Feedback from the Governors

The work of the Governors on the Patient Experience Group is focused on ensuring that the Trust provides the best care for patients and families.

The breadth of care delivered by the Trust is vast and continues to grow, so the challenge going forward is to ensure all clinical areas are well supported.

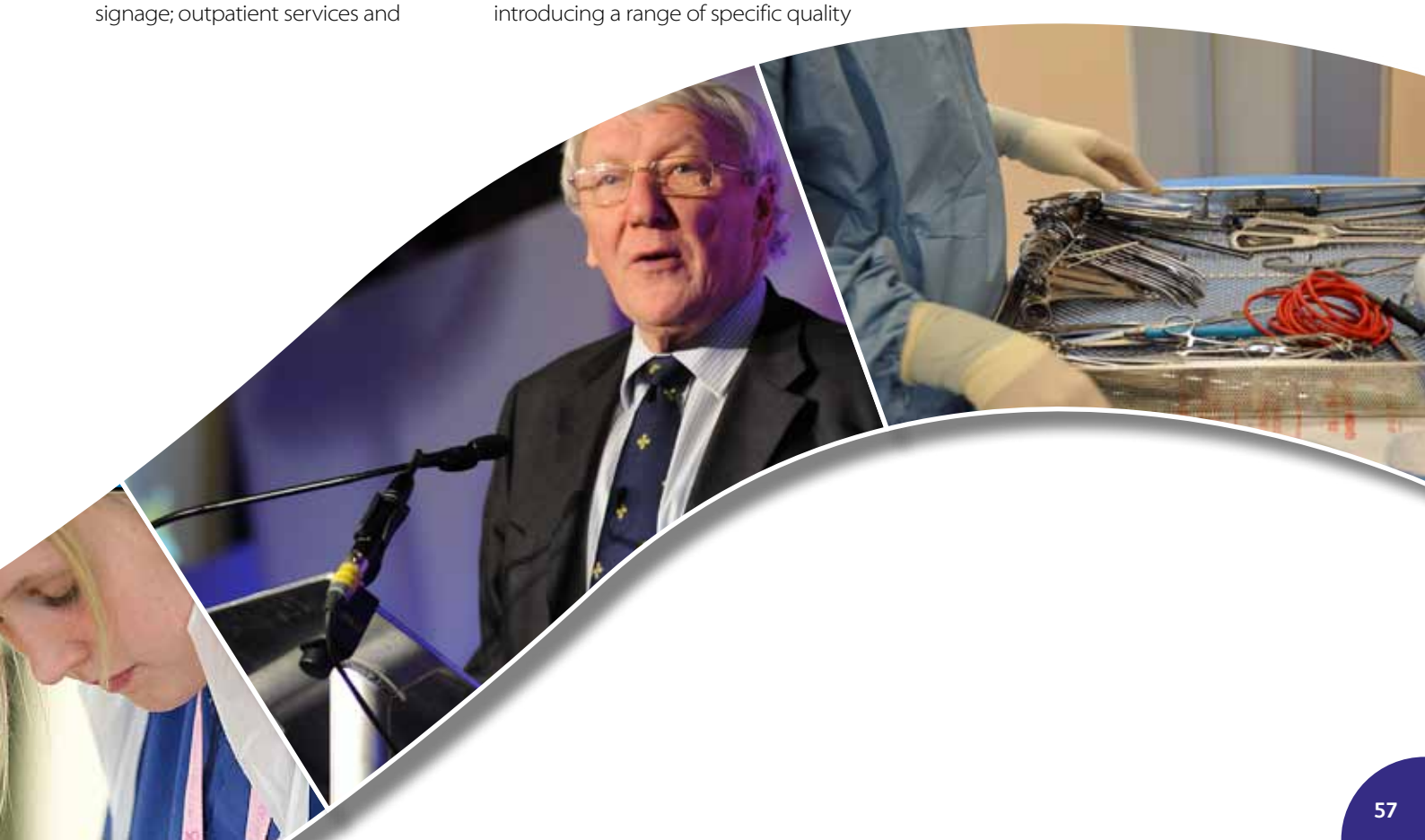
The Governors have continued to be included in a wide range of initiatives, ranging from review of food services; signage; outpatient services and complaints management, to name a few.

The Clinical Team have presented to the Governors on a number of occasions highlighting the excellent work being undertaken and also being honest in their aspirations and plans to continually improve services where they can.

Over the past year the Trust has continued to seek improvement in care, not only by meeting national regulatory standards, but by introducing a range of specific quality measure that clinicians are involved with.

The Governors are well supported by Brenda Smith, Non Executive Director, who provides a direct link to the Trust Board.

Jayne Bessant
Chair of Patient Experience Working Group



Health and Wellbeing Overview and Scrutiny Committee

Manchester City Council's Health Scrutiny Committee welcomes the opportunity to comment on the Central Manchester Foundation Trust Accounts for 2011-12.

Members of the Committee have been given the opportunity to comment and this statement includes a summary of their responses.

The Committee has noted the priorities for improvement for 2011/12 and that the

Trust has achieved 17 out of 19 of the targets set for these priorities.

The measures of patient experience highlighted on page 7 of your Quality Accounts document, show that four out of five of the feedback scores for questions asked of patients about their experience have seen a reduction on the previous year. This is disappointing, but we hope that the Trust will work to improve patient feedback over the next year. We note that electronic real time patient feedback devices have now been introduced to allow patients to report opinions about their care. This has made it easier for patients to provide information and it has also increased the number of patient responses. These can be collated regularly to allow the Trust to monitor patient views.

The Committee has monitored the transfer of community services from the Primary Care Trust since 2010. We note that over 45 community services and 100 staff have transferred to the Trust in this period. Last year, we recognised the challenges faced by hospital Trusts to integrate community services and to provide high quality safe care for patients using those services. We note that the Trust has worked hard to integrate community based services without affecting the level of care received by patients. We support the increase in the number of health visitors, arising from a review of the Health Visiting Service. This can only improve the care provided to patients. We also welcome the review of intermediate care services which will result in improvements for patients who have had falls; have Chronic Obstructive Airways

Disease and for those who want to make informed choices about end of life care.

The Committee notes the outcomes of your quality improvement projects, and we congratulate the Trust for achieving the targets in the following areas:

- patients being assessed for the risk of Venous Thromboembolism
- reporting of patient safety incidents
- reduction in the number of serious harm incidents
- reduction in the harm to patients caused by falls
- reduction in pressure ulcers
- reduction in cardiac arrest calls.

We note that reducing serious harm from medication errors and better reporting of these incidents has been identified as a priority and further improvements will be introduced over the next year.

The Committee has long recognised patient safety as a priority for all acute Trusts and we welcome the acute case management training programme for ward clinical staff (nurses, midwives and junior doctors); and the overall patient safety training for all staff within the Trust. We also note that the Trust is compliant with the five patient safety alerts highlighted by the Trust's Patient Safety and Risk Management Department.

Urgent Care has been an area of the work that the Committee has focused on over the past year. We are pleased to note that the Trust has achieved an average score of 95.4% of patients being seen within the four hour target. With further improvements to be implemented over the next year, we hope that the Trust maintains this target.

The Committee notes that the Trust has implemented the Strategic Health Authority's Advancing Quality

Programme in six key areas which are being monitored as part of the Trust's CQUIN targets and payment scheme. The Trust achieved improvements on three of the six targets, with deterioration in the quality of care received by patients with community acquired pneumonia, hip and knee replacements and strokes. We do note that the target for a minimum of 50% of eligible stroke patients to receive rehabilitation support from the Early Supported Discharge Service after they have been discharged home was achieved. The Quality Accounts document goes some way to explaining how the Trust will improve the care received by stroke patients. However there is no explanation of the reasons why patient's experience of care deteriorated for those patients with community acquired pneumonia; and hip and knee replacements; and no explanation of how the Trust intend to make the required progress in care for these patients. We recommend that the Trust should clearly set out the reasons for not meeting targets and actions that they will take to address issues in future Quality Accounts documents.

We acknowledge the achievement of improvement targets that have seen a reduction in the number of hospital acquired cases of C-Diff infection and MRSA. We also welcome the plans for the provision of an infection control service for community based services.

The Trust has recognised the need to improve the quality of care received by patients and their families at the end of life. Some improvements have already been achieved with further planned improvements identified. The Committee feels that it is important that end of life care is recognised by the Trust as a priority area of work.

This year, the Committee will conduct a piece of work on end of life care in Manchester and we hope that the Trust will support us in carrying out this work.

The Committee welcomes that the Trust has scored highly in patient perception audits in terms of same sex accommodation and privacy and dignity. The data from

April 2011 to date shows that 95% of patients surveyed believed that that they had not shared a room or bathroom with a member of the opposite sex. Where patients had identified that they had experienced mixing this was within critical care environments.

Overall this is a positive account of the measures the Trust has taken to improve quality over the past year, and we have identified some areas that require further attention. We look forward to working with the Central Manchester Foundation Trust over the next year.

Commissioner's Statement

CMFT has presented a detailed and impressive account of progress across the organisation. For 2011/12, the Trust had set itself 19 targets and achieved the majority of those and we wish to congratulate the organisation and its staff on the considerable achievement, as well as the considerable ambition and enthusiasm with which they have tackled the issues. The achievement of the NHS Litigation Authority assessment at level 3 (the highest level) is just an example.

We commend the intensive work on improving the care of acutely unwell patients and expect that this will help with achieving further quality improvement targets (such as mortality reduction). More clearly specified improvement targets may help with focussing the efforts further - this applies to other areas also.

There are further laudable successes reported on the reduction of harm from falls, healthcare acquired infections, single-sex accommodation, and no Never Events throughout the year.

For 2012/13, three key areas are identified (dementia, harm-free care, and mortality). These are of course very welcome but we wonder about the status and desired progress with other areas, particularly those not yet achieved (stroke, hip and knee replacement, community-acquired pneumonia) which remain a concern. We note that several sections on in the Account do imply a continuation of work in some of the areas reported on in 2011/12 and further targets for 2012/13, and future Accounts should explicitly report on those also.

The Trust's ambitious work on harm-free care is particularly welcome, as is the organisation's willingness to share learning with others. This is a key to success in ensuring even more patients benefit faster from successful work in care quality improvement.

The Trust has embarked on a considerable programme of quality improvement, and the Board of Directors is assured of the quality of all services, not least through the regular Intelligent Board Report. However, this Account could be more explicit in demonstrating that indeed all services are subject to improvement efforts and regular quality reviews.

Whereas there is some improvement shown in some locally collected data, the patient experience survey results used in the national CQUIN programme are in need of further improvement and we look forward to the trust's continued progress in this area.

The structure of the report could be clearer, by clearly relating the headings to sections and ordering and numbering them. Whereas the report makes very interesting reading to people familiar with the subject, we are concerned that others may find it difficult to comprehend some of the information.

The Trust has embarked on considerable and innovative work to improve staff experience, but this is not yet bearing fruit as indicated in the recent staff survey.

The Account makes only very brief reference to work on equality and diversity. This is an area of concern, given the recent judgment against the trust in a race-related case.

As Commissioners we have again worked closely with CMFT over the course of 2011/12, meeting regularly to review the Trust's progress in implementing its quality improvement initiatives. CMFT and NHS Manchester agreed 10 CQUIN (Commissioning for Quality and Innovation) goals for acute services in 2011/12. CMFT have achieved 7 goals (6 fully, 1 partially) and failed to achieve 1 goal. At the time of this report the final position is still to be agreed for 2 goals but we are expecting CMFT to partially achieve both of these. The goal not achieved was a national CQUIN on patient experience; performance on this indicator was below expectation across Greater Manchester. For community services, we had agreed 2 CQUIN goals, of which CMFT has achieved 1 fully and 1 partially.

This year, the Trust has taken on the responsibility for Trafford General Hospital and is working on integrating and spreading relevant quality improvement and assurance systems. Both commissioners will be monitoring progress with this to support successful integration.

Note:

Given the tight timescales for sign-off, we have not had the opportunity to consolidate full accuracy checks for the submission to Monitor but will do so with the Trust prior to publication of the final Quality Account.

NHS Manchester

Statement of Directors' responsibilities in respect of the Quality Report

Monitor has published guidance for the external audit on Quality Reports for 2011/12. A detailed scope of work for NHS Foundation Trust auditors has been detailed in the guidance. The report from the external auditors on the content of the Quality Report will be included in the Annual Report and the report will highlight if anything has come to the attention of the auditor that leads him/her to believe that the content of the Quality Report has not been prepared in line with the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12.

The Trust is also required to obtain external assurance from its external auditor over at least two mandated indicators and one local indicator included in their Quality Report. As a minimum the outcome of this external exercise over the indicators should be a Governors' report to Monitor and the Trust's Council of Governors.

Auditors' Report on the 2011/12 Performance Indicators

The Auditors have undertaken testing of the systems to support the preparation of the mandated indicators included in the 2011/12 Quality Reports as follows:

- C Difficile
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

The Governors have been engaged in deciding the local indicator to be audited for 2011/12 and this will be venus thromboembolism (VTE) prophylaxis. This is the same indicator as chosen by the Governors for the 2010/11 report as it was felt that sustainability regarding the quality of data needed to be evidenced.

Delegated Authority and Recommendation

The Board of Directors at its meeting in May 2012 delegated authority to the Audit Committee to sign off the Annual Report and accounts. Within the Annual Report the Quality Report has been presented and the Audit Committee on behalf of the Board was asked to confirm that the requirements of the Quality Report have been complied with.

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 2011/12;
- 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 2011 to June 2012
  - Papers relating to Quality reported to the Board over the period April 2011 to June 2012
  - Feedback from the commissioners dated 19/05/11, 24/08/11, 1/12/11 and 29/02/12
  - Feedback from Governors dated 18/05/12
  - Feedback from LINks dated 1/05/2012
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2011
  - The National Patient Survey March 2012
  - The National Staff Survey March 2012
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated June 2012
  - CQC Quality and Risk Profiles dated monthly throughout 2011/12.
- 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

30th May 2012 **Peter W Mount**, Chairman

30th May 2012 **Mike Deegan**, Chief Executive

Independent Auditor's 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 Governors of Central Manchester University Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Central Manchester University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Mandatory indicator – Cancer 62 day wait
- Mandatory indicator – MRSA blood stream infection cases

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

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 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 Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's Detailed Guidance for External Assurance on Quality Reports 2011-12; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

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

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

- Board minutes for the period April 2011 to June 2012;
- Papers relating to quality reported to the Board over the period April 2011 to June 2012;

- Feedback from the Commissioners in May 2012;
- Feedback from Governors in May 2012;
- Feedback from LINks in May 2012;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- The latest National Patient Survey dated April 2012;
- The latest National Staff Survey from 2012;
- Care Quality Commission quality and risk profiles;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2012; and
- Any other information included in our review.

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

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

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 31 March 2012 to enable the Council of Governors to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. 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:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- Reading the documents listed above under the respective responsibilities of the Directors and auditors.

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

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of my assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Central Manchester University Hospitals NHS Foundation Trust.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's Detailed Guidance for External Assurance on Quality Reports 2011-12; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

Jackie Bellard
Officer of the Audit Commission

The Audit Commission
2nd Floor
Aspinall House
Aspinall Close
Middlebrook
Bolton BL6 6QQ

30th May 2012

Carbon Reduction/ Sustainability

Overview: We remain committed to reducing energy consumption and carbon emissions in line with local and national targets. The first milestone is a 10% saving on carbon emissions by 2015. We are working with the Energy advisers from Manchester City Council and its partners to accelerate the work on carbon reduction.

Carbon Reduction: 2011/12 saw the introduction of a national carbon tax and carbon league tables. Our annual tax payment equated to approximately £320,000. As a result of measures taken to reduce emissions during this period we were ranked mid point in the national league tables. Further interventions will see our tax bill reduce and, at the same time, improve our league position. In the past 12 months we have seen a modest reduction in energy consumption.

There are now over 90 nominated Green Champions across the organisation committed to support the energy saving initiatives and effect a change in culture. Energy saving campaigns and staff training have been provided throughout the year using all forms of media, including a Green Challenge Day on 19th October, attended by more than 200 staff.

Waste Management: A new service provider was introduced in September 2011, and domestic waste is now sent to a Recovery Facility where between 75% and 90% of our general domestic waste is recycled.

As part of the recycling scheme, food waste from cafés, restaurants and kitchens around the organisation is now being segregated at source from other wastes. The food waste is taken to an anaerobic digester where the emitted gases are captured and used to drive turbines to generate electricity to the national grid, contributing to the government's renewable energy obligation. The residual solid waste, once thoroughly digested, is used as a soil conditioner/ fertiliser on farmland.

Procurement: The activities associated with procurement account for 60% of the carbon emissions within the NHS. Our Procurement Department continues to support and lead a number of initiatives in response to the Sustainability challenge. These include:

- reducing the number and cost of printing/copying devices, along with the greater use of integrated printing solutions;
- the use of remanufactured ink cartridges; and
- reducing direct deliveries from suppliers and encouraging where possible and advantageous the use of goods consolidators such as NHS Supply Chain.

In 2012/13 the Procurement Department will further investigate the CO2 impact of our supply chain, whilst continuing to support the above projects and increase awareness of initiatives that will reduce carbon emissions.

Sustainable Travel: The introduction of state-of-the-art hybrid buses onto the 147 route which runs through the Hospital site, has been a huge success. The hybrid buses use an electric/diesel hybrid engine and use approximately 30% less fuel and produce around 30% less CO2 than the previous diesel engine vehicles used on the route.

A motor cycle parking rail has recently been created near the Out-patients Department at Manchester Royal Infirmary. Security of the existing cycle shelters has been improved and additional cycle shelters are also planned in the future.

Equality, Diversity and Human Rights

Governance and Mainstreaming of Equalities

The year 2011/12 has seen continued investment 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.

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.
- 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 regarding equality and diversity are embedded within our workforce.
- Embed the Equality Delivery System (EDS) within the fabric of the organisation to deliver a patient focused service.

Manchester Pride

For the first time ever we decided to get involved in Manchester PRIDE 2011 and had a presence at both the Parade and the Lifestyle EXPO stand over the August Bank Holiday weekend. Volunteers from all around the organisation kindly gave up their time to staff the Lifestyle EXPO stand. A survey improving services for the Lesbian, Gay, Bisexual and Transgender (LGBT) community was conducted by the sexual health team.

Manchester Pride is Manchester's annual festival celebrating lesbian, gay, bisexual and transgender (LGBT) life. The NHS has participated in the Manchester Pride since 2004. We were keen to get involved to demonstrate our commitment to promote equality and diversity in employment and service delivery. The Pride festival was the perfect vehicle to challenge stigma, discrimination, and homophobia and to promote the needs of LGBT staff and encourage access to services for LGBT members of the community.

E-learning diversity training launch

The service equality team launched an e-learning equality and diversity module. The aim of the e-learning programme was to introduce staff to core equality and diversity principles around the key protected characteristics. The modules have been divided into each key category. The service equality team played integral part in conjunction with Skills for Health in developing the modules which have now been launched nationwide.

Task and Finish Wheel chair Group

We occupy a large site, which poses many challenges for patient access. Access and way finding issues are a key priority in relation to Equality, Diversity and Human rights and subsequently to the quality of service and patient experience.

We led a task and finish group working jointly with the clinical scientific division to resolve the issues our service users faced accessing our site and fulfilling our duties under the new equalities legislation. As a result of this piece of work 100 wheelchairs have been purchased to be strategically placed across our site for our patients.

Equality & Diversity Calendar

We launched our first Equality and Diversity and Multi-Faith calendar. It has been developed as both a resource and an educational tool in response to the diversity of both the community that we serve and our workforce.

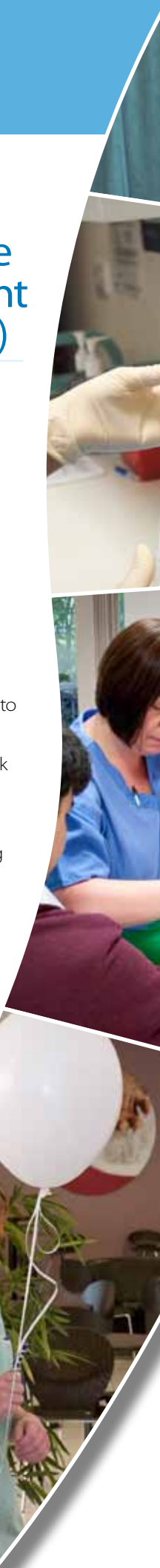
We hope this tool will enable the Trust and the community become more aware of the diversity we serve. But also we hope this enables us to develop and deliver services that are appropriate to the communities we serve.

Equality Impact assessment training

Following on from the review of the equality impact assessment framework in 2010, we have implemented a robust training programme across the organisation. We have trained around 70 staff from across the organisation. We have also launched a very successful EqIA champion process as part of embedding equality impact assessment process.

Equality Performance Improvement Toolkit (EPIT)

The Equality performance improvement toolkit was designed to demonstrate and collect North West NHS organisations individual and collective progress on delivering outcomes and benefits for all sections of the community. We worked extremely hard to integrate equality and diversity action planning and the EPIT goals to make a real difference in the way we embedded this work within the organisation. We completed the process and self assessed to be achieving on the majority of the goals that were submitted to the PCT.



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 2011/12.

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. In addition to being responsible for representing the interests and views of our Members, Governors also monitor the performance to ensure high standards are maintained.

Our Council of Governors has both Elected and Nominated Governors with Public Governors being elected by our public members, Staff Governors being elected by staff members and Nominated Governors being nominated from partner organisations.

During 2011/12, the Trust progressed a bid to acquire Trafford Healthcare NHS Trust with the acquisition being planned to take effect from 1st April 2012.

In light of the above, a Governor led review was undertaken to determine changes to the Trust's constitution which were approved by members (at the Annual Members' Meeting held on 27th September 2011) and subsequently by Monitor (Independent Regulator of Foundation Trusts). The following main changes were implemented over two phases (to take full effect from 1st April 2012):

- A new Borough of Trafford Public Member Constituency and three Governor posts
- New Nominated Governors for Trafford PCT (one) and Trafford Borough Council (one)
- Overall increase to the Council of Governors from 31 to 35 Governors
- Open Governor posts (those who received the highest number of votes after those elected) to be disestablished and transferred into allocated constituencies
- A new Nominated Governor for the Trust's Volunteer Services
- Reduction in the number of Youth Governor posts (from two to one)
- Changes to the number of Staff Governors to reflect the numbers of staff members in each constituency.

The Trust's Constitution dictates the composition of the Council of Governors and following the changes approved at the Annual Members' Meeting (27th September 2011), the table below outlines the previous and new composition:

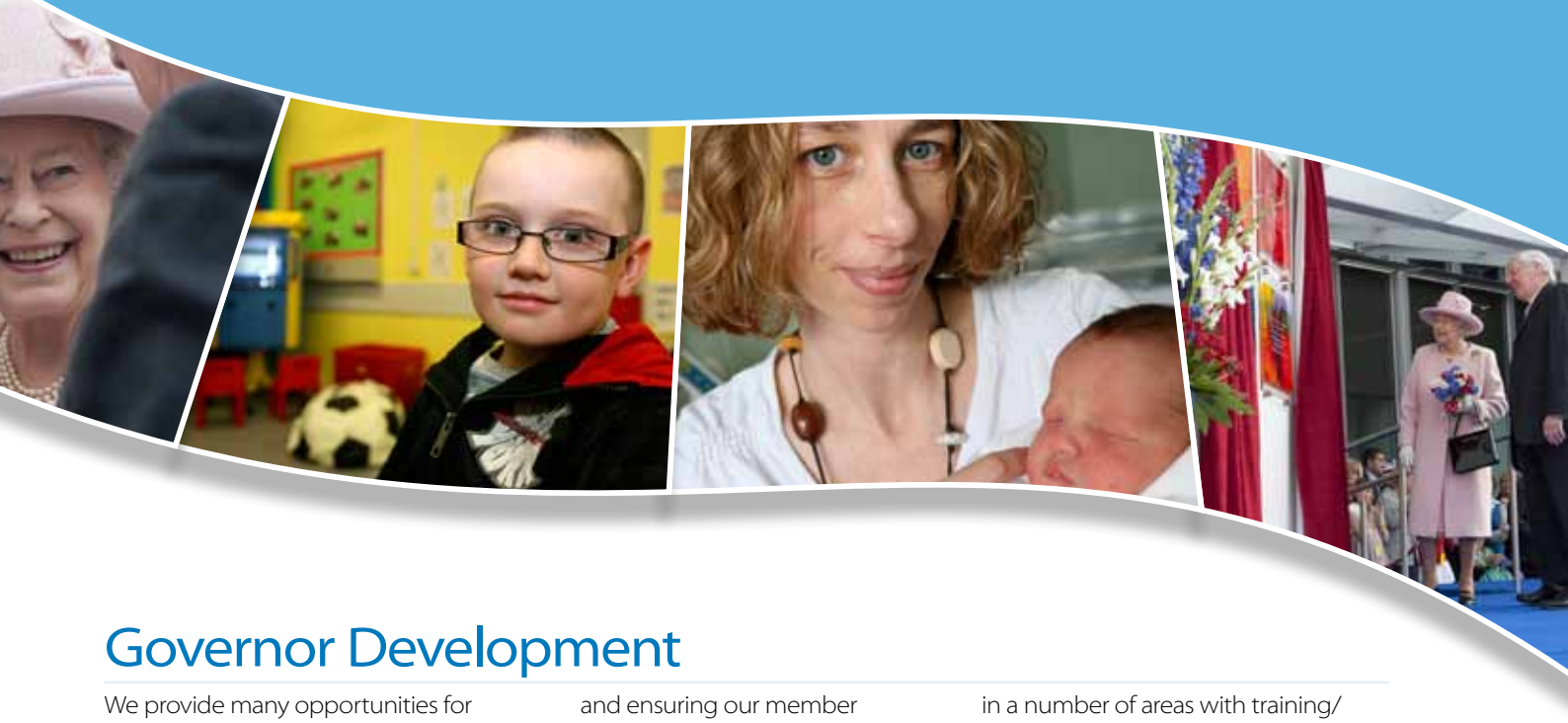
COMPOSITION OF THE TRUST'S COUNCIL OF GOVERNORS

GOVERNOR CONSTITUENCY/CLASS/PARTNER ORGANISATION		EXISTING	NEW
PUBLIC	Manchester	9	9
	Trafford	0	3
	Greater Manchester	2	4
	Rest of England & Wales	2	2
	Open (highest number of votes)	4	0
	Total	**17**	**18**
STAFF	Nursing & Midwifery	1	2
	Other Clinical	1	2
	Non-Clinical & Support	1	2
	Medical & Dental	1	1
	Open (highest number of votes)	2	0
	Total	**6**	**7**
NOMINATED	Manchester University	2	2
	Manchester PCT	1	1
	Trafford PCT	0	1
	Specialised Commissioning	1	1
	Manchester City Council	2	2
	Trafford Borough Council	0	1
	Youth Forum	2	1
	Volunteer	0	1
	Total	**8**	**10**
	OVERALL TOTAL	**31**	**35**

NB: There will be a phased implementation of the new composition so to permit existing Governors (in disestablished posts) to serve their term of office.

Public membership recruitment campaigns included the recruitment of new members into the new Trafford constituency (took place during March 2012), in preparation of the Trafford Healthcare NHS Trust acquisition with the Governor election process beginning June 2012 to fill the newly established Trafford Governor posts in addition to filling the seats of those Governors whose term of office ends this year.

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

We provide 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 have a key role in holding the Board of Directors to account and attend regular Performance Meetings in order to review the Trust's performance across patient quality, clinical effectiveness, patient experience, finance and productivity.
- 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 the final Annual Report/Accounts and Annual Plan and are consulted on the development of forward plans and any significant changes to the delivery of the 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 monitoring regeneration, employment, education and environmental initiatives.
- Governors actively participate in the appointment of Non-executive Directors.
- The Governors' Appraisal Panel (annual programme) has been successfully implemented which facilitates the 360o appraisal process for the Trust's Chairman and receives feedback on the appraisals of the Non-executive Directors.
- Governors also cast a critical eye over the health and wellbeing of our staff in areas such as staff survey findings, training programmes, sickness absence, appraisals etc.

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

- Annual Equality and Diversity Training – including patient case-studies
- Induction Training for all new Governors.
- Governor mentor/buddy assigned to our Nominated Youth Governor – support provided in preparation for Council of Governors' Meetings.
- Chairman led Annual Governor Development Sessions (Summer and Winter Events) – discuss topical health matters (impact on Trust/ Governor role).
- Governor attendance at External Governor Development Events – Foundation Trust Governors' Association.
- Governor Role Training Sessions – Governor role evolution and areas for further development including the impact of the Health & Social Care Act (2012).
- Annual Governor Development Programme informed via Governor questionnaire findings and Governor Working Group assessments.
- Annual Lead Governor elections/ succession planning – includes

Lead Governor role description and nomination/election 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 – comparable data findings being utilised to specifically highlight areas of particular strength and those requiring further support.
- Key Performance Meetings focusing on patient safety, patient experience and productivity and efficiency – review of Intelligent Board Reports enabling Governors to effectively hold the Board of Directors to account.
- A Governor Skill Mix Matrix has been developed which captures individuals' competencies/ expertise - matrix enables Governors' expertise to be utilised to its full potential when assigning/ progressing Governor led/ involvement work projects.
- Governor involvement continues to be a key priority which has recently included Governor active participation in Patient Environment Assessment Teams in addition to contributing towards the development of the Trust's IT Strategy. A Governor involvement programme is currently being developed in order to further progress this area of work and will include participation in Leadership Walks, Ward Accreditation Assessments and Complaints Panels.

Monitoring Arrangements:

Governor development is monitored in a number of ways:

- An annual questionnaire is completed by Governors which identifies development needs.
- The Chairman meets annually with the Lead Governor and the four Governor Working Group Chairs in order to monitor working group progress and identify areas for further development.
- Governors meet with the Chairman on a regular basis outside of the Council of Governors and Working Group Meetings, to highlight any development needs.
- The Governor Skill Mix Matrix enables any competency gaps (individually or the Council of Governors as a whole) to be highlighted and corresponding training needs to be identified.

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 2011 for those initial Governors who had been elected for a three year term of office.

The Trust's Governor Election Turnout Data - 2011

Date of Election	Constituencies Involved	Number of Members in Constituencies	Number of Seats Contested	Number of Contestants	Election Turnout
Sept 2011	Public – Manchester	5,891	6	21	15.8%
	Public – Greater Manchester*	5,061	1	4	19.6%
	Public – Rest of England & Wales*	1,154	1	2	18.5%
	Staff – Non-Clinical & Support	2,968	1	2	10.3%
	Staff – Other Clinical*	3,136	1	1	5.2%

*these governor vacancies were open seats to the candidate that polled the highest number of votes (after those elected) within the relevant constituencies namely one public governor across all three public constituencies and one staff governor across two staff constituencies from which nominations were received.

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 charitable healthcare sector and is currently Chief Executive of St Ann's Hospice. She hopes to make a positive contribution to ensuring equitable and high standards of care for patients and their carers/families.

Dave Brown – Manchester Constituency
Raised and educated in Manchester, Dave spent over 30 years in international IT/communications sales and project management. Retiring due to ill-health, treatment at Manchester Royal Infirmary gave him a new lease of life in 2005. He is very active within local organisations supporting regeneration, community care and older people and is a community advocate. Dave wants to contribute to the Trust's plans for managing change in the NHS while still maintaining and improving standards and achieving growth.

Abu Chowdhury - Manchester Constituency
As a Councillor (2004 – 2011), 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 increase future investment.

Peter Dodd – Manchester Constituency
Aged 58, Peter is now semi-retired, having survived a major stroke in 2006. Peter's first-hand experience of the Manchester Royal Infirmary 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 Trades Unionist, Peter also believes strongly in the importance of staff morale and welfare. As a Governor and a member of the Patient Experience Committee, Peter has been able to raise important issues such as the dignity of patients and the quality of hospital food. As Chair of the Governors' 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 The University of Manchester. Since becoming a governor, Keith has been able to bring his knowledge and expertise to areas such as staff health and well-being, 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 Governors' Membership Working Group he is also helping to explore new ways in which the Trust can communicate with the wider community.

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 Manchester Royal Infirmary. 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.

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 the Trust continuing to deliver high-quality services that are speedy, efficient and cost-effective, as well as free at the point of delivery. Sue belongs to the Governors' Membership Working Group and would like to see an increase in the membership of the Trust. She is also a member of the Governors' Patient Experience Working Group, both of which work towards customer focus and patient consultation.

Helen Scott – Manchester Constituency
Helen has worked in primary care as Head of NHS Manchester's Interpretation Service since 2005. She understands the potential obstacles facing Manchester's diverse and often excluded communities in accessing health care. Helen's own experience when her newborn baby contracted a life-threatening illness also gives her empathy with patients. She has extensive charity sector experience, with skills in business management, strategic and workforce planning, human resources and performance management.

Sue Webster – Manchester Constituency
Through her employer, British Telecom, 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. She chairs the Governors' Corporate Citizenship Working Group and continues to support improvements to patient care, having worked with the Regional Innovation Hub to encourage North West NHS staff to develop new products, technology and services.

Ivy Ashworth-Crees - Greater Manchester Constituency During the four years of being a Governor, Ivy's priorities have mainly focused on patient experience and in presenting their views and their concerns. Ivy takes a keen interest in patient satisfaction and believes that her job is to ask probing and challenging questions to the Executive Board for patients who need to find out more. Ivy welcomes being involved with 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 Manchester Royal Infirmary and believes that this Foundation Trust deserves recognition for striving constantly for medical excellence in the North West with Ivy wanting to strive with them too.

Malcolm Chiswick – Lead & Public Governor - 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.

Lynne Richmond – Greater Manchester Constituency Lynne has worked in the nursing/care sector for 40 years training as a State Registered Nurse 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 to carry out the duties required as a governor. Lynne's relationship with the Trust has been as a patient, a visitor, and liaising with Patient Advice and Liaison Service.

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.

Owen Henderson – Manchester Constituency – Resigned (January 2012)

Martin Rathfelder – Manchester Constituency – Term of Office ended (September 2011)

Roy Walters – Manchester Constituency – Term of Office ended (September 2011)

Staff Governors

Lawrence Cotter - Medical & Dental Constituency Following qualification at Manchester University in 1971, Professor 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, Professor Cotter is Hospital Dean in charge of the training of 450 medical students in the Trust.

From 2003 to 2011, Professor 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 Primary Care Trusts, the voluntary sector and service users has given therapy service manager Beverley a good insight into community issues. She joined the Manchester Royal Infirmary in 1983, and relishes the opportunity to represent staff in influencing the way the Trust provides services and its longer term strategy.

Erica McInnis – Other Clinical Constituency A clinical psychologist, Erica has worked for Manchester Learning Disability Partnership since 2004. She is an advocate for people with learning disabilities and those who care for them. Promoting quality patient experience, staff health and well-being, and community responsibilities are also key interests. Manchester born and bred, Erica served on the National Union of Student's Executive Women's committee, and as a trustee for an organisation which improves educational opportunities for the city's minority black and ethnic children.

Mary Marsden – Nursing & Midwifery Constituency Mary has worked within the NHS for the past 31 years and has been a Nursing and Midwifery Staff Governor for nearly three years. Mary has enjoyed taking on this role as during this period Mary 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 safety and clinical quality. I am looking forward to the future 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.

Kim Laurie – Nursing & Midwifery Constituency - Term of Office ended (September 2011)

Susan Turner – Non-Clinical & Support Constituency – Resigned (March 2012)

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 allows him to positively contribute to the strategic vision of the Trust.

Peter Clayton – University of Manchester
A consultant at the Royal Manchester Children's Hospital, Peter completed his medical training in Manchester in 1984. After carrying out research in the USA, he returned to Manchester to head a research group specialising in paediatric endocrinology. The group, which includes scientists, doctors and nurses, studies various aspects of the hormones that affect children's growth and development. Peter has been Professor of Child Health and Paediatric Endocrinology at The University of Manchester since 2001.

Mariam Gaddah – Volunteer Services
Attending a schools open day at the Trust encouraged Mariam to become a volunteer. She enjoys talking to patients and staff on her weekly visits to an acute rehabilitation ward at MRI, and became a governor to help represent both patients and volunteers. Mariam is also finding the experience useful as she plans to study medicine at Manchester University after completing 'A' levels in maths, chemistry, biology and English literature.

Angela Harrington – Manchester City Council
Angela is interim Head of Regeneration with Manchester City Council. 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 Strategic Lead for Urgent Care, Central Manchester Clinical Commissioning Group. She is the Chair of the Central Manchester Urgent Care Board and is a member of the Central Manchester Clinical Integrated Care Board. Helen is also a GP with a Special Interest in Intermediate Care. She is involved in local and national projects for falls and stroke. She is a member of the Stroke Board of the Greater Manchester and Cheshire Cardiac and Stroke Network, the Intercollegiate Stroke Working Party and has been a member of several expert groups for NICE (the National Institute for Clinical Excellence) and the Department of Health. Helen's strengths include an understanding of the health needs of the local population, policy changes within the NHS and service redesign.

Farhana Naseem – Youth Forum
Farhana joined the Youth Forum because she wanted to help young people put forward their ideas about hospital services, and boost their involvement with the

Trust. She was delighted to become a Governor as "it's an opportunity to represent young people, meet a broad range of people and do something for the wider community". She hopes to study dentistry at university after completing her 'A' levels in maths, chemistry and biology.

Jenny Scott - Specialist Commissioning Group
Jenny has 24 years' experience in healthcare planning, contracting and commissioning. She 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 office of the North of England Specialised Commissioning Group and has experience of a wide range of service issues both locally and nationally.

Gillian Wallis - The University of Manchester
Professor of Genetics at The University of Manchester, Gillian is involved in pioneering research work into osteoarthritis and its genetic basis. She has studied in South Africa, Switzerland and the US. Gillian is currently the Director of Education and Training for the Manchester Academic Health Science Centre, playing a key role in co-ordinating clinical and research training across The University of Manchester and its six partner NHS Trusts.

Kay Day – The University of Manchester – Term of Office ended (September 2010)

Saklain Farooq – Youth Forum – Term of Office ended (September 2010)

Abubaker Suleman – Youth Forum – Term of Office ended (September 2010)

Declaration of Interests

Details of the Council of Governors' declarations 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:

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

Over the course of the past year presentations/information has been received in relation to Staff Support Services, Appraisal Process, Staff Survey Findings, Youth Forum and Catering Provision.

Recent work projects include Governor involvement in developing a Staff Health & Wellbeing Strategy and a new staff appraisal system and Voices Project (staff engagement project) in addition to the continuing involvement in the Trust's Staff Recognition Programme.

Corporate Citizenship – advises and engages with our Corporate Citizenship programme with work projects being generated around four main themes namely Employment, Carbon Reduction, Travel & Transport and Cultural Partnerships.

Over the course of the past year in addition to the above main themes, presentations/information has been received in relation to LIME Hospital Arts, Equality & Diversity, Transforming Community Services, Cross City Bus Scheme, Whitworth Park Plans and our Procurement Chain.

Recent work projects include Governor involvement in developing cultural partnerships and supporting our employment and apprenticeships programme (Project Search and Manchester Health Academy). Support is also given to the development of carbon reduction initiatives (raising awareness).

Patient Experience - supports the implementation of our 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.

Over the course of the past year presentations/information has been received in relation to End of Life Care, Youth Forum, Stroke Services, Quality Care Rounds, Out-patient Development Work, In-patient Survey, Voices Project and Venous Thromboembolism Audit.

Recent work projects include Governor involvement in Annual Quality Report/Accounts review, Learning Disabilities, Cleaning Matters, Way Finding, Complaints and Patient Food.

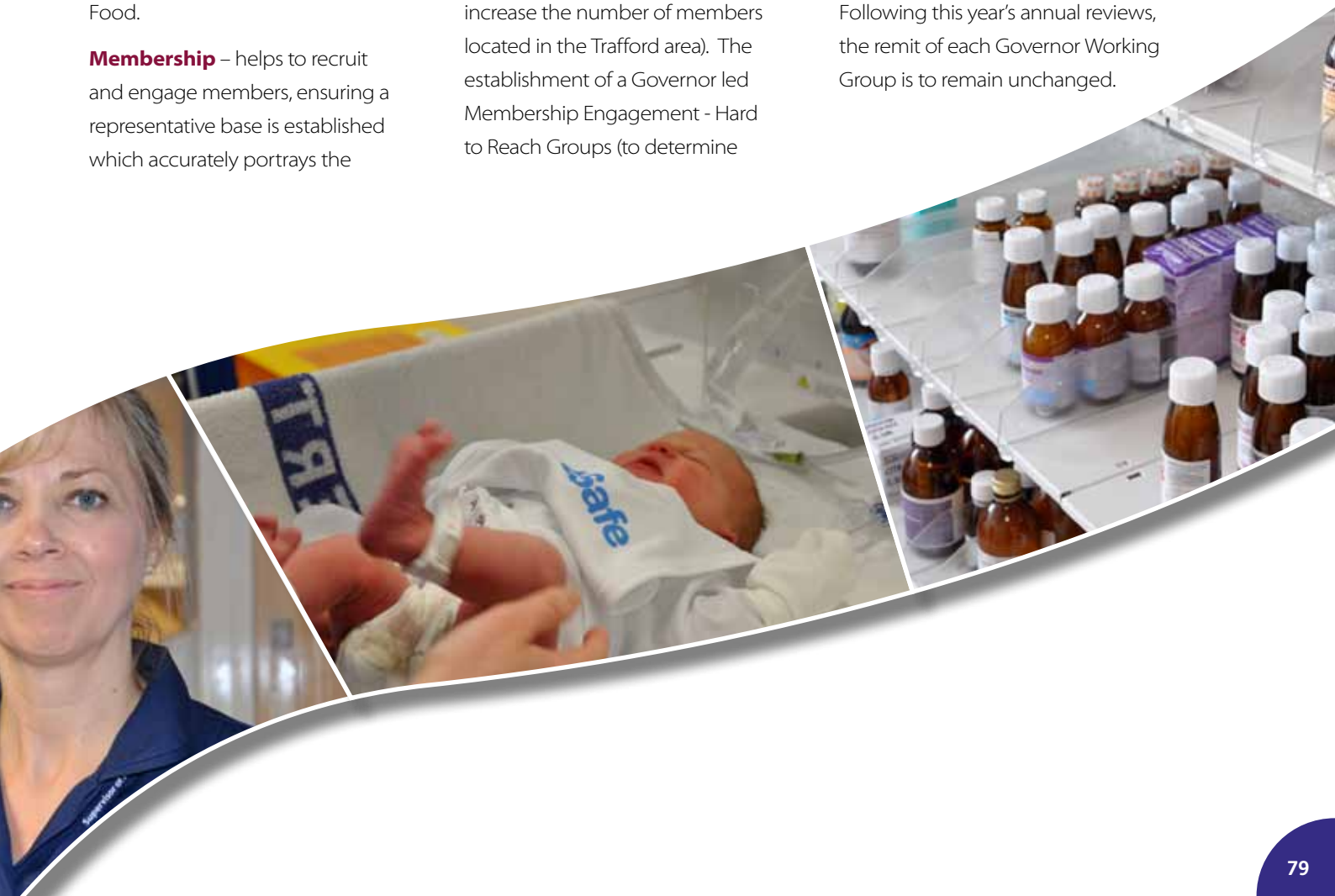
Membership – helps to recruit and engage members, ensuring a representative base is established which accurately portrays the diverse communities that we serve. Membership engagement best practice methodologies continue to be developed and supported by Governors.

Over the course of the past year presentations/information has been received in relation LIME Hospital Arts, Youth Forum, Volunteer Services and Volunteering Abroad.

Recent work projects included the establishment of a Governor led Constitutional Changes Membership Subgroup (determine/ progress changes to the Trust's existing Constitution), supporting the Public Member recruitment campaigns (two campaigns held to enlist both young members and to increase the number of members located in the Trafford area). The establishment of a Governor led Membership Engagement - Hard to Reach Groups (to determine key hard to reach community groups in order to develop relevant membership engagement initiatives) and supporting the production of Membership Engagement papers (in order to further determine/develop best practice methodologies). Governors continue to be actively involved in the planning of membership engagement events.

The Chairman meets with the Lead Governor and four Governor Working Group Chairs/Supporting Directors to undertake annual working group reviews in order to determine the achievements made during the course of the year, establish a focus of work for the coming year and identify any areas requiring improvement.

Following this year's annual reviews, the remit of each Governor Working Group is to remain unchanged.



Governor attendance at council of governor meetings – 2011/12

Governor Name	Council of Governors Meeting 22nd June 2011	Council of Governors Meeting 19th October 2011	Council of Governors Meeting 29th February 2012
Rabnawaz Akbar	✓	✓	✓
Ivy Ashworth-Crees	✓	✓	✓
Jayne Bessant	✗	✓	✓
Dave Brown	N/A	✓	✓
Malcolm Chiswick	✓	✓	✗
Abu Chowdhury	✓	✓	✗
Lawrence Cotter	✓	✓	✓
Peter Clayton	N/A	✓	✗
Kay Day	✓	N/A	N/A
Peter Dodd	✓	✓	✓
Brian Donaldson	✓	✓	✓
Saklain Farooq	✗	N/A	N/A
Mariam Gaddah	N/A	N/A	✓
Angela Harrington	✓	✗	✓
Owen Henderson	N/A	✗	N/A
Beverley Hopcutt	✓	✓	✓
Helen Hosker	✓	✓	✓
Richard Jenkins	✗	✓	✓
Kim Laurie	✓	N/A	N/A
Erica McInnis	N/A	✓	✓
Mary Marsden	✓	✓	✓
Alexena Morrison	✓	✓	✓
Farhana Naseem	N/A	✓	✓
Margaret Parkes	✗	✓	✓
William Keith Paver	✓	✓	✗
Martin Rathfelder	✓	N/A	N/A
Bernice Reid	✓	✓	✓
Lynne Richmond	✓	✓	✗
Sue Rowlands	✓	✓	✓
Helen Scott	N/A	✓	✗
Jenny Scott	✗	✓	✓
Abubaker Suleman	✓	N/A	N/A
Susan Turner	N/A	✗	✓
Gillian Wallis	✓	✓	✓
Roy Walters	✓	N/A	N/A
Sue Webster	✓	✓	✓
Julian Wright	✓	✓	✓

Director attendance at council of governor meetings – 2011/12

Director Name	Council of Governors Meeting 22nd June 2011	Council of Governors Meeting 19th October 2011	Council of Governors Meeting 29th February 2012
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 governor working groups – 2011/12

Governor Name	Membership Working Group			
	04.05.11	03.08.11	23.11.11	25.01.12
Rabnawaz Akbar	✓	✓	✓	✓
Dave Brown	N/A	N/A	✓	✓
Peter Dodd	✓	✓	✓	✓
Mary Marsden	✓	✓	✓	✓
William Keith Paver	✓	✓	✓	✓
Martin Rathfelder	✓	✓	N/A	N/A
Sue Rowlands	✓	✓	✓	✓
Helen Scott	N/A	N/A	✓	✓
Julian Wright	✓	✓	✓	✓

Governor Name	Patient Experience Working Group			
	20.05.11	16.09.11	25.11.11	03.02.12
Ivy Ashworth-Crees	✓	✗	✓	✗
Jayne Bessant	✓	✓	✓	✓
Dave Brown	N/A	N/A	✗	✓
Malcolm Chiswick	✓	✓	✓	✗
Abu Chowdhury	✓	✓	✗	✗
Peter Clayton	N/A	N/A	✗	✗
Kay Day	✗	✗	N/A	N/A
Peter Dodd	✗	✗	✓	✓
Brian Donaldson	✗	✓	✗	✓
Beverley Hopcutt	✓	✗	✓	✗
Richard Jenkins	✓	✗	✓	✓
Kim Laurie	✗	✗	N/A	N/A
Margaret Parkes	✓	✗	✓	✗
Lynne Richmond	✗	✓	✗	✓
Sue Rowlands	N/A	N/A	✓	✓

Governor Name	Corporate Citizenship Working Group			
	04.04.11	18.07.11	24.10.11	16.01.12
Dave Brown	N/A	N/A	N/A	✓
Malcolm Chiswick	✗	✓	✗	✓
Mariam Gaddah	N/A	N/A	N/A	
Angela Harrington	✓	✓	✗	✓
Richard Jenkins	N/A	✗	✗	✗
Mary Marsden	✓	✓	✓	✓
Roy Walters	✗	✓	N/A	N/A
Sue Webster	✓	✓	✓	✓

Governor Name	Staff Health & Wellbeing Working Group			
	20.04.11	20.07.11	02.11.12	11.01.12
Lawrence Cotter	✗	✗	✗	✗
Brian Donaldson	✗	✗	N/A	N/A
Helen Hosker	✓	✗	✗	✗
Kim Laurie	✓	✗	N/A	N/A
Erica McInnis	N/A	N/A	N/A	✓
Alexena Morrison	✓	✓	✓	✓
Margaret Parkes	✓	✗	✓	✓
William Keith Paver	✓	✗	✓	✓
Martin Rathfelder	✗	✗	N/A	N/A
Bernice Reid	✓	✓	✓	✓
Lynne Richmond	✓	✓	✗	✓
Susan Turner	N/A	N/A	N/A	✓
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 pages 71 and 72 for details)

Membership Community

Our membership community comprises of 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).

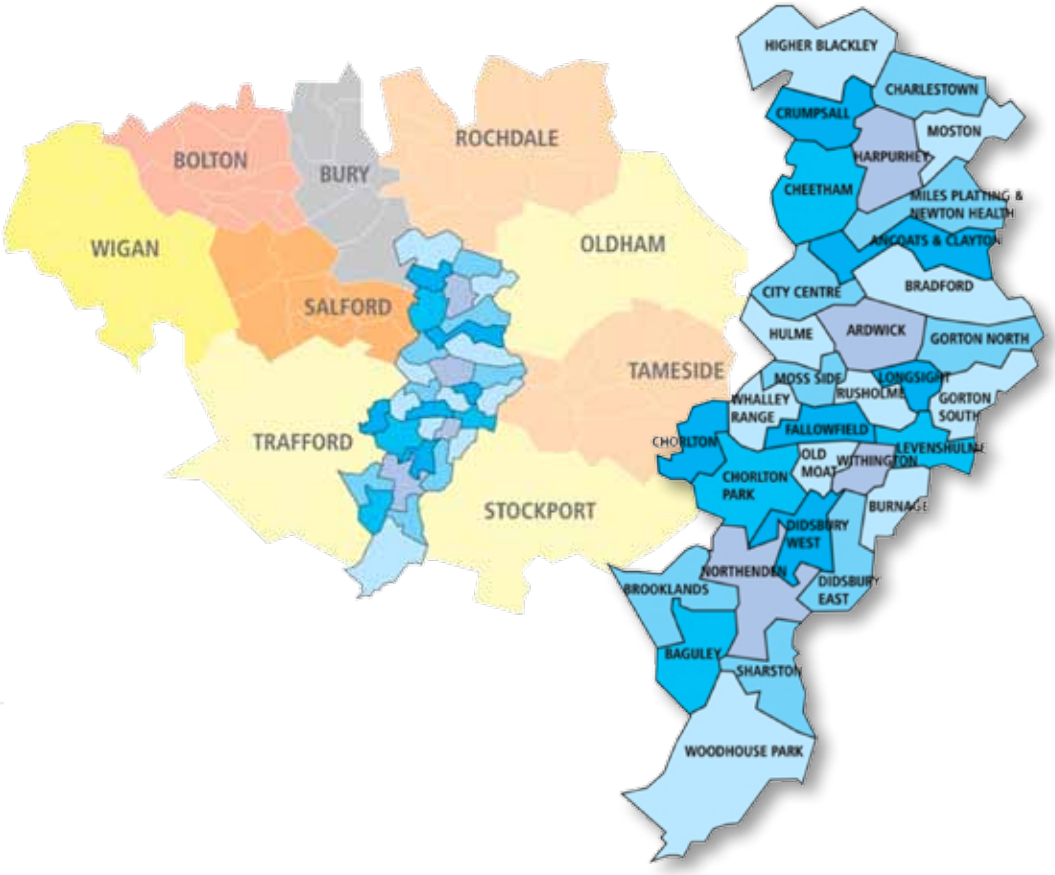
Public Members

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 3 areas:

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

The map below illustrates the Manchester and Greater Manchester areas (areas which fall outside of these wards are captured in the Rest of England & Wales constituency)



Staff Members

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 4 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 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 2011/12 the Trust held two public membership recruitment campaigns the first of which was to address short fallings in the membership profile and the second in order to capture new members from the Trafford area in preparation of the planned Trafford Healthcare Trust acquisition. As a result of this, the Trust exceeded its previous membership target (12,000 Public Members) to achieve a public membership of over 13,000 Public Members at year end in addition to housing a staff membership of around 10,500 following the transfer of Community Staff.

At year end, our membership community comprised of over 23,000 which is anticipated to grow by a further 1,500 staff members following the transfer of Trafford Healthcare NHS Trust staff (1st April 2012) to create a combined overall membership community of approximately 25,000 members

As a result of the above transfer of Community Services and planned acquisition of Trafford Healthcare NHS Trust, in order to reflect the growth in the corresponding population footprint that we now serve we have exceeded our overall public membership target set by Monitor (at authorisation). We therefore 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 2011/12 was focused upon addressing public membership profile short-fallings in particular young people (aged 11 - 16 years) in addition to white, British males. This was achieved via 2 recruitment events the first of which was held in our Children's hospital in addition to several local young people's venues. New members were recruited from the Trafford area by holding a second recruitment event across all Trafford Healthcare NHS Trust hospitals (Trafford Hospital, Altrincham General and Stretford Memorial).

Membership promotion was further facilitated via our Facebook page which includes a statement from our Lead Governor outlining the benefits of becoming a member in addition to a Membership Display Stand which is rotated throughout the various entrances to our hospital sites.

A key priority area for the forthcoming year is to target membership recruitment in the young people's age group to sustain an 11 – 16 year old membership population of around 4%. In addition, hard to reach groups will continue to remain

a recruitment focus with particular targeting of minority ethnic groups. Membership promotion will continue to be facilitated by our Membership Display Stand, our Foundation Trust Website (including social media sites), Newsletters and Poster Displays throughout the Trust and on hospital public transportation.

Monitoring Arrangements

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.

Membership Engagement

In addition to upholding our membership community, we have 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 and by developing engagement best practice methodologies.

In 2011/12 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 community 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 regarding service provision at the Trust and Trafford Healthcare NHS Trust.
- Governor attendance (youth and adults) at the Youth Forum Meetings which has facilitated effective engagement between young members and Governors.
- Patient and Public Involvement representatives are permanent members of the Governors' Membership Working Group and assist in the development of membership engagement best practice methods.
- A Governor led Membership Subgroup has been established in order to identify membership engagement practices for hard to reach groups.

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 we serve, 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 Communication and Engagement

We have a number of forums to engage with staff which includes the Local Negotiating Committee, the Trust Joint Negotiating and Consultative Committee (TJNCC), the HR Committee and the Trust Issues Group. Through these groups we engage in partnership working with staff and staff side colleagues.

During 2012 we embarked on a review of our employment policy framework to ensure that it remains fit for purpose. The revised policies and procedures are discussed with staff side and a plan of training for managers will be devised to support the implementation of the new procedures.

The employment relations activity is regularly reviewed by the Human Resources Team and is reported on at a Trust and Divisional Level and at formal joint staff side meetings to monitor cost and consistency.

A staff poll was held in September 2011 and 1,072 staff responded. 67% said that communications in the organisation had improved over the last 12 months with the introduction of the weekly bulletin, changes to Team Brief and the launch of staffnet (which replaced our previous intranet). Improvements to internal communications continue with the launch of CMFTV which means that information can be broadcast to staff and visitors over TV screens located throughout the organisation.

Staff Survey

Operating on such a large scale poses many challenges in terms of the National Staff Survey. For the 2010 survey, there were issues with ensuring all staff received the information; explaining the confidential nature of the survey and ensuring surveys were delivered to the correct locations for our 10,000 staff.

Over the last 12 months, several initiatives have been rolled out to overcome these barriers. A dedicated staffnet (intranet) site has been developed to explain, promote and communicate the results from the survey. This site contains all past survey results, posters and division-specific information so that all staff can access a wealth of resources. Surveys were sent to home addresses to ensure swift, accurate delivery to the correct individuals and a group of staff visited the survey provider's headquarters to learn more about the process and how their information is protected.

We will continue to build upon our staff engagement initiatives and work closely with staff to understand anxieties about the survey in order that they can be resolved.

Summary of performance - NHS staff survey

The response rate for the census results in 2011 has deteriorated slightly from last year which furthers the need for real engagement of staff to understand their reluctance.

However, despite a challenging year and a period of great transition for many staff, the overall picture of results has remaining largely the same. Great strides have been taken in staff appraisals and e-learning continues to grow rapidly as a key method of training and development. The table below details the areas in which we are above and below average compared to other acute Trusts.

Sample Data

	2010/2011		2011/2012		Trust Increase or Reduction
Response Rate	Trust	National Average	Trust	National Average	
	43%	54%	37%	52%	-6%

	2010/2011		2011/2012		Trust Improvement or Deterioration
Top 4 Ranking Scores	Trust	National	Trust	National	
KF21: Percentage of staff reporting errors, near misses or incidents witnessed in the last month (the higher the score the better)	99%	95%	99%	96%	No Change
KF14. Percentage of staff appraised with personal development plans in last 12 months (the higher the score the better)	63%	66%	78%	68%	Improvement +15%
KF17: Percentage of staff suffering work-related injury in the last 12 months (the lower the score the better)	11%	16%	13%	16%	Deterioration +2%
KF12. Percentage of staff appraised in last 12 months (the higher the score the better)	70%	78%	88%	81%	Improvement +18%

	2010/2011		2011/2012		Trust Improvement or Deterioration
Bottom 4 Ranking Scores	Trust	National	Trust	National	
KF19: Percentage of staff saying hand washing materials are always available (the higher the score the better)	40%	67%	48%	66%	Improvement +8%
KF29. Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell (the lower the score the better)	30%	26%	33%	26%	Deterioration +3%
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)	63%	74%	66%	74%	Improvement +3%
KF27. Perceptions of effective action from employer towards violence and harassment (the higher the score the better)	3.58	3.56	3.43	3.58	Deterioration -0.15

Voices Project

The Voices project was commissioned by the Board of Directors to consider a radical approach to improve staff engagement and staff perception of well being following the results of the 2010 staff survey. A working group was convened by the Chairman who commissioned a programme entitled 'Voices'. This resulted in 18 focus groups along with a consultation undertaken both online and using postcards involving a cross section of over 400 staff across all bands, divisions and staff groups including medical staff.

Detailed results have been categorised according to themes, pulling out elements that staff felt most positive about, those they were dissatisfied with and those they most wanted to change. The key themes that emerged were:

- Leadership style and culture
- Staffing and patient care
- Facilities and resources
- Policies and processes
- Communication and change

Addressing these factors is expected to lead to improvements in staff engagement, motivation and job satisfaction. Action plans are in development and implementation of changes is expected imminently.

We're Proud of You Awards

The Annual We're Proud of You Awards were established to recognise the fantastic work of our employees. Every day individuals and teams go above and beyond the call of duty and the awards allow us to acknowledge their outstanding contribution.

2010 saw the introduction of an online application, reducing the length of time needed to submit a nomination. A dedicated staffnet site was also developed which contains details of the awards, how to apply and photographs and videos of previous winners.

Each year a gala dinner is held for all winners and highly commended entrants. This event is hosted by the Chief Executive and Chairman who personally congratulate staff on their achievements.

This year we are continuing to build on previous success and furthering promotion of the awards to include new colleagues at Trafford.

Sickness Absence Figures 2011/12

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 per fte
123,372	2,992,593	76,051	8,199	9.3

Source: The Electronic Staff Records (ESR) system

Period covered: January to December 2011

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.

Some of this information also appears in the Quality Accounts on page 8.

Staff Health and Well-being

We are fully committed to the heath and well-being of our employees. As a health service, health and well-being applies as much to our employees as it does to the local population and we want to do as much as we can to enable our employees to be at their best, be energised, motivated and committed to their work.

We have been involved in well-being initiatives for many years. We have in place Occupational Health and Counselling services which receives positive feedback from staff.

Recently we have reviewed our range of activities and initiatives which contribute to staff health and well-being, have identified gaps and developed plans, where possible, to address these.

We established a Staff Health and Well-being Strategy group in 2010. It has a wide range of members including governors, staff, managers and representatives from Human Resources and Occupational Health & Safety, to undertake this multifaceted work and develop a strategy to identify the relevant issues and on-going work plans.

Progress so far has included:

- Development of the strategy document
- Establishment of an annual programme of health and well-being information available each month via our internal communications
- Liaison with Sodexo to highlight healthy eating options on the café menus
- Entry of teams in to the NHS Northwest Corporate games
- Development of a measured mile walk around the hospitals site

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 our 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 2011/12.

Key Achievements

HR Equality & Diversity (E&D) Steering Group

The HR Equality & Diversity Steering Group comprises all section heads from HR and meets quarterly. The group's aim is to guide the directorate's approach to the management of E&D in the employment agenda. Below are its key achievements from the last twelve months.

HR Equality & Diversity Work Programme

The action plan was designed to improve HR processes and performance in ensuring compliance with the Strategic Equality Objectives and the Equality Act. Below are some of the highlights from this action plan. Over the last twelve months, the HR directorate has:

- Updated and published revised E & D Policies to support the implementation of the equality agenda within the Trust.
- Reviewed and changed HR Occupational Health procedure to ensure compliance with the Equality Act 2010.
- Delivered Recruitment and Selection Training every six weeks.
- Prepared and published an Annual Workforce Profile for 2010/11

- Supported and developed staff networks.
- Delivered E & D mandatory training.
- Implemented the revised Equality Impact Assessment (EIA) framework.
- Delivered E & D training for Managers.

Equality & Diversity Employment Policy Framework

The employment policy framework is designed to reflect the employment law provisions in relation to discrimination and this is reflected in a range of specific Equality & Diversity policies:

- Equality & Diversity in Employment
- Disability Policy
- Special Leave Policy
- Flexible Working, Maternity & Adoption Leave
- Dignity at Work Policy

Equality Impact Assessments

We have implemented a new Equality Impact Assessment Framework. All new and revised Human employment policies undergo the Equality Impact Assessment to identify and minimise any negative impact on any of the equality groups.

Equality & Diversity Training for Staff

Equality & Diversity training is provided as part of the Corporate Induction Programme and the annual Mandatory Training Scheme. In addition, an Equality and Diversity Workshop for line managers to increase knowledge around Equality in Employment was delivered bi-monthly. This training session proved to be very popular and further sessions have been planned for 2012/13.

Equality Networks

We have continued to develop and support the following three staff networks:

- Black and Minority Ethnic (BME) Staff Network
- Disabled Staff Network
- Lesbian, Gay, Bisexual and Transgender (LGBT) Staff Network

The aims of the networks are to support staff from different equality groups and to enable us to gain a better understanding of issues faced by staff in the workplace.

Over the last 12 months the networks have contributed to policy development and other initiatives. For example, the Disabled Staff Network contributed to our Access Group which was set up to look into physical access issues for patients and staff. Members from the LGBT Staff Network were part of the planning group for Manchester Pride. LGBT Staff Network carried out a staff survey about the experiences of LGBT staff to canvass opinion on the future direction and purpose of the LGBT Staff Network.

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.

We have a Disability Policy and any ongoing or new 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.

A Disabled Staff Network has also been developed. This 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.

Supported Traineeships (Project Search)

HR is always looking to identify new opportunities designed to confront and address the barriers that minority groups sometimes face. A practical example of this is on the on-going work we do with 'Project Search'. We are a 'beacon' site in the UK for 'Project Search' which is a 12 month employment focused education programme for young people with disabilities. Launched in September 2010, the programme goes from strength to strength. Six 'graduates' from the class of 2010/11 went on to obtain paid employment either directly within the Trust or with Sodexo. The students have taken up roles in departments such as Clinical Coding in the Eye Hospital and within the Dispensing team within Pharmacy.

For the class of 2011/12 a new classroom on site has been equipped, and the expectation is that this year's students will again take up work in a wide variety of placements throughout the organisation. We have a great determination to match the unique skills of the students with the right opportunities.

The HR Project Team works in partnership with external stakeholders to deliver this productive and rewarding programme, and more information is available via the project website at www.traineeships.cmft.nhs.uk.

Education

Links with the Manchester Health Academy (MHA) have been strengthened throughout the year, and, as the lead sponsor, we have reinforced our commitment to supporting the MHA work programme and curricula. In particular, we have helped deliver a complimentary work programme to sixth form students designed to enhance the healthcare curriculum and enrich learning. Specific work experience programmes for the MHA and other schools and colleges in the local community is a particular priority to ensure skills and employment opportunities for young people are nurtured and maximised.

Community Engagement through Employment Initiatives

We remain totally committed to supporting the regeneration of the neighbourhood local to our sites. A practical example of this is the pre-apprenticeship training course which was successfully launched in April 2011 and represents a significant offer to the local unemployed community to learn about key job roles and how apprenticeships dovetail into our overall employment and training proposal. Working in partnership with Manchester City Council, local job centres, and various employment support providers, we are ensuring that local people receive comprehensive support and information regarding new and genuine employment and training opportunities here.

Workforce Statistics 2011/12

	Staff 2011/12	%	Staff 2010/11	%
Age				
0-16	0	0%	0	0
17-21	100	1%	92	1%
22+	9847	99%	8,592	99%
Ethnicity				
White	8039	81%	6940	80%
Mixed	192	2%	168	2%
Asian or Asian British	837	8%	780	9%
Black or Black British	306	3%	244	3%
Other	121	1%	109	1%
Not Stated	452	5%	443	5%
Gender				
Male	1842	19%	1,746	20%
Female	8105	81%	6,938	80%
Not Stated	-	-	-	-
Recorded Disability	187	2%	103	1%

* Sodexo staff are not included in the numbers in the table.

Summary of Workforce Statistics 2011/12 – key points

- There continues to be no significant change to the age profile of the workforce with 99% of the workforce aged 22+.
- Approximately 4 out of 5 of our workforce is White. 14% are from a Black and Minority Ethnic (BME) background which is slightly lower than 2010/11. 5% of the staff have not stated their ethnicity.
- The percentage split between male and female staff has slightly changed with the female population of employees increasing by 1%.
- 2% of staff have recorded a disability and has doubled since the last report. However this data does not truly reflect the number of disabled staff within the organisation.

E-Learning

The implementation of e-learning has been an ongoing innovative development, especially for the provision of Corporate Induction and Mandatory Training. Such has been the popularity of these programmes, since October 2011 Corporate Mandatory Training has been provided solely by e-learning and this has given staff an even greater flexibility than previously applied. There are 47 courses provided via the updated e-learning platform with access to 195 individual modules. The compliance rates for undertaking mandatory training for 2011/12 was in line with the previous year's impressively high figures and the number of staff accessing training via e -learning has increased significantly year on year delivering the following benefits:

- Increased accessibility
- Significant time and cost savings
- A reduction in the time away from the workplace

New Apprenticeship Opportunities

The NHS at present is experiencing ever-increasing priorities, a challenging financial climate and increasing customer expectations, and so we expect that the next few years will be even more demanding, challenging and complex. To ensure that we are able to deliver the changes required to provide high quality health care, demonstrated in a Foundation Trust environment, it is crucial that our support staff are prepared and equipped with the necessary qualifications, skills and competencies to perform effectively within their roles. We have therefore decided to implement new apprenticeship programmes for support staff which will ultimately improve the quality and provision of our current education programmes ensuring staff working within support roles are fit for purpose.

As part of both a national and regional drive to increase the numbers of apprenticeship opportunities within the NHS, we have also committed and have signed up to the 'Apprenticeship Promise'. The promise means that we will:

- Consider all Band 1-4 (Agenda for Change) vacancies as potential Apprenticeship opportunities and advertise them as such.
- Establish an accurate record of minimum level 2 attainment across the organisation, offering those without, the opportunity to undertake an Apprenticeship.
- Actively promote the opportunities for progression to those who successfully complete their apprenticeship.
- Sign up to the 2012 Top 100 Apprenticeship Employers list to showcase the volume and range of Apprenticeship opportunities in the North West NHS.
- Share best practice and lead the evidence base illustrating the health and well-being impact of education and employment, through an annual case study.

The OD&T (Organisational Development & Training) department is now accredited to deliver level 2 and 3 'apprenticeship' programmes within healthcare support, Radiology, Pharmacy and Healthcare Science as part of a suite of qualifications available through the qualifications and credit framework (QCF).

The first programmes in 'Healthcare Support' began in November 2011 and so far we have enrolled over 80 new apprentices, who are undertaking either level 2 or 3 programmes. The programmes are offered to both existing staff and new employees. The apprenticeship programmes replace the old NVQ awards and incorporate three key elements which include a QCF diploma, B-Tec certificate and functional skills qualification. Generally, level 2 apprenticeships take 12 months to complete and a level 3 will take 18 months.

Ultimately by offering these programmes the organisation will benefit in many ways, for example, becoming a competitive employer of choice for jobs seekers; attract high quality recruits and improve the skills and productivity of existing staff; increasing staff morale and retention. It is our aim to increase the number of apprenticeship programmes over the next 12 months and to be able to provide opportunities to those staff who may not have previously been considered for apprenticeship qualifications, which can be adapted to suit both the needs of the individual and the employer.

Infection Prevention and Control

We have remained on track with another impressive year with regard to Healthcare Associated Infection (HCAI) objectives. This year we have achieved the lowest number of incidents for meticillin resisitant *Staphylococcus aureus* (MRSA) blood stream infections and *Clostridium difficile infection* (CDI) since the performance objectives were introduced.

Our sustained success was demonstrated following an invitation to undertake a 'Critical Friend' review to two Shelford Group Trusts in London. Subsequent to the visit we had established wider links with other organisations who wish to share our framework for clinical practice.

Other positive challenges this year included the assimilation of Infection prevention and control provision for Manchester Community Health Services.

Key achievements this year

The MRSA bacteraemia target has remained a challenge for 2011/12 and was set at 6 compared to 17 for 2010/11. The actual number of attributable MRSA bacteraemias for the organisation for 2011/12 was 4. An in-depth review of these cases was undertaken and lesson learnt identified. These were fedback to clinical areas and will be incorporated into future practice.

We continually apply 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.

The Trust had an agreed target of 96 attributable cases of Clostridium difficile infection (CDI) in all patients over the age of two for the year 2011/12. The actual total number of attributable cases was 82, which is significantly lower than the target agreed.

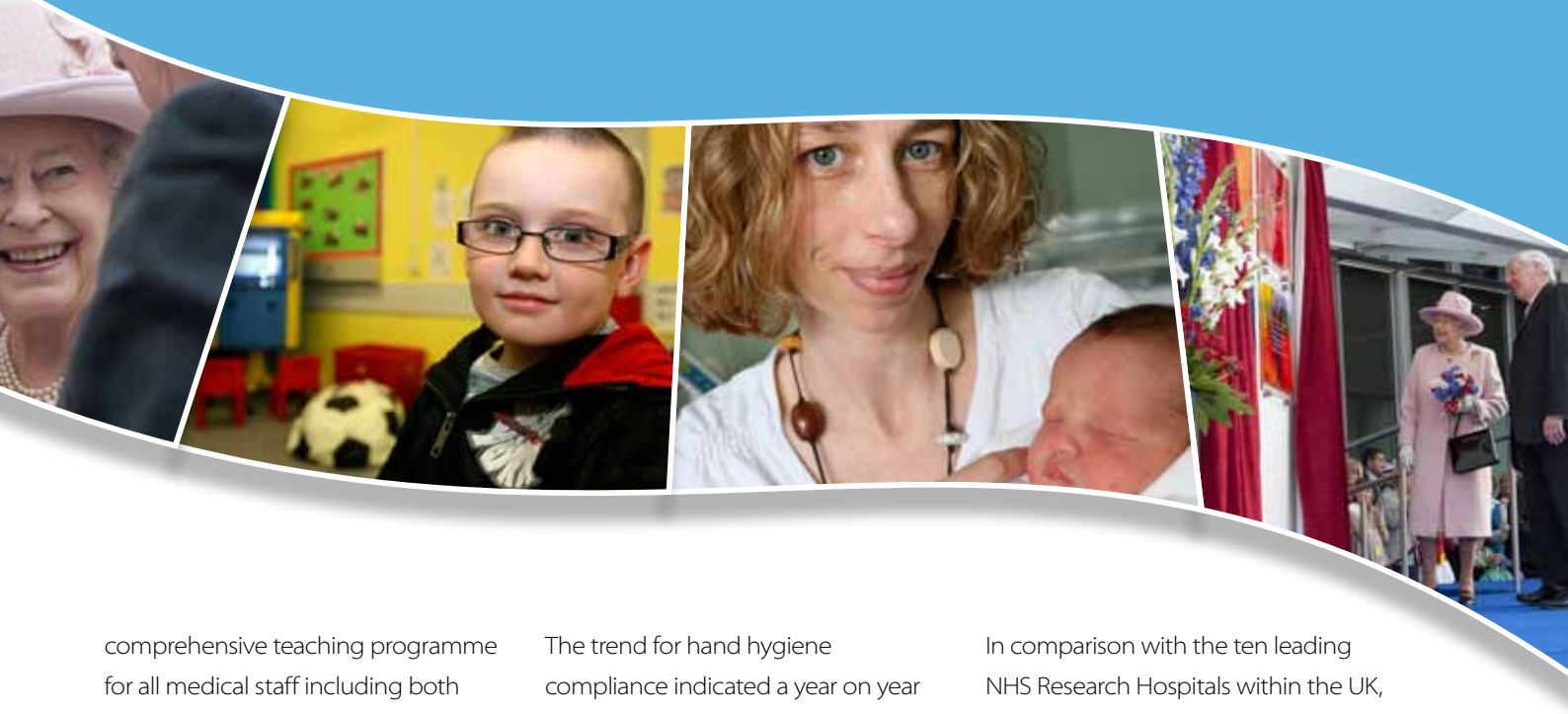
Local activity for seasonal influenza peaked much later in the 2011/12 season, where approximately 12% of samples were Influenza positive. This is representative across the North West region. Preparation for prevention and control arrangements included ensuring staff were trained in the use of respiratory protection and the Influenza policy amended to reflect current national guidance.

In addition we vaccinated 2,921 members of staff against seasonal influenza during the winter period of 2011/12. This was achieved by the organisation of local vaccination clinics within each hospital, in addition to the drop-in sessions organised by the Occupational Health Department

A local challenge for the organisation has been the increased incidence of multi-resistant coliforms from a number of wards. The Infection Prevention and Control Team (IPCT) continue to address the issue proactively and undertake extensive communication and education programmes in addition to an annual review of antibiotic policy and extended screening and surveillance.

The responsibility for auditing Aseptic Non Touch Technique (ANTT) and Visual Inspection of Phlebitis (VIP) score was devolved to all Divisions in April 2011; this was to encourage ownership of ANTT and best practice at local level and is monitored via the Quality Care Rounds (QCR) undertaken each month by the divisional matrons.

The ANTT education programme however remains within the remit of the IPCT, throughout the year we have continued to provide a

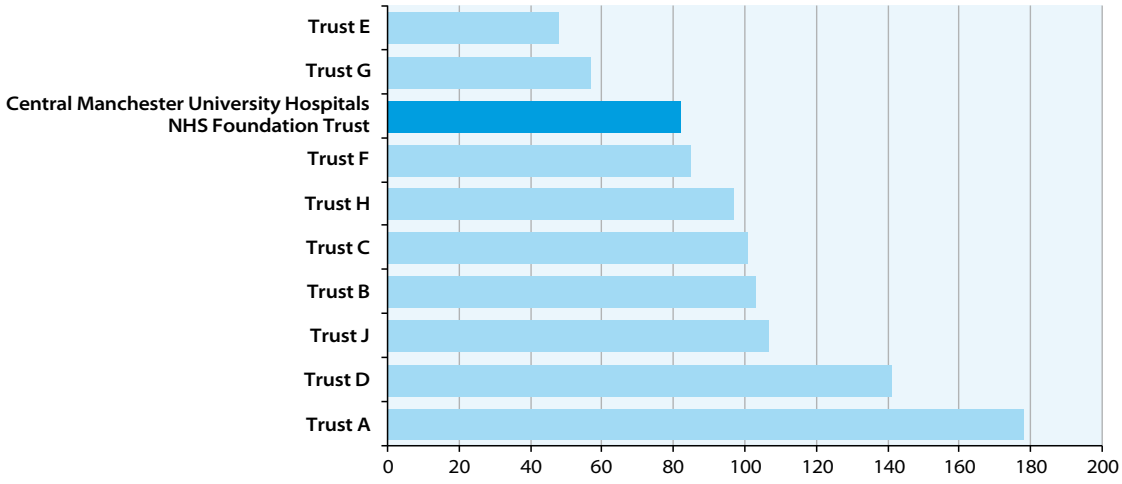


comprehensive teaching programme for all medical staff including both new members of staff and also established senior medical personnel. The number of staff in receipt of this training throughout 2011/12 is in excess of 260.

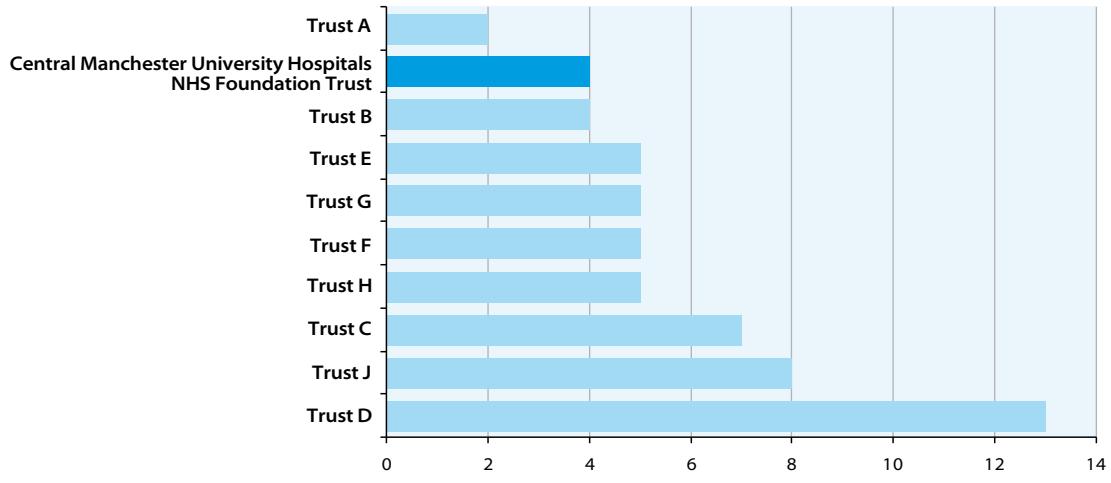
The trend for hand hygiene compliance indicated a year on year consistent level and remained at 97-98% during 2011/12. This is also monitored within the QCR.

In comparison with the ten leading NHS Research Hospitals within the UK, CMFT is one of the top performing Trusts for reportable Healthcare Associated Infections (HCAI, see tables below.

Shelford Group Clostridium difficile cases (Trust-apportioned) April 2011 - March 2012



Shelford Group MRSA bacteraemia cases (Trust-apportioned) April 2011 - March 2012



Performance Against Trust Key Priorities 2011/12

Key Priority 1 - Achieving the highest standards for patient safety and clinical quality		Achievements in 2011/12
The delivery of high quality, safe clinical services underpins all that we do. Achieving the highest standards for patient safety and clinical quality contributes to the achievement of all aspects of our vision; specialist and tertiary service provision, research and innovation and acute and community service provision.	• The number of hospital deaths (as measured by the Hospital Standardised Mortality Rate) is at or below the expected level (< 100) before rebasing each year	HSMR of 100 before rebasing achieved
	• Achievement of the highest level (NHSLA level 3) for our risk management processes by March 2012	Achieved across both standard areas assessed (General and maternity services)
	• Any planned or unplanned reviews of the quality of our services undertaken by the Care Quality Commission (the CQC are responsible for improving the quality of care provided by healthcare organisations in England) are passed each year	Two reviews undertaken by the CQC, both of which were passed
	• Community services achieve registration with CQC, proving that they meet all essential standards, by April 2012	Registration achieved

Key Priority 2 - Delivering excellent clinical services that meet all national targets		Achievements in 2011/12
Achieving national targets demonstrates that we are providing high quality services in line with public expectations.	• Targets for healthcare associated infection (C Diff, MRSA), cancer waiting times, waiting times and A&E waits set in the Monitor Compliance Framework achieved each year	Infection control, cancer waiting times and elective non admitted waiting time targets were met throughout 2011/12. A&E target was met for first 3 quarters, but not in the final quarter. Elective access waiting times for admitted patients were reduced as per the agreed recovery plan with commissioners, with delivery evident and consistent from January 2012.
	• Reduction in healthcare associated infection rates achieved each year	Reduction in healthcare associated infections achieved on 2010/11

Key Priority 3 - Improving the patient experience		Achievements in 2011/12
We aim to be the 'provider of choice' for service users and carers so that we can retain existing patient flows and attract new patients.	• Improved patient/user/staff satisfaction for cleanliness, food and environment achieved each year	Patient feedback using real time patient feedback devices demonstrates improved satisfaction with the management of pain relief and overall patient satisfaction. Marginal improvements in satisfaction with food, privacy and dignity, equality and diversity. Cleanliness and communication scores are similar to those reported in 2010/11
	• Improvement in patient satisfaction achieved based on analysing complaints received each year	There has been a continued increase year on year in the number of compliments received through the Chief Executive's office from satisfied service users There has been an overall increase in the number of complaints but a decrease in the number of dissatisfied responses NB – the organisation has grown relative to the increase in the number of complaints

Key Priority 4 - Maintaining financial viability and stability		Achievements in 2011/12
It is vital that we remain financially viable, and are able to generate surpluses, so that we can continue to provide the services that we already deliver and develop new services to improve the health of the population of Greater Manchester and beyond.	For 2011/12 this means: • EBITDA margin of 8%, leading to a surplus of 1% achieved through delivering savings of £55m (7.6%) • Programme of on-going investment in equipment and facilities managed within £49m budget • Liquidity ratio of 12 days' cover of operating expenses, maintained throughout the year • Maintain level 3 financial risk rating as defined in Monitor's Compliance Framework	For 2011/12 this means: EBITDA margin of 7.1%, leading to a surplus of 0.6% achieved through delivering savings of £46m (6.4%) Programme of on-going investment in equipment and facilities managed within £xxm budget (MG) Liquidity ratio of 19 days' cover of operating expenses, maintained throughout the year Maintain level 3 financial risk rating as defined in Monitor's Compliance Framework

Key Priority 5 - Developing our specialist and tertiary portfolio		Achievements in 2011/12
Expanding the depth and range of the specialist and tertiary services that we provide is key to achieving our vision of being *a leading provider of specialist and tertiary services across the NHS.*	• Accreditation as a centre that can receive patients with major trauma (known as a Major Trauma Centre), for both adults and children, achieved by March 2012 • Accreditation as a centre for specialist services such as vascular surgery, cancer surgery, children's services, cancer services achieved as each service is reviewed over the three year period	Accreditation as a Major Trauma Centre achieved

Key Priority 6 - Integrating Community Services previously provided by Manchester Community Health into CMFT		Achievements in 2011/12
Providing community services will enable us to improve the patient experience and release efficiency savings through the development and implementation of integrated pathways of care – that means joining-up the services provided in hospital with those provided in the community.	• Smooth transfer of staff and services from Manchester Community Health into the organisation achieved by March 2013	All services successfully transferred over to the Division of Medicine and Community Services or the relevant Corporate team by 1st April 2012.
	• The Trust seen by patients and carers, public, healthcare professionals and commissioners as a long-term provider of community health services by March 2014	Plans for development and integration of community services overseen by Community Integrated Care Board (CICB) Central Manchester participating in King's Fund 'Discovery' Programme on service integration.
	• Quality and productivity gains delivered through the integration of care across the community and the hospital by March 2014	Transforming Community Services Board overseeing the integration of services to deliver quality and productivity gains. The first two priority areas identified are Health Visiting and Intermediate Care

Key Priority 7 - Implementing the Research and Innovation Strategy		Achievements in 2011/12
Our emphasis on research and innovation helps us to achieve our vision of being an internationally renowned centre for translational research, but it also underpins all our other strategic aims through providing a pipeline of innovations (that will ultimately benefit our patients) and helping us to attract the best clinical and support staff.	• Progress achieved towards target of being in the top 5 for research and innovation and internationally recognised by 2015/16	New strategic p partnership agreed with NIHR Devices for Dignity programme to develop new treatment for patients with chronic conditions. Early stage Proof of Concept fund established to support and develop new devices and diagnostics for the benefit of patients. Two new spinout companies established to develop exciting new technologies to improve surgical care and monitor patients with heart conditions. Awarded top prize in the NHS Innovation Challenge Prize for the work to increase the number of patients using home dialysis. £14.5 million of external research funding was awarded to researchers working within the Trust Clinical research studies have continued to increase year on year, with 789 clinical research studies underway

Key Priority 8 - Engaging stakeholders, demonstrating leadership for corporate and social responsibility and strategically positioning CMFT		Achievements in 2011/12
Working in partnership with commissioners, the City Council, The University of Manchester, governors and members enables us to fulfil our aim of being a good corporate citizen, shape our services in response to the requirements of the community and ensure that the city region of Manchester continues to thrive.	• The number of Foundation Trust members maintained at 12,000 from 2011/12 to 2013/14	The number of Foundation Trust members increased to 12,500 following recruitment of members in Trafford to reflect the acquisition of Trafford Healthcare Trust.
	• Re-development of the former Royal Eye Hospital as a landmark building on Oxford Road providing facilities for healthcare related research, education and R&D completed by March 2013	Former Royal Eye Hospital re-development on track with a number of leases agreed covering education and research
	• Carbon emissions reduced by 20% on 2011 levels by March 2014	Carbon emissions reduction by 10% in 2015. Increased staff training and energy saving schemes planned by March 2013

Key Priority 9 - Implementing the Workforce Strategy		**Achievements in 2011/12**
Our staff are our most important resource. It is through our staff that we are able to achieve our strategic aims and deliver our vision. It is therefore vitally important that they are fully supported, treated fairly and effectively developed in their roles and that they feel that their contributions are valued.	• Improvement on the previous year and relative to other similar (large acute) hospitals achieved in the overall Staff Survey score achieved each year from 2011/12 to 2013/14	22 out of the 37 Key Findings in the annual staff survey increased between 2010/11 and 2011/12 A major staff engagement initiative 'Voices' was initiated resulting in an extensive action plan that is currently being implemented.
	• Average increase of 10% across all Human Resource Key Performance Indicators achieved year-on-year	Significant increase in Local Induction rates, 10% increase achieved in Appraisals very high achievement rates for KPIs around Corporate Induction (98%) and Mandatory training (95%) maintained, action plans in place around KPIs that did not improve.
	• All staff will have received an appraisal each year	98% of staff (excluding maternity leave and long term sick) received an appraisal in 2011/12.

Key Priority 10 - Developing a long term strategy for IM&T		**Achievements in 2011/12**
Information technology and electronic communications are a key part of all our operational processes - improving our IT and communications can enable us to improve the patient experience and become more efficient.	• Preferred option for key clinical systems decided by March 2012	Achieved
	• Essential hardware replaced by March 2012	PAS Infrastructure replaced
	• Voice recognition, which supports admin processes by converting spoken word to text without the need for typing, fully implemented by March 2013	Voice Recognition implementation on course RMCH - implemented Surgery / Saint Mary's – near completion Specialist Medical Services - in progress Manchester Royal Eye Hospital/Dental/ Clinical and Scientific Services - started
	• Pathway to electronic patient record defined by March 2012	On course

Key Priority 11 - Organisational development of the Children's Division		Achievements in 2011/12
Bringing three children's hospitals (Royal Manchester Children's Hospital, Booth Hall and Saint Mary's) into one has been a significant achievement. It is now a priority to ensure that the staff are enabled to work together to deliver the anticipated benefits of having all children's services together within our brand new state-of-the-art Royal Manchester Childrens Hospital.	• Organisational development plan for RMCH implemented by March 2012 • Outcomes evaluated and revised plan produced based on evaluation by March 2013	ILM Level 5 Certificate in Management and ILM Level 5 Newly Appointed Consultant programme developed and made available for Children's managers/clinicians. Appraisal system and OLM rolled out across the Division. Information from IIP re-assessment, 2011 Staff Survey and 'Voices' staff engagement initiative made available in April to support the development of an improvement action plan. Customer service training programmes and NVQ units delivered for Children's staff

Key Priority 12 - Education and developing our healthcare workforce		Achievements in 2011/12
Our staff are our most important resource - it is important that we ensure that they are properly equipped to carry out their role and given the opportunity to develop to their full potential. Through providing education and training we are also playing our part in developing the doctors and health professionals of the future.	• 5 year Strategic Plan for Postgraduate Medical Education launched by March 2012 • Student satisfaction with undergraduate teaching improved by March 2013 • Percentage of clinical and academic tutors with formal accreditation maintained at over 95% • 10% increase in Staff Survey Key Finding 11 – The number of staff receiving job-relevant training, learning or development in last 12 months	Strategic plan developed Monitoring of student satisfaction with undergraduate teaching improved Accreditation levels maintained

Change is an ever-present force in the NHS and presently structural reform, competition, choice and transparency are driving a number of significant changes through the system. The future blueprint for the NHS as yet still unclear brings uncertainties for all parts of the system.

Competition

The NHS Act sets out a set of reforms that seek to strengthen the role of choice and competition in the NHS. There is the mandatory adoption of Any Qualified Provider (AQP) contracts and the on-going requirement for service changes to satisfy the Co-operation and Competition Panel (CCP). Each of these developments may have a material impact on the volumes of the patients we treat in the future or may have little or no impact. The impact of these changes is continually monitored within the Trust and wherever possible we seek to identify opportunities, working with commissioners and partner organisations to deliver high quality and highly regarded clinical services.

Changes in Commissioning

The desire to shift the locus of commissioning to GPs was at the heart of the NHS White Paper and, despite the increasing role being described for the newly created NHS Commissioning Board, this thrust remains. Clinical Commissioning Groups (CCGs) are now being established to undertake the majority of commissioning for 'local' services. Across the country, CCGs are in their very early stages of development and relationships both between CCGs and with providers will take some time to mature. At CMFT we have been working closely with colleagues in Primary Care and have effective relationships that bring confidence and reassurances that we can jointly navigate the future without major surprises to either party.

Service Delivery Changes

Responding to a number of drivers many services are facing a future typified by greater concentration and consolidation. We have seen this with children's cardiac services already and there are other national consultations of a similar nature in the pipeline. The NHS Greater Manchester Safe and Sustainable programme is seeking to find a better way to deliver safe, high quality, accessible healthcare services provided by thriving, viable organisations within the funding available in relation to:

- Urgent and emergency care
- Surgical services
- Acute medicine
- Cancer
- Long term conditions
- Women and children
- Cardiac and stroke

It is expected that this will lead to the provision of certain services on fewer sites to ensure patients are able to be seen by clinicians with the right level of expertise and improve quality standards. Once again the precise outcome of this work is uncertain but there are likely to be opportunities and threats to some of the services we currently deliver within CMFT.


Family Support Services
snacks
royal manchester
children's hospital charity
supporting excellence in treatment,
care and research
Registered charity number 1049274

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 2011/12 with a comparison for 2010/11:

	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

	Annual Plan 2011/12	Quarter 1 2011/12	Quarter 2 2011/12	Quarter 3 2011/12	Quarter 4 2011/12
Financial Risk Rating	3	3	3	3	3
Governance Risk Rating	Green	Amber/Green	Amber/Green	Amber/Green	Amber/Green
Mandatory Risk Rating	Green	Green	Green	Green	Green

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

The Trust highlighted from the outset of 2011/12 that there was a risk to delivery of the 18 week access target for GP referrals. This was primarily due to a shortage of clinical capacity within Royal Manchester Children's Hospital. We agreed a timescale with commissioners as to how this would be resolved and waiting times reduced accordingly. This timescale was achieved and since January 2012 this target has been met.

At the time of writing the Q4 governance rating is not formally known, although the Trust is expecting on the basis of its A&E performance during Q4 that a similar rating will be determined to that of Q3. Despite advanced planning and the opening of an additional 35 medical beds with associated staffing, intermediate care expansion and enhanced patient transport services, demand during Q4 was to such an extent that the 95% A&E 4 hour target was not achieved with a performance level attained of 93.6%. The annual performance was 95.4%.

Working with our Patients and Visitors

Reminiscence Project

As part of the wider Dementia project currently in progress, the Patient Experience & Quality Team together with the Specialist Nurse for Dementia, held two Reminiscence patient engagement sessions on Ward 45 (Female) and Ward 46 (Male) in the Division of Medicine and Community Services. The Reminiscence workshops allowed the team the opportunity to engage with patients with Dementia in order to gain their views on how their day rooms could be improved to better accommodate their needs whilst staying in hospital.

Working in partnership with Salford Museum & Art Gallery, the team was offered two Memories Matter boxes of objects, the Basket of Memories and the In the Kitchen, to use during the two reminiscence sessions. The original objects contained in the themed boxes, textiles and photographs of vintage furniture, pictures, posters and objects from the 1930s, 1940s and 1950s helped to trigger memories, stimulated the participants' reminiscences and enabled them to share their memories of the past, places and events that mattered most to them.

Twelve patients, six from each ward, attended the workshops and together with the team they produced two mood boards representing their proposed day rooms using the objects and photographic materials available. Following the sessions the team is hoping to improve the day rooms according to the participants' suggestions.

Tameside Sight

The aim of the engagement project with Tameside Sight was for the Patient Experience Team and staff at Manchester Royal Eye Hospital to have the opportunity to gain the service users' views on the Talking Leaflets, a project lead by our Interpretation & Translation Service.

The team gave the participants the opportunity to use and test the Talking Leaflets and provide their feedback on how they felt those could be of assistance to patients with vision impairments and suggest ways in which they could be improved. The participants were also invited to raise their issues and concerns about their experiences as patients relating to the hospital environment, accessibility to the services provided, wayfinding and access to information and communication, both verbal and written.

Following the session, three members of the group agreed to share their patient stories as part of an ongoing project to support staff in understanding the patient experience. This involved sharing their experiences via a DVD. A report was produced and was shared across a number of reporting structures within Manchester Royal Eye Hospital and Tameside Sight so that responses and actions can be developed.

The optimum outcome from the focus group activity described within the report is to implement parallel work streams to redress some of the current concerns raised and described.

Big Word telephone interpreting

The telephone interpreting service was rolled out during 2011 after a pilot during 2010. The telephone interpreting service provides access to interpreters 24/7 with provision of 250 languages and 671 dialects to ensure that staff and patients are able to communicate effectively with one another. It is a quick three step process using either a standard handset or the Polycom 'starfish' unit.

Telephone Interpreting can be used:

- For short sessions with patients
- Emergency or unplanned sessions
- Calling patients at home

We have bespoke training sessions on how to use the service and there are currently 120 departments with access codes, an effective cost saving for users of the service and a management information provision to show daily usage for budget holders.

Chinese Menu Taster Day

A consultation was undertaken with the Chinese community around various disciplines that affect the Chinese community when they attend as in-patients. One of the topics around nutrition produced valuable information on Chinese culture and the needs and beliefs of the patients. As a result our partners Sodexo have been able to source and supply three menu choices specifically for the Chinese population as well as the option of rice to ensure that they had the correct nutrition to enhance their recovery and well being.

We held a taster day event in February that included staff and members of the Chinese community on the panel to discuss the choices available and to accept feedback on the available choices.

The event was seen as a huge success by the Chinese community groups, who were very enthusiastic about having their voices heard and seeing the action of us having listened to their recommendations.

Further recommendations were made to us and Sodexo for provision of another nutritional, milder option of food whilst convalescing as an in-patient and Sodexo was happy to take those recommendations on board and will assist in seeing that the request made by the Chinese community is addressed and met.

ESTU (Emergency Surgical Trauma Unit) Staff Engagement Sessions

After amalgamating two wards into the new ESTU, there was a need to allow staff to have the opportunity to identify areas of development required to support the functioning of the team. It also offered an opportunity to consider improvements to working practice especially between clinical/nursing staff and the AHP (Allied Health Professional) staff. In particular staff could consider suggestions that would have a positive benefit on the patient and staff experience for ESTU. In addition it was felt that a team building exercise for staff would provide the opportunity to identify issues and to propose recommended solutions.

An experience based design approach was used with the staff to allow them to have their say about the current patient and staff experience on the ward and the way in which they felt it can be improved. They developed their own action plans to support this improvement process. This supports the theory that engaged staff are more motivated and will therefore subsequently deliver a better patient experience.

The action plans are now forming the improvement process within the ward team as well as the leadership team, with the patient experience team facilitating an away day for the leadership team to identify how to improve the experience for all on ESTU.

Accessible Information

A recent survey held in the Division of Surgery on the current hospital communication tool provided some real time feedback on how well the communication tool is accepted and used within the division. A training plan was created and is being maintained in the Division of Surgery on how to use the current tool to facilitate communication between staff and patients. However, it was identified that there is a need to update the current book and enhance it, based on future technological developments as well as other pieces of bespoke pictorial communications happening for those patients who have difficulty communicating in English.

As a result a working group has been put together to create and consult of a new updated tool that will be bespoke to us and will meet the clinical needs of various departments by producing pictorial guides on day to day procedures and activities. This tool will be used throughout all our hospitals to ensure that patients are able to see continuity and thus enhance the communication resources between clinicians, staff and patients.

Governing Service Quality

Arrangements in place to govern service quality can be seen in both the Quality Report and the Annual Governance Statement within this Annual Report. The Trust has regard to Monitor's Quality Governance Framework in arriving at its overall evaluation of the organisation's performance, internal control and board assurance framework. Summary action plans are in place to improve the governance of quality information about patient care activities which can be found in more detail in the Quality Report.

Complex Needs

Aligning to the organisation's objectives to improving the patient experience – a Patient Stories initiative has been implemented to facilitate staff from all disciplines and all levels to hear patient's with complex needs and their and carer tell their stories and how we have made them feel.

Inclusion of the carer experience of communication and how they are made to feel was intrinsic to the project. The filming of them telling us their stories was undertaken with carers of young people with learning disabilities and complex needs alongside the young person. The story is described using Experienced Based Design Methodology in the context of their journey through clinical services including positive and negative experiences, how we made them feel and how we can improve.

Carers are recognised as being experts in their experiences and this has led to them being involved in the design of training tools for staff regarding effective communication with patients with learning disabilities, and the need to balance their experiences with staff's clinical expertise.

The stories are used within patient experience training sessions to highlight the importance of the need for holistic care that benefits from conversations about the patient/carer "feelings", balanced with the clinical care pathways.

The stories provided a framework of evidence to establish an accessible communications working group which is developing communication aids for patients/carers with sensory impairment, learning disability and low literacy levels.

Access Group Work

We have undertaken a project regarding access to and across the Trust. There was an acknowledgement that access caused many problems for patients and the public on the site and was a constant theme in complaints,

PALS and patient experience work. To support us to procure an external access audit the team undertook a staff questionnaire and engaged with patients and the public in all the hospitals on site to ascertain their views on access.

Key themes arose regarding signage to departments and the fact that this was often confusing and incorrect. Many issues were raised regarding those patients with disabilities and their access to the site – there were issues with wheelchair access, the height of light switches, the ability to open the toilet doors and the signage for those with visual impairments.

As a result of the staff and patient and public engagement, a report was submitted and an external auditor was appointed, signage across the site is now being installed to correct the issues raised, and there is ongoing work through the life cycling process to address the other issues raised, particularly those regarding disabled access to all areas of the site.

AM3 Project Work

Ward AM3 provides support to patients with complex physical and psychological needs. A number of challenges face staff in providing appropriate and effective care. Within this is an acknowledgement that the client group for AM3 traditionally face socio-economic issues that impact upon their needs, behaviours and attitudes. These need to be considered by staff when delivering patient care. The ward manager in this area has been keen to support the development of her staff in order to respond to the varying needs of patients.

We facilitated staff sessions over a month to allow for all to be involved in the project. Staff were asked to consider their roles and responsibilities within the wards achievements and also the areas that they identified as needing improvement. Team building exercises also allowed for them to build action plans together to improve the experience provided on the ward. Staff realised that they all had an individual role to play in the smooth running of the ward and the delivery of patient experience.

Since undertaking the work the staff have reported better team working and are taking more responsibility for the day to day running of the ward. There has been a reduction in incidents registered and staff are proactively ensuring that there is a culture where lessons are learned from any adverse incidents of negative feedback from patients.

Staff have also introduced a new process for the administration of pain relief within 15 minutes of being requested; this has seen a large reduction in the number of call bells used to ask for analgesia as well as a general sense of improvement in the patient experience on the ward, this is supported through the patient experience tracker data results.

Patient Experience DVDs

A portfolio of patient experience DVDs has been developed as part of the drive to improve patient experience and understand the complexities of how we deliver services impact upon our diverse servicer users. These tools have been used extensively as part of the awareness raising and training on how we can improve services across the organisation.

Market place

Our Marketplace Event held on the 16th December 2011 was an opportunity for all divisions to showcase the practical service improvements that had been implemented, regarding equalities, inclusion and patient experience. This was achieved via a series of stalls from each division displaying projects and initiatives that had made an impact on the patient experience and also, where appropriate, a presentation from that Division. Also featured was a selection of patient stories detailing personal experiences of being a patient here.

All staff were invited to attend,

together with Foundation Trust members, Governors, Divisional Directors, local community groups and Youth Forum members. The event proved to be very popular with around 200 attendees and was an excellent shared learning opportunity for all staff and visitors.

Community Healthcare Services – Customer Experience

From April 2011, around 1,200 staff transferred from the Primary Care Trust into our organisation bringing with them 45 community based healthcare services. These range from Health Visiting, Children's Community Nursing, School Nursing and Community Dentistry across the city, to District Nursing, Community Nutrition and Active Case Management for adults within Central Manchester. Staff within these services supported by corporate services have worked hard with the help of service users, patients and their carers, to improve the quality of services begin to better integrate services with those of the acute services within the Trust.

Service User Reference Group

An example of collaborative working to help integrate services has been in operation during 2011 in the redesigning of Intermediate Care Services in central Manchester.
A multi-agency group of staff representing the Trust, the city council, Primary Care Trust commissioners, local GPs and Ambulance Services have been looking at ways to ensure people in Central Manchester can be prevented from unnecessary admittance to hospital, together with speeding up discharge from hospital, where it is considered appropriate. A number of project groups have been established dealing with falls, chronic obstructive pulmonary disorder (COPD), end of life care in nursing homes and continuing healthcare.

A variety of patient involvement methods have been used to assist decision making including patient stories, patient surveys and setting up an Intermediate Care Service User Reference Group. This Group meets bi-monthly and comprises project leads from the Trust and representatives of voluntary & community groups including amongst others, the Manchester Local Involvement Network (LINk), Carers Groups, Age Concern (Manchester), Manchester Council for Community Relations, Manchester Alliance for Community Care and Women's Royal Voluntary Service. The purpose of the group is to receive reports from the redesign team and act as a critical friend. In addition, a number of workstreams may develop with these and other groups designed to inform the redesign process. Furthermore, the group is connected to the Central Manchester Clinical Integrated Care Board where decisions regarding commissioning healthcare for central Manchester are likely to be formulated and discussed in the future.

Community Patient Experience Outcomes

Many of our community healthcare teams have used patient surveys as a means of gathering the experiences of around 1,500 patients, carers, service users and staff surveyed during the past 12 months.

For each survey, action plans have been produced so that each service can improve quality after involving patients. For example, the Central Manchester Community Continence Service and District Nursing Service have produced newsletters for their patients, increasing awareness of their services; the Family Nurse Partnership Team have produced easy read comic strip type advice arising from comments from their service users and the Child Health Team after surveying their GPs, have helped improve connections with their services.

It is expected that over the coming 12 months, an increasing number of services will undertake patient stories and use Experience Based Design techniques to improve service delivery.

Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service (PALS) has been in its current form since late 2005, during this time PALS have responded to over 15,696 patient, relatives, carers and staff enquiries, concerns and complaints. Since 1st April 2011 PALS have responded to 3,280 general telephone enquiries covering subjects such as car parking facilities, welfare rights, confirmation of appointment details, and issues relating to Primary Care Trusts.

PALS continues to work with and, where necessary, support people to make complaints; however, PALS and staff primary focus over the past years has been to build upon resolving concerns on the spot through facilitating access to key staff members and supporting face to face meetings in a timely manner where possible. PALS experience has found that meeting between patients, their relatives and staff provide an effective forum to resolve complaints, and we are striving to build upon this in the coming year.

Responding to a wide number of contacts that have a varying degree of complexity does present challenges for PALS, for many of the situations are 'real time' events. For this reason PALS are continually reviewing their practice to ensure they can prioritise and respond to contacts in a timely fashion. PALS are also mindful of the reports released through the year by the Patient Association, Mencap and the Health Service Ombudsman regarding the concerns and failures of patient care; so ensure feedback from their learning and contact themes are provided at the Trust's various governance meetings to support the organisational learning.

With our acquisition of Trafford General Hospital from the 1st April 2012, PALS will merge with the Trafford Patient Experience team in providing a service to people contacting us regarding the services provided there.

In responding to concerns it can sometimes easily be overlooked the excellent work that take place within the Trust and how this is appreciated by those who use our services. Through the year PALS have received a large number of compliments from patients and their relatives, and have ensured they are acknowledged and passed onto the staff identified. The following comments are an example of the many sent to PALS:

"I wish to extend my thanks to the staff at the cardiac intensive care unit for their professional and efficient care of my late husband. We were kept well informed throughout and showed a high level of empathy to both myself and my husband."

"I have never had to stay in hospital before and my perception of the NHS was mostly driven by negative press coverage. I want to thank you from the bottom of my heart for the care I received on CLDU. I can truly say that the care and attention I received was simply outstanding; the level of service was amazing. I have stayed in a number of top hotels and I can truly say that I have never received care and attention like I received from the staff on CLDU."

"The staff in CSU made me feel relaxed and took time to answer any questions I had and fully explained each step of my recovery. I was also very impressed by the professionalism shown to my family and myself. I must admit I was more than apprehensive when I came on to the ward but the pure professionalism and relaxed atmosphere helped me mentally prepare for the operation and I was able to feel assured that I was in very capable hands. The team are a credit to your hospital and the NHS."

"The doctor reassured me all the time and took away the awful feelings I get when attending hospital. Everyone in the department is so kind and caring and that makes people like me feel so much better. I am so grateful for all you do for me. Thank you so much, I don't remember all the names of the staff but each one of them is a STAR."

"I wanted to write and tell you how wonderful the 2 staff were who performed my procedure. The radiologist was so incredibly kind and professional; he really is a credit to the NHS and a prime example of the combination of clinical skill and human compassion which should be the benchmark for all NHS staff. Mr C and his staff shine out as beacons of kindness and great skill and professionalism."

"Every problem I have ever had the staff have always helped me and not let it get in my way. I would like to mention my amazing surgeon Mr B who performed surgery on me when I was born. I have had a lot more operations than I have had birthdays but the surgical teams continue to do excellent work to improve my health and give me brilliant strength. I would not be here today if it wasn't for them. The RMCH is such a happy place to be even when you are poorly."

"After several miscarriages and a complex history I was fortunate to meet Dr T at Saint Mary's. She listened, she was determined to get to the route of my problems and she did. I was elated, finally I had an answer and I was started on medication immediately. I was monitored very closely by my Consultant personally and my haematology nurse who was a great support. I was eventually induced at 35 weeks and gave birth naturally to my beautiful daughter. I hope my story gives you something back; without your continual research and your findings I may never have had live children. People are quick to complain but not reward, I will be eternally grateful to your team."

Research and Innovation

Research and innovation is at the forefront of each of our hospitals and is the cornerstone of first-class healthcare. In 2011 we have continued to strengthen our research resources through the National Institute for Health Research (NIHR) Manchester Biomedical Research Centre, with our main academic partner The University of Manchester.

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

Excellence in research

In partnership with The University of Manchester, we have been chosen by NIHR to run one of only three Musculoskeletal Biomedical Research Units (BRU) in the UK. The highly regarded Manchester Musculoskeletal Research Group successfully applied for just under £5 million to set up a nationally recognised BRU, which opened on 1st April 2012. On top of the awarded funding from NIHR, the Department of Health has also agreed to provide a capital investment of £1.27 million towards state-of-the-art equipment for the unit.

The research team, led by Professor Deborah Symmons, will pioneer new methods of assessing early response to treatment in adults and children with musculoskeletal disease, new ways of preventing rheumatoid arthritis and its complications, new therapies for arthritis and new resources for patients to help them achieve the best response to treatment.

Improving our research services

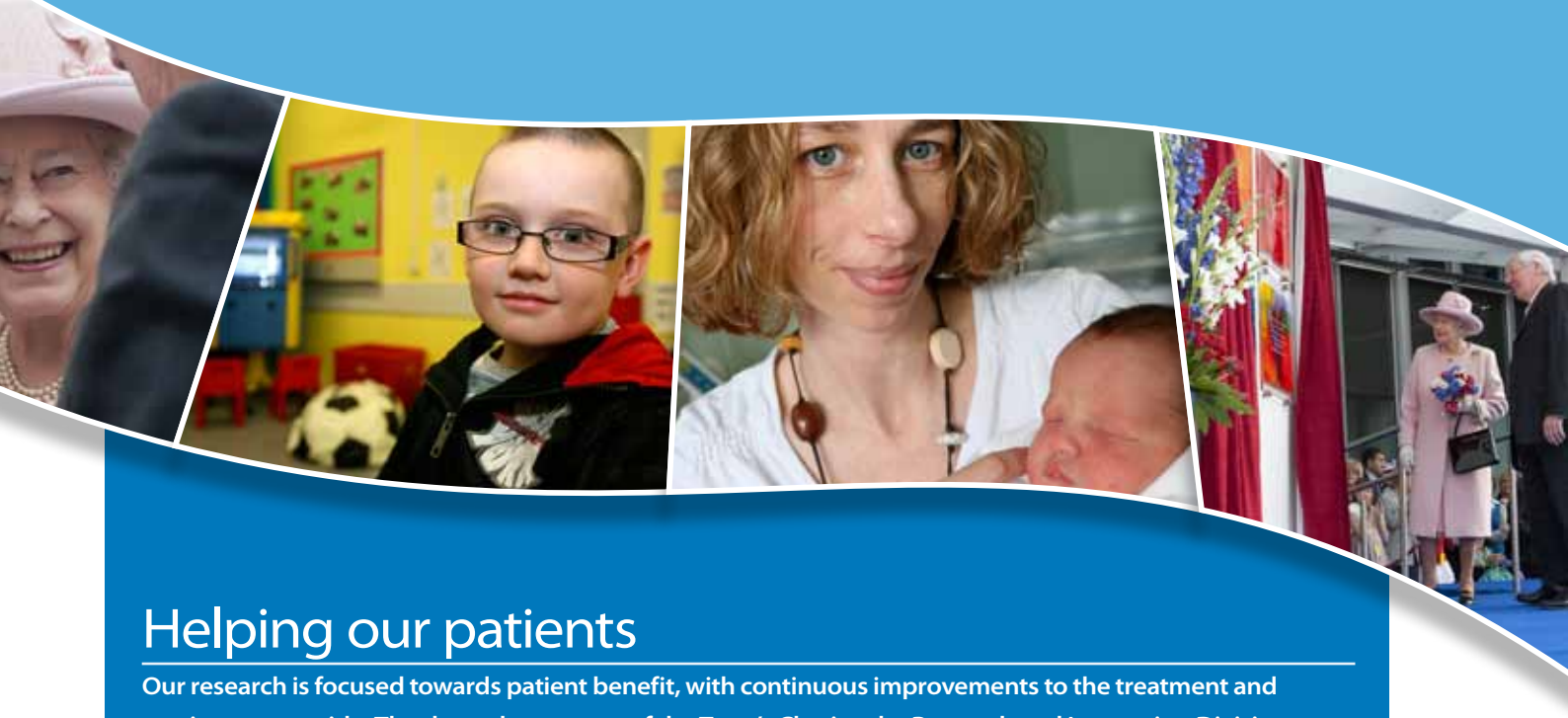
During 2011/12:

8,126	patients receiving NHS services, provided or sub-contracted by the Trust in 2011/12, were recruited to participate in research approved by a research ethics committee
£14.5m	of external research funding was awarded to researchers working within the Trust
789	clinical research studies were underway, of which
46	were in the follow-up stages
286	new studies were approved, of which
242	were approved within 30 working days
147	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
147	Research Passports were processed, allowing external researchers access to our facilities

Translating our research into treatment

In February 2012 Professor Graeme Black and colleagues from the NIHR Manchester Biomedical Research Centre developed a new genetic test offering better diagnosis and treatment for hundreds of patients at risk of inherited blindness. The test will give more patients a definitive diagnosis to their condition and allow some to preserve their sight for longer.

The new test has been developed to make it as affordable as possible for the NHS and work is currently underway to launch a series of genetic test services based on new technologies to improve treatment of cancer, heart disease and many other common and rare conditions.



Helping our patients

Our research is focused towards patient benefit, with continuous improvements to the treatment and services we provide. Thanks to the support of the Trust's Charity, the Research and Innovation Division awarded a total of £200,000 to eight different research studies in the areas of Research for Patient Benefit and Experimental Medicine.

Claire Stevens, ***Consultant in Paediatric Dentistry***, and the team at the University Dental Hospital of Manchester set up a 12-month study to look at whether using intravenous sedation (IV) to help anxious teenagers cope with treatment, initially funded by a £13,000 Research for Patient Benefit grant from the Trust and NIHR Manchester Biomedical Research Centre.

The study involved 50 participants, all of whom were very anxious to the point of some needing psychiatric care, assessing whether sedation with the drug propofol was a viable alternative to 'happy air' (inhalation sedation) or a full general anaesthetic for those aged 12-16 years old.

The results astounded the team with only two of the 50 patients failing to have their treatment. The study has led to a permanent IV sedation service being set up which is now fully booked five months in advance for treatment.

One happy patient said of the treatment "the afternoon of my life", while other comments include "I knew what was happening but wasn't bothered, all I could think was I'm chuffed with myself for doing it" and "I actually enjoyed the treatment."

The sedation service has also reduced pressure on the waiting list for general anaesthetics, and generated additional income for the hospital so it is self-funding.

Dr Sandip Mitra, ***Consultant Nephrologist***, and the renal team at Manchester Royal Infirmary have been commended for their innovative approach to redesigning dialysis in hospitals. Haemodialysis is a process which filters waste products and excess fluids in the blood of a patient with renal disease, most patients require three sessions a week, each lasting four hours.

Seeing an opportunity to redesign dialysis, the team introduced using haemodialysis machines designed for the home environment. Not only does this treatment give patients a better quality of life and independence, but is estimated to make annual savings of approximately £1 million based on 70 patients receiving home dialysis.

One of the patients to benefit from this treatment, David Colye, said "For me, the best solution is carrying out my home dialysis overnight. This completely frees up my working days giving my life back to me. The quality of life I enjoy now is as close to having a real kidney as it is possible to get and I strongly recommend it to all haemodialysis patients."

The renal team were awarded the £100,000 by the NHS for their innovative work, which will be used to improve the service further with the aim of rolling out a national training scheme.

The next generation of leaders

We are dedicated in developing the next generation of researchers through the NIHR Manchester Biomedical Research Centre Academy for Training and Education. In October 2011 the Biomedical Research Centre awarded six one year clinical research fellowships to young researchers in a variety of areas including endocrinology, paediatrics and maternal and fetal health. These awards are in addition to the previous 19 fellowships the Training Academy has awarded to researchers since 2008. Three of these fellows went on to be awarded prestigious external fellowships from the Medical Research Council in 2011.

A number of our researchers have been recognised nationally for their outstanding research, including Dr Jenny Myers, Consultant Obstetrician. Dr Myers was awarded a prestigious NIHR Clinician Scientist award which recognises research leaders of the future. The award will fund a study into the prediction and prevention of adverse pregnancy outcomes in women with chronic vascular disease.

Research in numbers

4mm is the size of a new stent device used at the MRI in the first four operations in the UK to repair abdominal aortic aneurysms. The stent is designed to enable a much broader group of patients to benefit from minimally invasive surgery

8 global first recruits to trials at the Children's Clinical Research Facility (CCRF) based in the Royal Manchester Children's Hospital. The facility has had overwhelming success and has doubled its nursing team since 2009

10 years ago the Wellcome Trust Clinical Research Facility opened its doors, since then

450 clinical trials have taken place at the facility

700 patients will benefit each year from a new genetic testing service for patients with inherited blindness, developed by BRC Director Professor Black and colleagues

5,000 samples were banked by the BRC Biobank in its first year of operation

Investment in facilities

The Wellcome Trust Clinical Research Facility and the Wellcome Trust Children's Clinical Research Facility secured £5.5 million in funding from NIHR to carry out research in areas of high priority and unmet clinical need including arthritis, mental health, cardiovascular disease, diabetes, dermatology, paediatrics and genetic medicine. This funding confirms the quality of research coming out of Manchester and will help further translate basic science to improved treatment for patients.

Manchester Former Royal Eye Hospital

Manchester currently sits in one of the UK's top three biomedical clusters, which is set to be utilised through the redevelopment of the Former Royal Eye Hospital into Citilab. The site will provide an international centre for companies working in healthcare research and increase collaboration opportunities and encourage new and exciting innovation into the NHS.

Some of this information also appears in the Quality Accounts on page 8.

The next 12 months

"With the opening of the NIHR Manchester Musculoskeletal Biomedical Research Unit and the continued funding of the Wellcome Trust Clinical Research Facility and Wellcome Trust Children's Clinical Research Facility, we will continue to expand and develop our research facilities."

Professor Colin Sibley
Head of Research and Innovation Division

The former Manchester Royal Eye Hospital, now known as Citilab, due to open in early 2014 as a centre for biomedical research companies

Highlights and Developments

Genetics Team finds vitamin link to childhood health problems

A group of genetic medicine researchers and doctors announced that they had identified a completely new inherited childhood disorder that can be treated with a form of vitamin, helping to prevent anaemia and epilepsy.

The condition is caused by an inherited change in an important enzyme called dihydrofolate reductase (DHFR). DHFR plays a significant role in how the body handles certain vitamins called folates. When the body is lacking DHFR, children can develop serious health problems including anaemia and epilepsy. (April 2011)

Haemodialysis Team win prestigious NICE award

The home haemodialysis team based at the Manchester Royal Infirmary which developed an innovative approach for patients on haemodialysis, won a special NICE award at its annual conference. The NICE Shared Learning Award recognises inventive solutions to clinical problems.

The winning programme allows patients to perform haemodialysis in their own homes, avoiding the need for regular visits to hospital for treatment. The largest of its kind in Europe, it is open to all patients in the Manchester area undergoing treatment for kidney failure. Significantly improving their quality of life, patients undergoing haemodialysis at home typically require less medication and have greater treatment flexibility with often much better clinical outcomes. (May 2011)

Galaxy House benefits from Arts and Health Mentoring Scheme

Galaxy House was involved with a cultural mentoring outreach programme from the Whitworth Art Gallery. It aimed to promote mental health and well being through creativity and cultural engagement. It has enhanced the appearance of Galaxy House by transforming a sterile and purely functional space into a colourful, homely environment which is enjoyable to live and work in and has encouraged the children to be creative in order to fulfil their cultural entitlement.

The staff and children visited the gallery to engage with the collection and participate in workshops which initiated ideas for the 39 artworks that were built at Galaxy House. (May 2011)

Pioneering computer game helps eye specialists

Mr Tariq Aslam, a consultant at Manchester Royal Eye Hospital drew on his teenage passion for computer programming to create a special test to check the vision of children as young as four, in a way that can flag up problems caused by glaucoma, drug side-effects, brain tumours and other conditions.

He found that it was very difficult getting children to sit still and concentrate while machines designed for adults measured what they could see at the edge of their vision. Crucial information could not be obtained because the children often moved their eyes wrongly or did not respond correctly. This was having an impact on the child's diagnosis and treatment options.

He realised that the ideal way to overcome a short attention span and lack of co-operation was to get children involved in playing a computer game, which would automatically measure their peripheral vision depending on exactly how they played. (May 2011)

Fully refurbished Dental Departments open for business!

The work to refurbish the Department of Child Dental Health and extend the Orthodontic Department at the Dental Hospital came to an end in May.

The work, which took four months, included the installation of a new reception desk, three new treatment rooms, additional space for Orthodontic treatment, refurbishment of the Children's Clinic and Sedation Suite, including a recovery room.

Every effort was made to provide an environment which is modern, yet welcoming and child-friendly. The open plan clinic now houses 8 state-of-the-art chairs with flat-screen TVs and facilities for ambidextrous working. (May 2011)

The New Health Academy Building is Officially Opened

Students and teachers at Manchester Health Academy were celebrating following a visit from Olympic hero and former British triple jumper and world record-holder Jonathan Edwards CBE.

Jonathan visited the Wythenshawe-based Manchester Health Academy to mark the official opening of the new £20 million building that provides first-class sports and wellbeing facilities for its students aged 11-16 and over.

He also officially welcomed Manchester Health Academy to London 2012's Get Set network in recognition of its commitment to and exciting work around the Olympic and Paralympic values. The Olympic values are friendship, excellence and respect and the Paralympic values are inspiration, courage, determination and equality.

Jonathan spent time talking to students about his own experiences and how he made it to the top of his sport, passing on his sports knowledge and advice. He also observed the youngsters in action, with displays that included football and orienteering.

HIV testing to be offered to all medical patients

Manchester Royal Infirmary has started a new initiative to identify patients who are undiagnosed as HIV Positive. From 6th June, all patients admitted to the Medical Assessment Unit are now asked for their permission to be tested for HIV. When a patient is admitted, they have routine blood tests performed that test a range of things from kidney function to blood group. Now, if they give their permission, they will also be tested for HIV.

In Manchester, 4.47 people in every 1,000 are HIV positive. With such a high prevalence rate - and the fact that many people deem themselves low risk - the hope is that by offering it to all medical patients we will be able to diagnose those patients that would not necessarily think to request a HIV test. (June 2011)

NW team leads UK trial of genetic screening to reduce drug side effects

Around 330 patients with a range of different common inflammatory diseases participated in the UK's first large-scale trial to find out if taking a genetic test before they receive the widely-used drug azathioprine can help reduce the risk of serious side effects.

The trial was led by researchers at the National Institute for Health Research's Manchester Biomedical Research Centre (BRC) and The University of Manchester.

They found that patients with very low levels of an enzyme (thiopurine methyltransferase) which helps the body to process the drug are more at risk of serious side effects.

"There is a lot of excitement about this new area of research, called stratified or personalised medicine, where tests are used to try to work out the most effective or safest treatments for each patient," says Dr Bill Newman, a member of the trial team who is based in the Department of Genetic Medicine at Saint Mary's Hospital. (June 2011)

National Innovation Award for Renal Team

The dialysis team at the Department of Renal Medicine at Manchester Royal Infirmary was awarded the top prize of £100,000 in the Department of Health's Innovation Challenge.

The prize was awarded for the innovative approach to dialysis care designed and adopted by Consultant Nephrologist Dr Sandip Mitra and his team. The team developed a home haemodialysis programme which enables and trains patients to dialyse at home. Patients who choose to go on the programme undergo training at their own pace so that they are fully prepared and confident from the outset.

Launched five years ago, the programme has demonstrated significant benefits both in outcomes, patient experience, efficiency and cost savings.

The award has been acknowledged by Health Ministers Simon Burns and Lord Howe who said they were impressed by the work of the MRI renal team.

Health Secretary Andrew Lansley said that the initiative "powerfully demonstrates how patients can benefit when you give freedom and power to those on the frontline who know best how to improve services for patients."

The innovation also attracted the attention of both national and local media including The Guardian, Nursing Standard, BBC North West Tonight and Granada Reports. (June 2011)

Eye Hospital hosts event for National Eye Health Week

To celebrate National Eye Health Week, the Manchester Royal Eye Hospital hosted an engagement event on 16th June.

The event showcased many aspects of eye health and the need for regular eye tests. (June 2011)

Orthoptists put you straight

The Manchester Community Orthoptists is a tiny service that makes a big impact on children's visual development, this June they once again took part in National Eye Health Week. The event was a great opportunity to promote this award winning service.

To celebrate this years event the Orthoptist's from Newton Heath Health Centre held a stall in the foyer of their busy local ASDA in Wythenshawe. The theme of the event was 'Are You Sure Their Eyes Are Perfect?' educating parents about the kind of eye problems children can have and what to do about it. The stalls and information available helped to dispel the myth that children will grow out of squints and emphasised how important it was to pick up any eye problem early for treatment to be successful. (June 2011)

Zero tolerance to violence against staff

We launched a zero tolerance campaign to combat violence against NHS staff.

Posters went on display in the Manchester Royal Infirmary's Accident and Emergency Department, depicting staff who have been attacked and sustained facial injuries. The bold imagery has been designed to shock people into thinking about their actions.

The posters carry a strong message that '98% of people who assaulted our A&E staff in 2010 were successfully convicted' making it clear to patients and visitors that any violence towards staff won't be tolerated.

The campaign is a joint initiative between ourselves and Greater Manchester Police. (June 2011)

3-D movie shows what happens in the brain as it loses consciousness

Brian Pollard, Consultant Anaesthetist at the Manchester Royal Infirmary told the European Anaesthesiology Congress in Amsterdam that real-time 3-D images seemed to show that losing consciousness involves a change in electrical activity deep within the brain, changing the activity of certain groups of nerve cells (neurons) and hindering communication between different parts of the brain.

Professor Pollard said: "Our findings suggest that unconsciousness may be the increase of inhibitory assemblies across the brain's cortex. These findings lend support to Greenfield's hypothesis of neural assemblies forming consciousness."

The team use an entirely new imaging method called 'functional electrical impedance tomography by evoked response' which enables high-speed imaging and monitoring of electrical activity deep within the brain and is designed to enable researchers to measure brain function. (June 2011)

Doctors lead the way in Xenon anaesthesia research

An anaesthesia research team from the Trust announced that it was midway through an international study which is exploring the benefits of using a revolutionary new anaesthetic. We are the only centre in the UK where this research is being carried out.

The new method of anaesthesia uses the naturally-occurring gas 'Xenon' and may provide a whole raft of benefits for the patient and healthcare professional when compared with alternative methods. Early studies have shown impressive protection of the heart and brain during surgery.

There are many benefits to the patient and recent technological advances have reduced the cost of Xenon anaesthesia, increasing the possibility of offering this unique anaesthetic to more patients in the future. (July 2011)

RMCH brings past into the present

The contents of a time capsule uncovered at the former Royal Manchester Children's Hospital at Pendlebury were given a new home. It was discovered in the grounds at the entrance to the former Zachary Merton building and contained a newspaper from 1805, two newspapers from 12th March1935, 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 believed to have been buried.

Now it is being preserved in a glass case in the new RMCH where both staff and patients can delve into the past. (July 2011)

RMCH 'CHiPs' in to help critically ill children

The Royal Manchester Children's Hospital announced it is taking part in a research study looking at the control of blood sugar levels in critically ill children. The Control of Hyperglycaemia in Paediatric Intensive Care (CHiP) began in 2008. Along with ten other hospitals, RMCH has been exploring whether the tight control of blood sugar levels can speed up recovery time. Our Paediatric Intensive Care Unit has achieved the accolade of being the highest recruiter for a non-paediatric cardiac site. (July 2011)

Health Fair for National Sickle Cell Awareness Month

Manchester Sickle Cell and Thalassaemia Centre held a health fair to improve understanding of sickle cell and thalassaemia, as part of National Sickle Cell Awareness Month.

The event featured a health expo on how to feel better and live longer, through eight illustrated exhibits beautifully displayed in art and action - interactive stalls, artistic performances, juicing, cookery demonstrations and health demonstrations. (July 2011)

Specialist Maternity Team Win Prestigious Award

One of our specialist maternity teams celebrated after collecting a prestigious award from Parliament! Our joint cardiac/maternity team won Highly Commended in the 'Best example of a service for women with complex medical needs in pregnancy' category at the All-Party Parliamentary Group (APPG) Maternity Services Awards, for their work caring for women with complex heart disease throughout pregnancy, the leading cause of maternal mortality. (July 2011)

Surgeons first in the UK to use new aneurysm repair device

Vascular surgeons at Manchester Royal Infirmary carried out the first four operations in the UK to repair abdominal aortic aneurysms using a new stent device, designed to enable a much broader group of patients to benefit from minimally invasive surgery.

The pioneering surgery was carried out by Mr Ferdinand Serracino-Inglott and his team, using the new Ovation abdominal stent graft system made by US company TriVascular Inc.

An aortic aneurysm occurs when the aorta, the largest artery which runs through the body, balloons or widens. The aneurysm weakens the wall of the artery and can lead to it rupturing, with potentially fatal consequences. A stent is used to allow blood to by-pass the aneurysm.

This is known as endovascular aortic repair (EVAR). (July 2011)

Future of Trafford Healthcare NHS Trust

We were very pleased to learn that we had been selected by the Board of Trafford Healthcare NHS Trust as their preferred partner to take forward the future development of local hospital services for the people of Trafford. (July 2011)

CQC praises services at Manchester Royal Infirmary

We welcomed feedback from the Care Quality Commission (CQC) following an unannounced review visit at Manchester Royal Infirmary. The report found that Manchester Royal Infirmary is meeting all the essential standards of quality and safety that the CQC reviewed.

We were really pleased with the outcome of the review and in particular with the feedback from patients. Comments such as "the staff are brilliant" and "the staff are kind, considerate and always willing to help" are testament to our passion and determination to deliver excellent patient care.

The visit focused on our compliance with essential outcomes relating to supporting staff and dietary requirements and how well Manchester Royal Infirmary is meeting them. (August 2011)

Project Search celebrates successful first year

"Disability not inability" - Those were the words of Chairman Peter Mount as he spoke at a celebration event to mark the completion of an innovative scheme. Project Search aims to provide diverse and sustainable opportunities that support young people with disabilities through skills training and potential employment.

We are one of 10 NHS pilots across the country to launch the scheme. Project Search is a 12 month project that provides on the job training opportunities, leading to permanent opportunities through a series of three 10 week internships. The trainees are based full time on an employer's site and supported by a number of partnership organisations working together to deliver this collaborative initiative. (August 2011)

Former MRI consultant gets evidence into practice

Manchester Royal Infirmary Respiratory Physician Richard Feinmann and his team in Uganda won a prestigious award at the British Medical Journal Group Awards. He was part of a Ugandan team trialling a new technique to diagnose Tuberculosis (TB) resulting in more people being treated.

Having spent 15 years at MRI, one would have forgiven Dr Feinmann, 65, for putting his feet up after his retirement. Instead he chose to volunteer at the International Hospital Kampula for a year where encountered a continent that had 100,000 cases of TB. He explained that after the AIDS epidemic in the early nineties, the cases of TB rose due to the immune systems of HIV/AIDS sufferers being lowered.

However, diagnostic tests are extremely expensive so along with Target TB, he carried out research in to low cost intervention into the diagnoses of TB in Sub-Saharan Africa. (August 2011)

Pharmacist swaps life in Manchester for Sierra Leone

Pharmacist Suzanne Thomas swapped life in Manchester for Sierra Leone as she took a career break to volunteer at the Ola During Children's Hospital with the Welbodi Partnership. Suzanne developed training programmes for children's doctors and nurses to help improve child health in the country for a year. (August 2011)

Manchester to host new £5m arthritis research unit

A new national research unit based in Manchester which will investigate the treatment of arthritis and other diseases affecting the joints and muscles was announced.

The Manchester NIHR Biomedical Research Unit (BRU) is run in partnership with The University of Manchester.

Led by Professor Deborah Symmons, the team of researchers and clinicians will pioneer new methods of assessing early response to treatment in adults and children with MSK disease, new ways of preventing rheumatoid arthritis and its complications, new therapies for arthritis and new resources for patients to help them achieve the best response to treatment. (August 2011)

Families put the art back into our Newborn Intensive Care Unit

Families from across the region, whose children were born prematurely or poorly, worked with staff on the Newborn Intensive Care Unit (NICU), at Saint Mary's Hospital, to help improve the surroundings for other families.

After moving into the new Saint Mary's in July 2009, families welcomed the fact that the new unit was full of state-of-the-art equipment and it was much bigger and brighter than in the old hospital. However, staff soon realised that whilst the new unit ensured we could provide babies from across the region with the best possible care, the size and the clinical setting meant it was sometimes overwhelming to the families visiting it. (September 2011)

Lord Howe sees renal innovation in action

Lord Howe, Parliamentary Under-Secretary of State in the Department of Health visited Manchester Royal Infirmary to speak to patients benefitting from an award-winning innovation.

In June, the renal team at Manchester Royal Infirmary was awarded an Innovation Challenge prize for their work in offering renal patients dialysis at home. As well as making treatment easier and more convenient for patients, it has also saved the NHS thousands of pounds. They were formally presented with their prize by Lord Howe. (October 2011)

Anyone who has a Heart

An innovative light sculpture was switched on. 'Anyone who has a Heart' was made by artists Andrew Small and Steven Almond and was commissioned by Lime arts and the Trust through a special arts programme allocation from Charitable Funds.

The sculpture aims to catch attention through its form, textures and movement, giving a sense of fun and playfulness for all ages. When you walk around the sculpture it triggers the light display. When you hold onto the stainless steel hand grips there are electrodes embedded in the handgrips that monitor your heart rate and translate that into a red light display synchronised with your pulse. (October 2011)

A House to Relish!

Ronald McDonald House Manchester celebrated its Topping Out with a couple of very special guests. Sir Geoff Hurst and Sir Bobby Charlton attended to show their support for the new House.

It will provide a 'home away from home' environment for families who need to stay close to their children who are in-patients in our Children's Hospital and Saint Mary's.

The house is being built by Ronald McDonald House Charities and will provide 60 en-suite bedrooms, communal lounges, kitchens, dining areas, playrooms, laundry facilities, a teenage room and a quiet room, over five floors. (November 2011)

Pharmacy staff pitched their ideas to expert 'Dragons' Den' panel

Pharmacy staff pitched ideas about how to improve service delivery to a specially-selected panel of 'Dragons'.

The competition, which was run with Pfizer Ltd, saw project leads explain their ideas to the Dragons Den, comprising of eight senior leaders and directors from our Trust, South Manchester and Sheffield Hospitals as well as from Pfizer. (November 2011)

National Accolade for Communications

Yvonne Davies, Head of Communications and PR, was named Communicator of the Year by the Association for Healthcare Communications and Marketing at its award ceremony.

Yvonne and her team were also highly commended in two categories - Best Internal Communications for our Welcoming Community Services internal communications around the transfer of Community Services and Best Media Campaign for the Take That and Party, but not too much! media handling around the Take That concerts earlier in the year regarding the influx of alcohol-related admissions to our A&E. The team was also shortlisted in the Best Website category for the new-look website that was launched in April. (November 2011)

John Thomson Brings Christmas Cheer to Children's Hospital

John Thomson turned on the Christmas lights at Royal Manchester Children's Hospital.

He also presented our charity with a cheque for £20,000 he won on ITV1's The Chase.

John said: "Not being a marathon running kind of guy, I thought it would be in my best interests to utilise my true strength, mainly my intellect which paid off very nicely on ITV's The Chase. It was a genuine highlight of my TV career." (December 2011)

Worsley Man has CT Scan

Most Clinicians could be forgiven for running a mile when they heard they had a 2000 year old patient but when Professor Judith Adams was brought the head of Worsley Man for scanning, by senior conservators from the Manchester Museum, she was positively thrilled.

The head was found in a Manchester peat bog during the 1950s and, like Lindow Man, was initially thought to be a modern murder victim. The police investigated and after an autopsy the Coroner ruled the head was ancient. The head was kept in a pathology store until the 1980s when its significance was realised because of the discovery of Lindow Man. The head even seemed to share the same pattern of injuries: blows to the head, garrotting and a slit throat. It was precisely these injuries that a team of medical and other experts wanted to investigate.

Thanks to the help of Professor Adams and her team in the Radiology Department it was possible for us to take the head over for computed tomography (CT) scanning. Although he has been scanned before, the CT technology has become more sophisticated over the years and it is hoped that a fresh look might reveal new insights about how Worsley Man died. (December 2011)

Saint Mary's Birth Centre at Salford opens for business

The team at the new Saint Mary's Birth Centre, based at Salford Royal Hospital, were delighted to announce the birth of their first baby. Nina Olcyzk was born on Tuesday 6th December at 10.39 am and her delighted parents were featured in the Salford Advertiser to celebrate the arrival. (December 2011)

Music to the ears of patients

It was music to the ears of patients when the Cantus Chamber Choir of Sale Grammar School spread a little Christmas cheer. They dropped into the Royal Manchester Children's Hospital and Manchester Royal Eye Hospital to perform for patients, staff and visitors. (December 2011)

NHSLA Level 3 Success

Christmas came early for staff when they were told that they had achieved NHS Litigation Authority (NHSLA) Level 3 following a rigorous two day assessment recently. We are one of only seven Trusts in the country to have been awarded Level 3 across both general and maternity services. (December 2011)

Celebrating the festive season

Schools, organisations and a couple of famous faces helped to celebrate the festive period at the Royal Manchester Children's Hospital. There was definitely room at the inn for all the visitors throughout December. Coronation Street, Waterloo Road and Hollyoaks' stars visited RMCH together with many other organisations including the Royal Air Force, Eventbooths, GMP Tactical Aid Unit, Lancashire County Cricket Club and Salford City Reds.

Both Manchester football teams painted the hospital red and blue and delighted patients and their families, along with staff when they came armed with presents. Players including Manchester United's Rio Ferdinand and Manchester City's Mario Balotelli put a smile on everyone's faces. (December 2011)

New Altrincham Hospital - One Step Closer

The new Project Board was held in January. It will ensure continuity in delivery of the project, following the transfer of the management of Trafford Hospitals to our organisation. The new hospital will be built on Railway Street, Altrincham in partnership with our preferred developer, Citybranch Limited, and their technical partner, Pochin's PLC. (January 2012)

New Genetic Eye Test Announced

Inherited blindness; a new genetic test offers better diagnosis and treatment for many more patients. Professor Graeme Black, Professor of Genetics and Ophthalmology announced a unique genetic testing service for patients with inherited blindness at the UK Eye Genetics meeting in Bristol. The test will give many more patients a definitive diagnosis of their condition and allow some to preserve their sight for longer with directed medical management and new treatments. (January 2012)

Saint Mary's gets to the heart of maternity care

Saint Mary's won the RCM Award for 'Excellence in Maternity Care', one of the UK's top midwifery prizes at the Royal College of Midwives (RCM) Annual Awards.

The award was given for their work with pregnant women with complex heart problems, one of the leading causes of maternal mortality. The two midwives and their wider team set up a specialist service in 2004. This involved appointing a specialist midwife and also moving antenatal appointments for these women from the outpatients department to the antenatal clinic. This simple change meant that the focus was more on the women's' pregnancy and wellbeing, rather than their heart condition, and generated very positive responses from the women using the service. (February 2012)

Culture Shots spark lively interest

Culture Shots, the first ever Museums and Galleries Week to be held in a hospital setting, gave our staff a chance to sample more than 70 taster sessions. Patients and visitors of all ages were also attracted to the activities which ranged from craft workshops to handling animal sessions and live performances.

The aim of the week was to promote health and wellbeing by exposure to a wide range of arts and cultural events taking place across all five hospital sites (February 2012)

Maternity Service CNST Achievement

The Maternity Service at Saint Mary's achieved CNST level 3 again. The standards and assessment processes are designed to improve the safety of women and babies and encourage a proactive approach to improving care. The assessment required the assessors spending two days on site reviewing audit reports, guidelines, and other written reports. (February 2012)

Patients at the Heart of the NHS - Partners in Care Conference

Patients and health professionals came together in Manchester to learn from each other about delivering the best care for patients.

The Partners in Care Conference was the first time an NHS organisation and The Patients Association came together to organise such a learning event. It was hosted by the Patients Association's Vice President, Angela Rippon. (February 2012)

£5.5 Million to Support Research Awarded

The Wellcome Trust Clinical Research Facility and The Wellcome Trust Children's Clinical Research Facility (WTCRFs), at the Trust were celebrating after securing £5.5 million from the National Institute for Health Research (NIHR) to carry out research into many of the major diseases and illnesses that affect the population of Greater Manchester and the wider North West. We are one of three leading hospital trusts, working closely with The University of Manchester, to be awarded funding.

The WTCRFs will expand world class Experimental Medicine in areas of high priority and unmet need including arthritis, mental health, cardiovascular disease, diabetes, dermatology, paediatrics and genetic medicine. The WTCRFs will also support the brand new £6 million NIHR Manchester Musculoskeletal Biomedical Research Unit and Translational Research Partnership in Joint and Related Inflammatory Disease in their goal of 'Treating Arthritis: Right First Time'. (March 2012)

New collaboration key to clinical needs

A collaboration that could lead to the developments of new treatments and technologies to address unmet clinical needs was announced this month between the Trust and Devices for Dignity (D4D), a national Healthcare Technology Co-operative. (March 2012)

Short Break Service praised by CQC

We received welcome feedback from the Care Quality Commission (CQC) following a review of the Short Break service. The report found that the service is meeting all the essential standards of quality and safety.

We were really pleased with the outcome of the review and in particular with the feedback from patient's parents. Comments such as "a fantastic service" and another saying that their son getting a place at the home was like "winning the lottery" are testament to our passion and determination to deliver excellent patient care.

The CQC praised our staff for engaging very well with service users and treating them with respect as well as recognising the positive and warm relationships our staff have with service users. (March 2012)

Acquisition of Trafford Hospitals Gets Final Green Light

The acquisition of Trafford Healthcare NHS Trust by our Trust received approval by The Secretary of State for Health.

This approval was the final stage following the approvals by: Our Board of Directors, The NHS Co-operation and Competition Panel (CCP), Care Quality Commission and Monitor (Independent Regulator of NHS Foundation Trusts).

This meant that the acquisition was all set to take place on 1st April 2012. (March 2012)

Official Opening of Our Hospitals by Her Majesty the Queen and His Royal Highness the Duke of Edinburgh

The official opening of the new hospitals by Her Majesty The Queen and His Royal Highness The Duke of Edinburgh took place on 23rd March 2012.

Over 1,000 staff, patients and guests were involved. A specially commissioned piece of music by the Royal Northern College of Music 'Diamonds, feathers and saxophones' was played as the Royal party exited the Royal Eye Hospital and Her Majesty was presented with the score in a commemorative book. (March 2012)

Activity and Performance

Accident and Emergency Attendances

	2010/11	2011/12
First Attendances	203,012	200,372
Follow-up attendances	153	6,809
Total	**203,165**	**207,181**

In-patient/Day case Activity

	2010/11	2011/12
In-patient (emergency)	61,347	64, 879
In-patient (elective)	16,738	17,163
Day cases	56,035	58,129
Total	**134,120**	**140,171**
Day cases as a % or elective activity	77.0%	77.2%
Day cases as a % of total activity	41.8%	41.47%

In-patient Waiting List

	31st March 2012		
	In-patient	Day case	Total
Total on Waiting List	2,673	6,089	8,762
Patients Waiting 0-3 months	1,739	3,947	5,686
Patients Waiting 3-9 months	750	1,774	2,524
Patients Waiting over 9 months	184	368	552

Out-patient Activity

	2010/11	2011/12
Out-patients first attendances	177,764	200,458
Out-patients follow-up attendances	471,980	542,472
Total	**649,744**	**742,930**

Bed Usage

	2010/11	2011/12
Average in-patient stay	2.7 days	2.6 days

General Information

	2010/11	2011/12
Number of babies born	6,543	7,285
Total number of operations/procedures	155,460	138,903
Renal Transplants (including kidney/ pancreas)	202	225
Number of Cataract Procedures	9,230	10,656

The 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 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 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 (DfES 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.
- Trustee Central Manchester University Hospitals Charity
- Patron NEBATA (North of England Bone Marrow and Thalassaemia Association)
- Trustee and founder of the charity Helping Uganda Schools.

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.

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.
- Deputy Lieutenant in the County of Greater Manchester.

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

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

- Professor Rod Coombs is 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

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

BA, MBA, ACA, FRSA (Fellow Royal Society of Arts); Doctor of Letters (Salford University – for services to broadcasting and the region)

- 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.

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.

Steve Mycio, Non-executive Director (Appointed December 2009)

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

- Deputy Chief Executive (Regeneration), Manchester City Council (retired September 2011)
- From 1998 until 2008, 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.

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.

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.

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 nine 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. Honours degree in Modern History, University of Oxford, 1984.

- Executive Director of Finance since May 2007.
- Prior to joining the Trust, 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 (June 2009 – October 2011 on secondment from November 2009)

Attendance at Board Meetings

	May 11	Jul 11	Sept 11	Nov 11	Jan 12	Mar 12
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, NHS Institute.

Professor Rod Coombs, Non-executive Director: Deputy President, The University of Manchester; Director of Manchester Growth Hub (part of LEP Local Enterprise Partnership) and Non-executive Directorships for: Manchester Science Park Ltd; One Central Park Ltd; UMI3 Ltd (subsidiary of The University of Manchester).

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

Brenda Smith, Non-executive Director: Member of the Board of Governors, The University of Manchester; Member of North West Business Finance Investment Advisory Panel; Director of Smithbiz Associates, Media Advistory Services to provide equity and corporate finance; Member of the Strategic Advisory Group for East Cheshire Hospice.

The Register of Interests of Directors can be viewed by contacting the Director of Corporate Services (see back cover)

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

Steve Mycio, Non-executive Director: Directorships: Manchester Health Academy; Manchester United Foundation Trust; Manchester Credit Union.

Alexander Wiseman, Non-executive Director: Director of Alex Wiseman Associates Ltd.

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**, Director of Patient Services/Chief Nurse; **Adrian Roberts**, Executive Director of Finance; **Robert Pearson**, Medical Director; **Martin Hodgson**, Director of Children's Services.

(a) Remuneration (audited)

Name and title	2011-12			2010-11		
	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		
R Coombs, Non-Executive Director	15-20			15-20		
R Bradley, Non-Executive Director	15-20			15-20		
B Smith, Non-Executive Director	15-20			15-20		
S Mycio, Non-Executive Director	15-20			10-15		
A Wiseman, Non-Executive Director	15-20			10-15		
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 (to 31 October 2011)	70-75			125-130		
R Pearson, Medical Director	95-100	135-140		95-100	130-135	
A Roberts, Executive Director of Finance	155-160			155-160		

	2011-12	2010-11
Band of Highest Paid Director's Total	235-240	230-235
Median Total Remuneration	28,470	27,798
Remuneration Ratio	8.3	8.4

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Central Manchester University Hospitals NHS Foundation Trust in the financial year 2011/12 was £237,500 (2010/11 £232,500). This was 8 times (2010/11 8 times) the median remuneration of the workforce, which was £28,470 (2010/11 £27,798).

In 2011/12 nil (2010/11 nil) employees received remuneration in excess of the highest paid director. Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

(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 2012 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31st March 2012 (bands of £5,000)	Cash Equivalent Transfer Value at 31st March 2012	Cash Equivalent Transfer Value at 31st March 2011	Real increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
M Deegan, Chief Executive	7.5 to 10	27.5 to 30	35 to 40	110 to 115	662	425	222
G Heaton, Executive Director of Patient Service/Chief Nurse	2.5 to 5	12.5 to 15	45 to 50	140 to 145	946	770	149
M Hodgson, Executive Director of Children's Services	0 to 2.5	5 to 7.5	30 to 35	90 to 95	465	345	109
R Pearson, Medical Director	0 to 2.5	5 to 7.5	80 to 85	245 to 250	1,863	1,697	106
D Welsh, Executive Director of Human & Corporate Resources	-2.5 to 0	-2.5 to 0	60 to 65	180 to 185	1,368	1,292	31
A Roberts, Executive Director of Finance	0 to 2.5	0 to 2.5	45 to 50	145 to 150	828	700	104

The above table gives pension benefits up to 31 March 2012, and as Non-Executive members do not receive pensionable remuneration, therefore there are 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.

Emergency Preparedness

Emergency Preparedness within the Trust is delivered by the Emergency Planning Team in collaboration with multi-agency partners. We have a Major Incident Plan in place to deal with those events that cannot be handled within routine service arrangements, together with Business Continuity/Internal Emergency Plans which escalate and manage internal disruptions within the organisation.

All our Emergency Plans, including more specific plans that deal with Heat-wave, Fuel disruption, Decontamination, Special Paediatric Plans, Pandemic Flu and Burns are held on an Emergency Planning website which during 2012 will be subject to an overhaul to incorporate details of all resilience planning activities, training and exercising across all hospitals and community services which fall under our umbrella including newly acquired Trafford Hospitals.

As part of our statutory requirements under the Civil Contingencies Act 2004 there is a minimum requirement for NHS organisations to undertake a live major incident exercise every three years; a table top exercise every year and a test of communication cascades every six months. To uphold our commitment to this a 'live' Emergo style Major Incident exercise was carried out in June 2011 which tested a Trust-wide response including both adult and paediatric casualties. Further tabletop exercises were also undertaken throughout 2011/2012 testing critical area plans and specialist services including Burns. Communication cascades are held regularly testing both in hours and out-of-hours responses.

To ensure we are prepared to respond to internal or external incidents and emergencies during 2012 and beyond we will continue to train, exercise and review our Emergency Planning arrangements with particular emphasis on special event planning including the Olympic Games and integration of all our hospitals, whilst working towards key resilience work streams cascaded down nationally through the changing face of the NHS and the command and control structures that will emerge over the coming year.

Annual Governance Statement

1st April 2011 to 31st March 2012

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/ key priorities 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 Manchester PCT (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 full 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 2011/12. The Medical Director is supported by three Associate Medical Directors with specific responsibilities.

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.

The Medical Director is the Responsible Officer for the Trust, for the purposes of the revalidation of doctors with the General Medical Council. He is supported in this role by an Associate Medical Director with responsibility for revalidation.

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 NHS North to discuss national and regional HR policy issues. Meetings are also held with a number of national organisations to discuss common HR strategies.

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 2012 and up to the date of approval of the Annual Report and Annual Accounts.

Capacity to Handle Risk

The Chief Executive chairs the Trust Risk Management Committee and actual risks scoring 15 or above are reported. Risk reports are received from each responsible 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 a 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, mortality 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 requirements of registration. As an annual submission is no longer required the organisation has developed a system of ongoing annual 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 2011/12 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 Annual Governance Statement in March 2013.

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 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. It 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 Annual Governance Statement.

A significant level of assurance has been given by Internal Audit during 2011/12 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 2011/12 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 2012 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 2011/12 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.

The Trust is working with an independent team of equality professionals to review and assess its equality and diversity processes and strategy to determine areas for improvement.

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 Acute Trust Risk Management Standards at Level 3 and CNST Risk Management Standards for Maternity Services at Level 3.

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 3
- Compliance Against CNST – Maternity Standards at Level 3
- Patient Environment Action Team Inspections
- Senior Leadership Walk-rounds
- 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.

Clinical Effectiveness Scrutiny Committee

The Clinical Effectiveness Scrutiny Committee performs 'deep diving' into the quality of patient care and patient safety through focused scrutiny on key issues.

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.

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 4-5% removed from tariff uplifts each year will require significant efficiencies over the next 5 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.

- **Adult Critical Care Capacity – Clinical**

Increasing demands on adult critical care services particularly for specialist referrals has 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 August 2013 for the entire project. A new 20 bedded ICU and ancillary areas are scheduled for September 2012.

- **Infection Control – Clinical**

The Trust has continued to demonstrate significant performance during 2011/12 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 targets set against the number of patients treated remains very challenging. The performance objectives for 2012/13 include the allocation for Trafford Hospitals.

The Trust continues to adopt a zero tolerance approach to infection prevention and control and is continually improving services to meet these challenges. The Trust has re-launched its campaign of good practice.

- **Eye Hospital Capacity – Clinical**

Managing follow up Macular Treatment patients within correct treatment intervals remains challenging. Actions to mitigate this risk have included the appointment of additional consultants exploring new ways of working, revision of patient pathways and identification of additional space at Trafford Hospital.

- 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 2010 survey results each Division has developed action plans to address concerns raised and these plans are reviewed on a regular basis. In addition, the 'Voices' project, championed by the

Chairman, was launched. Focus groups of staff together with surveys were implemented and a set of recommendations for action has been agreed by the Board. Further work will be undertaken following an analysis of the 2011 staff survey.

- **A&E Performance – Clinical**

Compliance with the 4 hour A&E target was not achieved in Quarter 4, 2011/12 despite exhaustive operational efforts to plan for the usual pressures associated with winter and remedial measures implemented during Quarter 4, 2011/12.

The Trust is benefitting from expert support from the Department of Health's intensive support team.

- **Referral to Treatment Time – Clinical**

The admitted target of 95% within 23 weeks was not delivered for the first 3 quarters of 2011/12 due to an extensive backlog of patients who had already waited in excess of 23 weeks, primarily in the Children's Division.

A performance framework was developed to address and track the actions being implemented to address the shortfall. The Trust delivered on its recovery plan for Quarter 4, 2011/12.

- **Trafford Healthcare Trust Acquisition – Organisational**

The risk assessment in respect of the Trafford Healthcare Trust acquisition was structured around six key high level risks relating to pre and post acquisition.

Internal project management arrangements have functioned effectively and robust operational management arrangements have been put in place for the Trafford Hospitals Division.

- **Incorrect linkage of patient records resulting in mismatched blood group – Clinical/ Organisational**

This was a composite risk of four component parts. A robust action plan was put in place and all risks are on target for address by the end of April 2012.

- Information/Data – Organisational

The Trust has undertaken 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 focused 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. The Information Governance Toolkit assurance submission for 2011/12 saw an increase to 84%.

There were no Serious Untoward Incidents of data loss or confidentiality breaches reported during 2011/12.

Annual Quality Report

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 (as amended) 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.

The Trust has robust data quality procedures in place that ensure the robustness of data used in the Quality Account. 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 Account 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 Account 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 30th May 2012

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 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 and risk 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, of 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 2012.

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 was implemented during 2011/12.

So far as each Director is aware there is no relevant audit information of which the Trust's Auditor is unaware and each Director has taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Trust's Auditor is aware of that information. Each Director is regarded as having taken all the steps that they ought to have taken as a Director in order to do the things mentioned above and made such enquiries of his/her fellow Directors and of the Trust's Auditors for that purpose and taken such steps (if any) for that purpose as are required by his/her duty as a Director of the Trust to exercise reasonable care, skill and diligence.

Audit Committee Annual Report 2011/12

The Audit Committee Report reviews the work and performance of the Audit Committee during 2011/12 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, the principles of integrated governance and Monitor's Compliance Framework.

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 key priorities.

Committee Membership

The Audit Committee membership during 2011/12 comprised:-

Mr Anthony Leon – Deputy Chairman of the Board and Chair of the Audit Committee

Mr Rod Coombs – Non Executive Director

Lady Rhona Bradley – Non Executive Director

Mrs 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 2011/12 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 Terms of Reference were reviewed by the Audit Committee in February 2012.

Attendance

Date	Anthony Leon	Rod Coombs	Rhona Bradley	Brenda Smith	Steve Mycio	Alex Wiseman
14/04/11	✓	✓	✓	✓	✓	✓
01/06/11	✓	✓	✓	✓	✗	✓
07/09/11	✗	✓	✓	✓	✗	✓
02/11/11	✓	✗	✓	✓	✓	✓
08/02/12	✓	✗	✓	✓	✓	✓

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. A review has been undertaken including consideration of market testing and a recommendation will be made to the Council of Governors in July 2012.

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 2011/12
- 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 2011/12

The Audit Committee has adhered to the Work Programme agreed in April 2011. All reports scheduled for each Committee meeting have been received on time.

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 business continuity risk of IT systems and the acquisition of Trafford Healthcare Trust.

External Audit

The Audit Commission presented its plan setting out the proposed work in relation to the 2011/12 accounts.

The accounts were audited by the Audit Commission and the findings presented to the Audit Committee in June

2011. 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 2010 to 31st March 2011. The Council of Governors subsequently received the report on the accounts from the Independent Auditor in June 2011.

The Audit Commission carried out an audit on the Quality Account 2010/11 and provided recommendations to the Audit Committee in September 2011.

Internal Audit

The Audit Committee received the Internal Audit plan for 2011/12 in April 2011. 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 2010/11 was presented to the Audit Committee in June 2011 and a significant assurance was given on the adequacy of the system of internal control.

35 Internal Audit reports were received, one was given a full assurance rating, 30 were given a significant assurance rating and 4 were given a limited assurance rating.

The Audit Committee received the status on implementing Internal Audit Recommendations at each meeting.

Performance against key indicators in the Internal Audit Plan was reviewed at each meeting by the Committee.

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 fulfil 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 programme of work was presented to the Committee in June 2011. Areas which continued to be covered during 2011/12 included:

- creating an anti fraud culture
- deterrence
- prevention
- detection
- investigation
- sanction
- redress

A Counter fraud annual report was presented to the Audit Committee in June 2011 and provided a summary of the counter fraud work undertaken based upon the annual work plan.

In February 2012, 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 given an overall rating of Level 2. This rating indicates that the Trust is performing effectively across the full range of counter fraud actions as outlined in NHS policy.

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.

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 Audit Committee in February 2012 received the process for the approval of Trafford Healthcare Trust's financial accounts.

The Audit Committee received the updated Board Assurance Framework on a regular basis.

Statement on Internal Control

The Audit Committee received the Statement on Internal Control 1st April 2010 to March 2011 in June 2011.

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.

Standing Orders

The Audit Committee received the revision to the standing orders, February 2012 prior to approval by the Board of Directors in March 2012.

Trust Annual Report

The Audit Committee received the Trust's Annual Report 1st April 2010 to 31st March 2011, in June 2011.

Priorities for 2012/13

The Audit Committee will review the arrangements to be put in place/developed in relation to:-

- Trafford Healthcare Trust Acquisition
- Compliance with Foundation Trust authorisation
- 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

Procurement of Internal Audit, Counter Fraud and External Audit Services

The Trust undertook a procurement exercise for Internal Audit and Counter Fraud Services in February 2012. The Chair of the Audit Committee, chaired the procurement panel.

Procurement for External Audit Services will take place in early 2012/13.

Conclusion

The Audit Committee has continued to consider a much wider spectrum of risk during the year. This will continue to be strengthened during 2012/13. Also in cooperation with the Finance Scrutiny Committee, particular emphasis will continue to be given to the finances of the Trust, taking into account the wider economic situation.

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 2012/13 on following up Internal and External Audit reports where limited assurances have been given and also monitoring the clinical audit process.

The Audit Committee has met its terms of reference as detailed throughout this report.

Anthony Leon
Chairman
Audit Committee 11th April 2012

The Remuneration and Nominations Committees

The Remuneration and Nominations Committee of the Council of Governors met once during 2011/12 to consider and approve the reappointment of a Non Executive Director. Professor Malcolm Chiswick, the Lead Governor, chaired the Committee and those Governors on the Committee were Mary Marsden, Staff Governor, Sue Rowlands, Public Governor, and Gilian Wallis, Nominated Governor. 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 2011. 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 and Nominations Committee of the Board of Directors has met during the year as required to determine the remuneration of the Executive Directors. The Committee is chaired by the Chairman of the Trust and consists of the Non Executive Directors of the Trust. 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. Executive Directors undergo annual appraisals which monitor their performance against the Trust's key priorities. There have been no Executive or Non Executive appointments made during 2011/12

Statement of Chief Executive's Responsibilities

as the Accounting Officer of Central Manchester University Hospitals 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 Central Manchester University Hospitals 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 Annual 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 Annual Reporting Manual have been followed and disclose and explain any material departures in the financial statements;
- 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 him/her 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

30th May 2012

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 2011/12 financial year is a surplus of £56.1m. A significant element of the surplus for the year, £51.7m, arises from an increase in the value of buildings and is a part reversal of impairments in previous years. Further detail is set out in note 10 to the accounts. This change is treated as an "exceptional item" and after excluding this, the reported results therefore reflect an underlying in year surplus of £4.4m.

The year-end cash balance of £60.3m reflects some slippage in capital expenditure, as well as a continued strong working capital position.

2. Analysis of Financial Out-Turn

The income and expenditure out-turn for the year was a surplus of £56.1k and the underlying surplus of £4.4m equates to 0.6% of our total income for the year.

3. Financing

In the year 2010/11 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. The Trust borrowed £7.5m of this during 2011/12 and will draw the remainder in 2012/13 as the scheme completes.

In addition to the above, the Trust has an un-utilised working capital 'overdraft' facility as required by our terms of authorisation, which was increased to £40m from September 2010.

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 margin	7.2%	3
EBITDA % of plan achieved	95.4%	4
Return on Assets	7.0%	5
I&E surplus margin	0.6%	2
Liquid ratio	19.3	3
Overall Financial Risk Rating		3

4. Conclusion

The 2011/12 financial year saw increases in the scope of the Trust's activities, representing a full twelve months of additional Community Services activity (taken on as part of Transforming Community Services) along with a significant increase in Maternity Services (as a result of work transferring from Salford Royal in November 2011, as part of implementing the Greater Manchester NHS 'Making it Better' programme).

With careful management through this transition, the Trust has met the overall financial requirements set by Monitor throughout the 2011/12 financial year.

Robust financial plans are in place for 2012/13 which take full account of acquiring Trafford Healthcare Trust from April 1st 2012, as well as the 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 30th May 2012

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 31 March 2012 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 notes to the financial statements.

I have also audited the information in the Remuneration Report that is described as having been audited.

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.

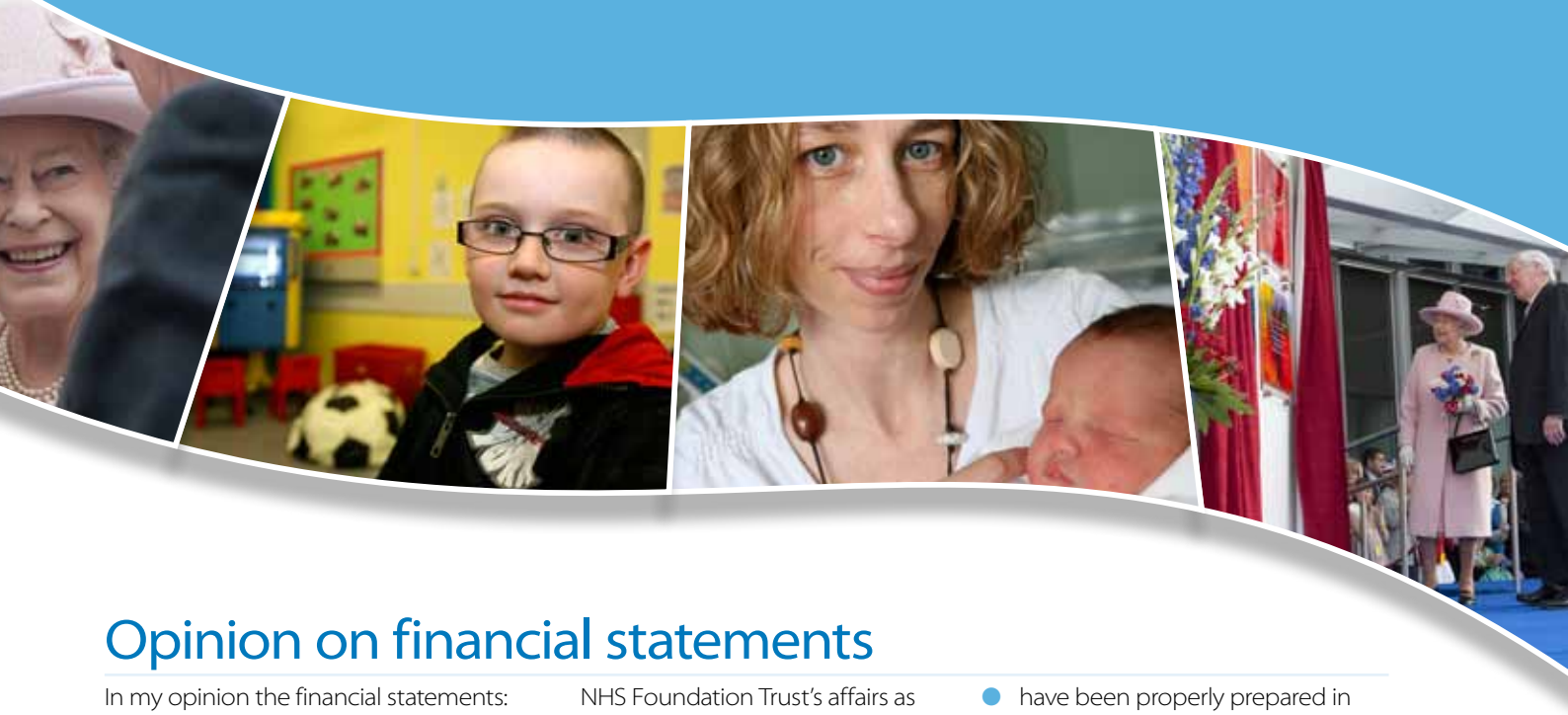
Respective responsibilities of the Accounting Officer and auditor

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 financial and non-financial 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 31 March 2012 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 report to you if in my opinion the Annual Governance Statement does not reflect compliance with Monitor's requirements. I have nothing to report in this respect.

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

30th May 2012

The Audit Commission
2nd Floor, Aspinall House
Aspinall Close
Middlebrook
Bolton BL6 6QQ

Foreword to the accounts

These accounts for the year ended 31st March 2012 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.

After making enquiries, the Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

These accounts have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Mike Deegan
Chief Executive
30th May 2012

Financial Statements

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2012

	NOTE	**2011/12** **£000**	2010/11 As Restated £000
Operating income from continuing operations	**2**	**757,207**	668,911
Operating expenses of continuing operations	**3**	**(725,055)**	(646,728)
Reversal of Previous Impairments	**12**	**51,660**	0
Operating surplus		**83,812**	22,183
Finance costs:			
Finance income	**8**	**161**	95
Finance expense - financial liabilities	**9**	**(27,278)**	(25,804)
Finance expense - unwinding of discount on provisions		**(65)**	(75)
Public dividend capital dividends payable		**(524)**	0
Net finance costs		**(27,706)**	(25,784)
Surplus / (Deficit) from continuing operations		**56,106**	(3,601)
Surplus / (deficit) of discontinued operations and the gain / (loss) on disposal of discontinued operations	**6**	**0**	0
Surplus / (Deficit) for the year		**56,106**	(3,601)
Other comprehensive income			
Revaluations		**(6,055)**	0
Total comprehensive income / (expense) for the year		**50,051**	**(3,601)**

A significant element, £51.7m, of the surplus for the year arises from the reversal of impairments in respect of the Trust's Building valuation carried out in year, note 10. This is treated as an "exceptional item" and before this item the Trust made a surplus of £4.4m.

The notes on pages 165 to 174 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2012

	NOTE	31 March 2012 £000	31 March 2011 As Restated £000	1 April 2010 As Restated £000
Non-current assets				
Intangible assets	**11**	**1,213**	2,015	2,426
Property, plant and equipment	**12**	**453,581**	413,948	420,544
Trade and other receivables	**22**	**5,246**	1,768	1,733
Total non-current assets		**460,040**	417,731	424,703
Current assets				
Inventories	**21**	**8,762**	8,710	9,409
Trade and other receivables	**22**	**35,343**	35,883	38,575
Non-current assets held for sale in disposal groups	**18**	**5,350**	7,000	7,000
Cash and cash equivalents	**25**	**60,306**	35,231	29,693
Total current assets		**109,761**	86,824	84,677
Current liabilities				
Trade and other payables	**26**	**(76,558)**	(58,110)	(57,210)
Borrowings	**27**	**(14,285)**	(8,880)	(8,225)
Provisions	**31**	**(7,084)**	(13,315)	(7,703)
Total current liabilities		**(97,927)**	(80,305)	(73,138)
Total assets less current liabilities		**471,874**	424,250	436,242
Non-current liabilities				
Trade and other payables	**26**	**(4,310)**	(4,017)	(4,714)
Borrowings	**27**	**(363,677)**	(370,462)	(378,342)
Provisions	**31**	**(5,648)**	(2,885)	(2,954)
Total non-current liabilities		**(373,635)**	(377,364)	(386,010)
Total assets employed		**98,239**	46,886	50,232
Financed by taxpayers' equity:				
Public dividend capital		**179,945**	178,674	178,428
Revaluation reserve	**33**	**16,102**	23,941	28,426
Income and expenditure reserve		**(97,808)**	(155,729)	(156,622)
Total Taxpayers' Equity		**98,239**	46,886	50,232

The financial statements on pages 161 to 196 were approved by the Audit Committee with delegated authority from the Board of Directors on 29th May 2012 and signed on its behalf by: Anthony Leon, Non Executive Director

Signed: ……(Chief Executive) Date: ……

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

2011/12	Public dividend capital £000	Revaluation reserve £000	Donated asset reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' Equity at 1 April 2011 - restated	**178,674**	**23,941**	**0**	**(155,729)**	**46,886**
Surplus / (deficit) for the year	0	0	0	56,106	56,106
Revaluations	0	(6,055)	0	0	(6,055)
Asset disposals	0	(6)	0	6	0
Public Dividend Capital received	1,271	0	0	0	1,271
Other reserve movements	0	(1,778)	0	1,809	31
Taxpayers' Equity at 31 March 2012	**179,945**	**16,102**	**0**	**(97,808)**	**98,239**

2010/11	Public dividend capital £000	Revaluation reserve £000	Donated asset reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' Equity at 1 April 2010 as previously stated	178,428	28,219	12,740	(175,983)	43,404
Prior Period Adjustment	0	207	(12,740)	19,361	6,828
Taxpayers' Equity at 1 April 2010	**178,428**	**28,426**	**0**	**(156,622)**	**50,232**
Surplus / (deficit) for the year	0	0	0	(3,601)	(3,601)
Public Dividend Capital received	246	0	0	0	246
Other reserve movements	0	(4,485)	0	4,494	9
Taxpayers' Equity at 31 March 2011	**178,674**	**23,941**	**0**	**(155,729)**	**46,886**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
31 March 2012

	2011/12	2010/11 As Restated
	£000	£000
Cash flows from operating activities		
Operating surplus from continuing operations	**83,812**	22,183
Operating surplus / (deficit) of discontinued operations	**0**	0
Operating surplus	**83,812**	22,183
Non-cash income and expense:		
Depreciation and amortisation	**21,745**	23,543
Impairments	**948**	0
Reversals of impairments	**(51,660)**	0
Decrease in trade and other receivables and other cuurent assets	**867**	2,370
(Increase) / decrease in inventories	**(52)**	699
Increase in trade and other payables	**18,741**	3,197
Increase / (decrease) in provisions	**(3,352)**	5,543
Other movements in operating cashflows	**31**	(186)
Net cash generated from operations	**71,080**	**57,349**
Cash flows from investing activities		
Interest received	**161**	95
Purchase of intangible assets	**(18)**	(506)
Sale of intangible assets	**0**	11
Purchase of property, plant and equipment	**(21,113)**	(18,347)
Sales of property, plant and equipment	**60**	0
Net cash generated from/(used in) investing activities	**(20,910)**	**(18,747)**
Cash flows from financing activities		
Public dividend capital received	**1,271**	246
Loans received	**7,500**	1,000
Loans repaid	**(2,224)**	(2,224)
Other capital receipts	**2,720**	151
Capital element of PFI obligations	**(7,061)**	(6,656)
Interest paid	**(1,170)**	(1,091)
Interest element of PFI obligations	**(26,108)**	(24,702)
PDC dividend paid	**42**	287
Cash flows from/(used in) other financing activities	**(65)**	(75)
Net cash generated from / (used in) financing activities	**(25,095)**	(33,064)
Net increase / (decrease) in cash and cash equivalents	**25,075**	5,538
Cash and cash equivalents at the 1st April 2011	**35,231**	29,693
Cash and cash equivalents at the 31st March 2012	**60,306**	35,231

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 2011/12 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.

The Trust has considered the requirements of International Accounting Standard 1 (IAS 1), Presentation of Financial Statements, and concluded that following the prior-period adjustment in respect of the writing out of Donated Reserves and Grant Liabilities that a third comparative column, for 1 April 2010, is not appropriate for the notes to the accounts as no additional benefit would be given to the reader of these accounts through any additional prior year data.

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 31 March 2012, 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 reduction in the reported value of the Trust's land and a significant increase in the reported value of the Trust's building assets. Future revaluations of the Trust's asset base may result in further material changes to the carrying value of non-current assets.

Notes to the accounts - 1. Accounting Policies (continued)

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.

Notes to the accounts - 1. Accounting Policies (continued)

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 first revalued on the basis of a modern equivalent asset valuation as at 31 March 2010, and have subsequently been revalued on this basis as at 31 March 2012.

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.

Notes to the accounts - 1. Accounting Policies (continued)

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.

Notes to the accounts - 1. Accounting Policies (continued)

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 the corresponding receipt credited to the Statement of Comprehensive Income, in accordance with the principles of IAS 20. They are subsequently valued, depreciated and impaired as described above for purchased assets.

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 in the same manner as Donated Assets and in accordance with the principles of IAS 20.

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.

Notes to the accounts - 1. Accounting Policies (continued)

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.

Notes to the accounts - 1. Accounting Policies (continued)

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 through the Statement of Comprehensive Income. The asset and provision are valued at fair value at the end of the reporting period.

Notes to the accounts - 1. Accounting Policies (continued)

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.

Notes to the accounts - 1. Accounting Policies (continued)

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 43, 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 2011/12, 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.nhsbsa.nhs.uk/pensions. 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:

Notes to the accounts - 1. Accounting Policies (continued)

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.

The last formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision. Employer and employee contribution rates are currently being determined under the new scheme design.

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. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2010 updated to 31 March 2012 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.

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. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).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 is payableFor 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 employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

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)	2011/12 £000	2010/11 As Restated £000
Income from Activities		
Elective income	**96,287**	94,597
Non-elective income	**119,305**	114,133
Out-patient income	**90,361**	85,137
A&E income	**15,068**	14,625
Other NHS clinical income	**316,256**	250,486
Private patient income	**1,960**	2,004
Total income from activities	**639,237**	560,982
Other operating Income		
Research and Development	**7,801**	9,485
Education and training	**47,144**	44,933
Charitable and other contributions to expenditure	**1,526**	1,168
Non-patient care services to other bodies	**41,817**	34,041
Other income	**19,084**	18,188
Profit on disposal of land and buildings	**0**	114
Profit on disposal of other property, plant and equipment	**4**	0
Gain on disposal of assets held for sale	**594**	0
Total other operating income	**117,970**	107,929
Total Operating Income	**757,207**	668,911

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.

	2011/12 £000	2010/11 £000	Base Year 2002/03 £000
Private patient and overseas visitors (non-reciprocal) income	**2,115**	2,161	3,242
Total patient related income	**639,238**	568,413	283,399
Proportion (as a percentage) not to exceed the base year cap	**0.33%**	**0.38%**	**1.14%**

2.3 Operating lease income

The Trust did not receive any operating lease income in either 2011/12 or 2010/11.

2.4 Operating Income (by source)	2011/12	2010/11
	£000	£000
Foundation trusts	**608**	900
NHS trusts	**1,092**	237
Strategic health authorities	**27,532**	23,034
Primary care trusts	**584,947**	518,969
Local authorities	**9,681**	2,498
Department of Health	**5,689**	6,389
NHS other	**696**	783
Non-NHS:		
Private patients	**1,960**	2,004
Overseas patients (non-reciprocal)	**155**	157
NHS Injury costs recovery scheme *	**1,979**	1,926
Non-NHS other	**4,898**	4,085
	639,237	560,982

* Injury cost recovery income is subject to a provision for impairment of receivables of 10.5% to reflect expected rates of collection.

Other operating Income		
Research and Development	**7,801**	9,485
Education and training	**47,144**	44,933
Charitable and other contributions to expenditure	**1,526**	1,168
Non-patient care services to other bodies	**41,817**	34,041
Profit on disposal of land and buildings	**0**	114
Profit on disposal of other tangible fixed assets	**4**	0
Gain on disposal of assets held for sale	**594**	0
Car parking	**2,520**	2,535
Estates recharges	**548**	682
Pharmacy sales	**161**	245
Accommodation rentals	**98**	129
Clinical excellence awards	**5,164**	5,425
Property rentals	**2,219**	1,878
Other income	**8,374**	7,294
Total other operating income	**117,970**	107,929
Total Operating Income	**757,207**	668,911

2.5 Mandatory and non-mandatory income from activities

	2011/12	2010/11
	£000	£000
Mandatory	**630,245**	552,810
Non-mandatory	**8,992**	8,172
	639,237	560,982

3. Operating Expenses	**2011/12**	2010/11
	£000	£000
Services from other Foundation Trusts	**2,883**	3,292
Services from NHS Trusts	**1,477**	2,212
Services from other NHS bodies	**1,263**	1,446
Purchase of healthcare from non NHS bodies	**4,708**	1,885
Employee expenses - Executive Directors	**1,218**	1,265
Employee expenses - Non-Executive Directors	**177**	175
Employee expenses - Staff	**430,390**	374,583
Drug costs	**64,084**	56,817
Supplies and services - clinical (excluding drugs costs)	**96,416**	88,649
Supplies and services - general	**3,986**	3,664
Establishment	**9,636**	8,331
Research and development	**6,004**	6,667
Transport	**1,849**	1,938
Premises	**61,085**	54,342
Increase / (decrease) in provision for impairment of receivables	**(252)**	1,080
Inventories write down	**0**	126
Depreciation on property, plant and equipment	**20,925**	22,763
Amortisation on intangible assets	**820**	780
Impairments of property, plant and equipment	**948**	0
Audit fees		
- audit services - statutory audit	**94**	124
Clinical negligence	**8,466**	7,692
Legal fees	**852**	1,855
Professional fees and consultancy costs	**2,022**	2,645
Training, courses and conferences	**2,377**	1,133
Patient travel	**158**	132
Redundancy	**42**	483
Other	**3,427**	2,649
Total	**725,055**	646,728

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

	2011/12			2010/11
	Total	**Permanently Employed**	**Other**	Total
	£000	**£000**	**£000**	£000
Salaries and wages	**358,046**	**358,046**	**0**	310,875
Social Security Costs	**24,836**	**24,836**	**0**	20,582
Pension cost - defined contribution plans				
Employers contributions to NHS Pensions	**36,717**	**36,717**	**0**	32,898
Termination benefits	**42**	**42**	**0**	483
Agency / contract staff	**12,009**	**0**	**12,009**	11,493
Total	**431,650**	**419,641**	**12,009**	**376,331**

4.2 Average number of people employed

	2011/12			2010/11
	Total	**Permanently Employed**	**Other**	Total
	Number	**Number**	**Number**	Number
Medical and dental	**1,223**	**778**	**445**	1,113
Administration and estates	**1,639**	**1,629**	**10**	1,581
Healthcare assistants and other support staff	**1,073**	**1,068**	**5**	1,158
Nursing, midwifery and health visiting staff	**3,783**	**3,263**	**520**	3,236
Scientific, therapeutic and technical staff	**1,903**	**1,898**	**5**	1,207
Agency / contract staff	**180**	**0**	**180**	212
Other	**147**	**147**	**0**	395
Total	**9,948**	**8,783**	**1,165**	8,902

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 2011/12 there were 15 (2010/11 there were 13) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £755k (for 2010/11: £535k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

4.5 Staff exit packages

2011/12

Exit package cost band	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
Less than £10,000	1	0	**1**
£10,000 - £25,000	3	0	**3**
Total Departures	**4**	**0**	**4**
Total Cost (£000)	**42**	**0**	**42**

2010/11

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Less than £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
£100,001 - £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

In 2010/11 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.

4.6 Directors' remuneration and benefits

The aggregate amount of Directors' remuneration for 2011/12 was £1,147k (£1,170k 2010/11). The Trust made a contribution to the NHS Pension Scheme, a defined benefit scheme, of £131k in respect of six Directors (2010/11 £132k in respect of six Directors).

4.7 Management Costs

	2011/12	2010/11
	£000	£000
Management costs	**20,837**	18,985
Income	**757,207**	668,911
Management costs as a proportion of income (%)	**2.75%**	**2.84%**

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

	2011/12	2010/11
	£000	£000
Lease payments	**1,609**	1,426
	1,609	1,426

5.2 Arrangements containing an operating lease

	2011/12	2010/11
	£000	£000
Future minimum lease payments due:		
Not later than one year	**1,434**	1,365
Later than one year and not later than five years	**2,833**	2,770
Total	**4,267**	4,135
Total of future minimum sublease payments to be received at the balance sheet date	**0**	0

The future minimum lease payments are in respect of 48 operating leases, of varying contract values and terms, giving an average payment per lease during the next twelve months of £30k.

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 2011/12 or 2010/11.

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 2011/12 or 2010/11. Remuneration details for statutory and regulatory services are disclosed at note 3.

6. Discontinued operations

There were no discontinued operations during 2011/12 or 2010/11.

7. Corporation tax

There was no corporation tax payable or receivable during 2011/12 or 2010/11.

8. Finance income

	2011/12	2010/11
	£000	£000
Interest on bank accounts	**144**	95
Interest on held-to-maturity financial assets	**17**	0
Total	**161**	95

9. Finance Costs

	2011/12	2010/11
	£000	£000
Interest on loans from the Foundation Trust Financing Facility	**1,170**	1,102
Interest on obligations under PFI contracts:		
- main finance cost	**20,032**	20,390
- contingent finance cost	**6,076**	4,312
Total	**27,278**	25,804

10. Impairment of assets (Property, plant and equipment and intangibles)

	2011/12	2010/11
	£000	£000
Changes in market price	**948**	0
Reversal of impairments	**(51,660)**	0
Total impairments	**(50,712)**	0

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.

2011/12 Valuation

The valuation report issued in 2011/12 showed an overall valuation increase in Buildings from the current net book value resulting in an upwards revaluation of £51.6m. However, there were downward valuations for some older buildings that resulted in a reduction in value (impairment) of £0.9m taken to the Statement of Comprehensive Income.

Additionally, there was a downward valuation for Land that resulted in a reduction in Land value of £1.4m taken to the Revaluation Reserve. There was a further movement in the value of Land at the former Booth Hall Children's Hospital of £4.6m in reclassifying it as "held for sale", giving a total revaluation movement for Land in year of £6.0m taken through the Revaluation Reserve.

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.

11 Intangible assets

11.1 Intangible assets current year

2011/12:	Software licences - purchased
	£000
Gross cost at 1 April 2011	**6,356**
Additions - purchased	18
Gross cost at 31 March 2012	**6,374**
Amortisation at 1 April 2011	**4,341**
Provided during the year	820
Amortisation at 31 March 2012	**5,161**

11.2 Intangible assets prior period

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 period	780
Gross cost at 31 March 2011	**4,341**

11.3 Intangible Assets Financing

	Software licences - purchased
Net book value	
Purchased as at 31 March 2012	1,198
Donated as at 31 March 2012	15
Total at 31 March 2012	**1,213**
Net book value	
Purchased as at 1 April 2011	1,992
Donated as at 1 April 2011	23
Total at 1st April 2011	**2,015**

11.4 Net Book Value of Intangible assets in the revaluation reserve

As at the 31 March 2012 no Intangible Assets formed any part of the balance in the Revaluation Reserve (31 March 2011: nil).

12.1 Property, plant and equipment 2011/12	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
2011/12:	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2011	**31,215**	**540,108**	**9**	**13,571**	**136,575**	**160**	**9,070**	**18,274**	**748,982**
Additions purchased	0	12,613	0	5,282	2,728	0	30	460	21,113
Additions donated	0	0	0	0	187	0	104	0	291
Additions government granted	0	0	0	0	77	0	0	0	77
Reclassifications	0	5,532	0	(5,977)	434	0	1	10	0
Revaluations	(6,055)	0	0	0	0	0	0	0	(6,055)
Transferred to disposal group as asset held for sale	(5,350)	0	0	0	0	0	0	0	(5,350)
Disposals	0	0	0	(174)	(74)	0	(37)	0	(285)
At 31 March 2012	**19,810**	**558,253**	**9**	**12,702**	**139,927**	**160**	**9,168**	**18,744**	**758,773**
Accumulated depreciation as at 1 April 2011	**0**	**218,193**	**9**	**0**	**95,028**	**153**	**6,922**	**14,729**	**335,034**
Provided during the year	0	9,214	0	0	10,038	6	1,009	658	20,925
Impairments	0	948	0	0	0	0	0	0	948
Reversal of impairments	0	(51,660)	0	0	0	0	0	0	(51,660)
Disposals	0	0	0	0	(48)	0	(7)	0	(55)
Depreciation at 31 March 2012	**0**	**176,695**	**9**	**0**	**105,018**	**159**	**7,924**	**15,387**	**305,192**

12.2 Property, plant and equipment 2010/11	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
2010/11:	£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 period	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**

12.3 Property, Plant and Equipment Financing	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
Net book value - 31 March 2012									
Owned	19,585	43,110	0	12,702	27,336	1	1,146	3,300	107,180
On-balance-sheet PFI contracts and other service concession arrangements	0	331,860	0	0	0	0	0	0	331,860
Government granted	0	2,630	0	0	1,752	0	3	32	4,417
Donated	225	3,958	0	0	5,821	0	95	25	10,124
NBV Total at 31 March 2012	**19,810**	**381,558**	**0**	**12,702**	**34,909**	**1**	**1,244**	**3,357**	**453,581**
Net book value - 31 March 2011									
Owned	30,990	40,594	0	13,571	31,360	7	2,123	3,462	122,107
On-balance-sheet PFI contracts and other service concession arrangements	0	277,316	0	0	0	0	0	0	277,316
Government granted	0	2,839	0	0	2,255	0	5	43	5,142
Donated	225	1,166	0	0	7,932	0	20	40	9,383
NBV total value - 31 March 2011	**31,215**	**321,915**	**0**	**13,571**	**41,547**	**7**	**2,148**	**3,545**	**413,948**

13 Intangible assets acquired by grant funding

	Software licences £000
Initial fair value	32
Carrying amount at 1 April 2011	19
Carrying amount at 31 March 2012	**12**
Measured using cost (not revaluation) model	

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 2011

Net book value	Land £000	Buildings exc. Dwellings £000	Assets under Construction & POA £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & Fittings £000	Total £000
Protected assets at 31 March 2011	31,215	321,915	-	-	-	-	-	**353,130**
Unprotected assets at 31 March 2011	0	0	13,571	41,547	7	2,148	3,545	**60,818**
Total at 31 March 2011	**31,215**	**321,915**	**13,571**	**41,547**	**7**	**2,148**	**3,545**	**413,948**

15.2 Analysis of property, plant and equipment 31 March 2012

Net book value	Land £000	Buildings exc. Dwellings £000	Assets under Construction & POA £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & Fittings £000	Total £000
Protected assets at 31 March 2012	19,810	381,558	-	-	-	-	-	**401,368**
Unprotected assets at 31 March 2012	0	0	12,702	34,909	1	1,244	3,357	**52,213**
Total at 31 March 2012	**19,810**	**381,558**	**12,702**	**34,909**	**1**	**1,244**	**3,357**	**453,581**

15.3 NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2011

	Land £000	Buildings excluding dwellings £000	Assets under Construction £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & Fittings £000	Total £000
As at 1 April 2010	21,757	0	0	6,390	1	0	278	**28,426**
Movement in year	(4,485)	0	0	0	0	0	0	**(4,485)**
As at 31 March 2011	**17,272**	**0**	**0**	**6,390**	**1**	**0**	**278**	**23,941**

15.4 NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2012

	Land £000	Buildings excluding dwellings £000	Assets under Construction £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & Fittings £000	Total £000
As at 1 April 2011	17,272	0	0	6,390	1	0	278	**23,941**
Movement in year	(7,833)	0	0	(6)	0	0	0	**(7,839)**
as at 31 March 2012	**9,439**	**0**	**0**	**6,384**	**1**	**0**	**278**	**16,102**

16. Investments

The Trust did not hold any investments in either 2011/12 or 2010/11.

17. Associates and jointly controlled operations

The Trust did not have any assets or liabilities in respect of associates and jointly controlled operations in either 2011/12 or 2010/11.

18. Non-current assets held for sale in disposal groups 2011/12

As at the 31 March 2012 the Trust held one non-current asset for sale in the value of £5.35m in respect of the Land at the former Booth Hall Children's Hospital.

The Trust has not been exposed to liabilities in respect of disposal groups in either 2011/12 or 2010/11.

19. Other assets

The Trust did not hold any other assets at either 31 March 2012 or 31 March 2011.

20. Other Financial Assets

The Trust did not have any other financial assets at 31 March 2012 or 31 March 2011.

21. Inventories

21.1. Inventories	31 March 2012 £000	31 March 2011 As Restated £000
Drugs	**3,290**	3,200
Consumables	**5,210**	5,281
Energy	**262**	229
Total	**8,762**	8,710

21.2 Inventories recognised in expenses	2011/12 £000	2010/11 As Restated £000
Inventories recognised as an expense in the period	**91,663**	81,866
Write-down of inventories recognised as an expense	**0**	126
Reversal of write-downs which reduced the recognised expense	**(12)**	0
Total	**91,651**	81,992

22. Trade and other receivables

	31 March 2012 £000	31 March 2011 As Restated £000
Current		
NHS receivables	**16,223**	16,824
Other receivables with related parties	**896**	339
Provision for the impairment of receivables	**(1,343)**	(1,529)
Prepayments	**3,591**	2,604
Accrued income	**4,070**	3,236
PDC receivables	**0**	430
VAT receivable	**3,018**	1,991
Other trade receivables	**8,888**	11,988
Total current trade and other receivables	**35,343**	35,883

	31 March 2012 £000	31 March 2011 As Restated £000
Non-current		
Provision for the impairment of receivables	**(124)**	(190)
Accrued income	**2,264**	1,958
Other trade receivables	**3,106**	0
Total non-current trade and other receivables	**5,246**	1,768

23.1 Provision for impairment of receivables (bad debt provision)

	31 March 2012 £000	31 March 2011 As Restated £000
At 1 April	1,719	639
Increase in provision	0	1,080
Amounts utilised	(252)	0
At 31 March	**1,467**	1,719

23.2 Analysis of impaired receivables

	31 March 2012 £000	31 March 2011 As Restated £000
Ageing of impaired receivables (bad debt provision)		
60 - 90 Days	**9**	9
90 - 180 Days	**126**	106
Over 180 Days	**1,332**	1,604
Total	**1,467**	1,719
Ageing of non-impaired receivables past their due date		
0 - 30 Days	**6,296**	14,709
30 - 60 Days	**2,530**	2,796
60 - 90 Days	**1,112**	1,017
90 - 180 Days	**616**	2,104
Over 180 Days	**838**	2,078
Total	**11,392**	22,704

24 Finance lease receivables

The Trust did not have any obligations under finance leases in either 2011/12 or 2010/11 that would generate receivables.

25. Cash and cash equivalents

	31 March 2012 £000	31 March 2011 £000
Balance at 1 April	35,231	29,693
Net change in year	25,075	5,538
Balance at 31 March	**60,306**	35,231
Made up of		
Commercial banks and cash in hand	139	135
Cash with the Government Banking Service	60,167	35,096
Cash and cash equivalents as in statement of financial position	**60,306**	35,231
Bank overdraft	0	0
Cash and cash equivalents as in statement of cash flows	**60,306**	35,231
Third party assets held by the NHS Foundation Trust	**17**	12

Third party assets held by the Trust of £17k (31 March 2011 £12k) are excluded from the cash and cash equivalents position.

26.1 Trade and other payables

	31 March 2012 £000	31 March 2011 As Restated £000
Current		
Receipts in advance	**14,262**	14,315
NHS payables	**11,176**	6,122
Amounts due to other related parties	**8,049**	7,520
Trade payables - capital	**951**	1,309
Other payables	**20,134**	17,347
Accruals	**21,850**	11,497
PDC dividend payable	**136**	0
Total current trade and other payables	**76,558**	**58,110**

	Financial liabilities 31 March 2012 £000	Financial liabilities 31 March 2011 As Restated £000
Non-current		
Receipts in advance	**1,212**	919
Other payables	**3,098**	3,098
Total non-current trade and other payables	**4,310**	**4,017**

26.2 Early Retirement Costs

Early retirement costs included in Note 26.1 above were nil at the 31 March 2012 (31 March 2011: nil).

27. Borrowings

	31 March 2012 £000	31 March 2011 As Restated £000
Current		
Loans from:		
Foundation Trust Financing Facility	**7,224**	2,224
Obligations under Private Finance Initiative contracts	**7,061**	6,656
Total	**14,285**	8,880

	31 March 2012 £000	31 March 2011 As Restated £000
Non-current		
Loans from:		
Foundation Trust Financing Facility	**36,828**	36,552
Obligations under Private Finance Initiative contracts	**326,849**	333,910
Total	**363,677**	370,462

The Trust borrowed a further £7.5m during 2011/12 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 2012 £000	31 March 2011 As Restated £000
Total long term borrowing limit set by Monitor	**398,400**	406,600
Working capital facility agreed by Monitor	**40,000**	40,000
Total prudential borrowing limit	**438,400**	446,600
Long term borrowing at 1 April	**370,462**	378,342
Net actual borrowing/(repayment) in year	**(6,785)**	(7,880)
Long term borrowing at 31 March	**363,677**	370,462
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 2011/12	Actual 2011/12
Minimum Dividend Cover	>1 x	176.4	**52.6**
Minimum Interest Cover	>2 x	2.04	**2.02**
Minimum Debt Service Cover	>1.5 x	1.54	**1.52**
Maximum Debt Service to Revenue	<10%	5.1%	**4.8%**

29. Other liabilities

The Trust did not have any "Other Liabilities" at 31 March 2012 or 31 March 2011.

30. Other Financial Liabilities

The Trust did not have any "Other Financial Liabilities" at 31 March 2012 or 31 March 2011.

31.1 Provisions for liabilities and charges

	Current		Non-current	
	31 March 2012	31 March 2011 As Restated	**31 March 2012**	31 March 2011 As Restated
	£000	£000	**£000**	£000
Pensions relating to former directors	**9**	9	**107**	110
Pensions relating to other staff	**207**	156	**1,539**	1,815
Other legal claims	**263**	77	**0**	150
Agenda for Change	**60**	8,775	**0**	0
Other	**6,545**	4,298	**4,002**	810
Total	**7,084**	13,315	**5,648**	2,885

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 2011	**119**	**1,971**	**227**	**8,775**	**5,108**	**16,200**
Arising during the year	3	51	36	0	9,907	**9,997**
Utilised during the year	(9)	(207)	0	(8,715)	(4,483)	**(13,414)**
Reversed unused	0	(116)	0	0	0	**(116)**
Unwinding of discount	3	47	0	0	15	**65**
At 31 March 2012	**116**	**1,746**	**263**	**60**	**10,547**	**12,732**
Expected timing of cash flows:						
- not later than 1 year	9	207	263	60	6,545	**7,084**
- later than 1 year and not later than 5 years	36	828	0	0	293	**1,157**
- later than 5 years	71	711	0	0	3,709	**4,491**
Total	**116**	**1,746**	**263**	**60**	**10,547**	**12,732**

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 2012 is £84,425k in respect of clinical negligence liabilities of the Trust (31 March 2011 £69,937k).

32. Contingent liabilities and assets

32.1 Contingent liabilities	31 March 2012 £000	31 March 2011 As Restated £000
Gross value of contingent liabilities	**(153)**	(129)
Amounts recoverable against liabilities	**0**	0
Net value of contingent liabilities	**(153)**	(129)

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 2012 (31 March 2011 nil).

33.1 Revaluation Reserve 2011/12

	Total revaluation reserve £000	Revaluation reserve - intangibles £000	Revaluation reserve - property, plant and equipment £000
Revaluation reserve at 1 April 2011	23,941	0	23,941
Prior period adjustment	0	0	0
TCS and merger adjustments	0	0	0
Revaluation reserve at 1 April 2011 - restated	**23,941**	**0**	**23,941**
Revaluations	(6,055)	0	(6,055)
Asset disposals	(6)	0	(6)
Other reserve movements	(1,778)	0	(1,778)
Revaluation Reserve at 31 March 2012	**16,102**	**0**	**16,102**

33.2 Revaluation Reserve 2010/11

Revaluation reserve at 1 April 2010	28,219	0	28,219
Prior period adjustment	207	0	207
Revaluation reserve at 1 April 2010 - restated	**28,426**	**0**	**28,426**
Revaluation Reserve at 31 March 2011	**23,941**	**0**	**23,941**

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 Chairman is a Member of General Assembly at the University of Manchester, one Non-Executive Director is a Member of the Board of Governors of the University of Manchester and a further Non-Executive of the Trust is the Deputy President of the University of Manchester. The Trust has a significant number of transactions with the University of Manchester, 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 £6m, are listed below:

The transactions and balances for 2011/12 were:-

	Net Income/(Expenditure)		**Net Receivables/(Payables)**	
	2011/12	2010/11	**2011/12**	2010/11
	£000s	£000s	**£000s**	£000s
Manchester PCT	**237,185**	192,294	**769**	2,520
Western Cheshire PCT	**151,955**	147,849	**(1,972)**	1,984
North West Strategic Health Authority	**46,609**	45,385	**10**	72
Stockport PCT	**44,576**	47,385	**(72)**	616
Trafford PCT	**34,476**	24,820	**930**	733
Salford PCT	**26,805**	25,315	**1,624**	243
London Strategic Health Authority	**25,491**	23,027	**(319)**	(431)
Tameside and Glossop PCT	**22,771**	19,765	**(124)**	47
Oldham PCT	**10,126**	8,759	**358**	65
Bolton PCT	**9,515**	8,548	**301**	130
Bury PCT	**9,293**	9,537	**18**	48
Heywood, Middleton and Rochdale PCT	**8,359**	7,457	**128**	60
Central and Eastern Cheshire PCT	**7,030**	6,820	**(20)**	109
Ashton, Leigh and Wigan PCT	**6,525**	7,430	**191**	355

The Trust has also received revenue and capital payments from its charitable funds, Central Manchester University Hospitals NHS Foundation Trust Charitable Fund (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 Manchester City Council and HM Revenue and Customs.

35.1 Contractual capital commitments

Commitments under capital expenditure contracts at 31 March 2012 were £26,982k (31 March 2011 £2,757k).

35.2 Other Financial Commitments

The Trust had no Other Financial Commitments at the 31 March 2012 (31 March 2011: nil).

36. Finance lease obligations

The Trust did not have any obligations under finance leases in either 2011/12 or 2010/11, except for the Trust's PFI scheme which is covered at note 37.

37. On-Statement of Financial Position Private Finance Initiative contracts

37.1 Total obligations for on-statement of financial position PFI contracts due:

	31 March 2012 £000	31 March 2011 As Restated £000
Gross PFI liabilities	**718,943**	745,631
Of which liabilities are due:		
Not later than one year	**26,684**	26,688
Later than one year, not later than five years	**99,437**	101,545
Later than five years	**592,822**	617,398
Less finance charges allocated to future periods	**(385,033)**	(405,065)
Net PFI liabilities	**333,910**	340,566
Net PFI obligation		
Not later than one year	**7,061**	6,656
Later than one year, not later than five years	**24,790**	25,414
Later than five years	**302,059**	308,496
	333,910	340,566

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 2012 Total £000	31 March 2011 As Restated Total £000
Within one year	**27,229**	26,316
2nd to 5th years (inclusive)	**118,698**	114,717
Later than 5 years	**1,310,704**	1,341,913
Total	**1,456,631**	1,482,946

37.3 Imputed finance lease obligations under on-statement of financial position commitments

	31 March 2012 Total £000	31 March 2011 Total £000
Commitments in respect of the lease rentals of the PFI		
Rentals due within one year	**26,684**	26,688
Rentals due within 2nd to 5th years (inclusive)	**99,437**	101,545
Rentals due Later than five years	**592,828**	617,398
Sub total rentals due	**718,949**	745,631
less interest element	**(403,519)**	(405,065)
Total	**315,430**	340,566

38. PFI schemes deemed to be off balance sheet

At 31 March 2012 and 31 March 2011, the Trust had no PFI schemes deemed to be off-Statement of Financial Position.

39. Events following the Statement of Financial Position date

Trafford Healthcare NHS Trust was dissolved on the 1st April 2012 (Dissolution Order reference 2012 No.803). All of the Trust's staff, property and liabilities have transferred to Central Manchester University Hospitals NHS Foundation Trust and Bridgewater Community Healthcare NHS Trust. These transfers have been formalised within two Transfer Orders as signed by the authority of the Secretary of State for Health. Staff were transferred to the receiving organisations under Transfer of Undertakings Protection of Employment (TUPE) regulations.

The financial impact of this acquisition will be that all assets and liabilities included on Trafford Healthcare NHS Trust's Statement of Financial Position and income and expenditure streams as recognised in the Statement of Comprehensive Income will transfer to the acquiring NHS bodies. For accounting purposes, all of the Trafford Healthcare NHS Trust's activities are considered 'continuing' as the merger is between NHS bodies.

40. Financial Instruments

International Financial Reporting Standard 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Primary Care Trusts and the way those Primary Care Trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. The Trust's treasury activity is subject to review by internal auditors.

Liquidity risk

Net operating costs are funded under annual service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust largely finances its capital expenditure from internally generated cash and funds made available by the Department of Health. Additional funding by way of loans with the Foundation Trust Financing Facility was approved at the time of Authorisation as a NHS Foundation Trust. The Trust is, therefore, exposed to liquidity risks from the loan funding, however these are approved and comply with the Prudential Borrowing Code.

Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations and therefore has low exposure to currency rate fluctuations.

Interest-Rate Risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. The Trust is not, therefore, exposed to significant interest-rate risk.

Credit Risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2012 are in receivables from customers, as disclosed in the Trade and Other Receivables note.

40.1 Financial assets by category	Loans and receivables £000	Total £000
Per Statement of Financial Position:-		
Trade and other receivables not including non-financial assets	**36,998**	**36,998**
Cash and cash equivalents	**60,306**	**60,306**
Total at 31 March 2012	**97,304**	**97,304**
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

40.2 Financial liabilities by category	Other financial liabilities £000	Total £000
Per Statement of Financial Position:-		
Borrowings not including finance leases and PFI obligations	**44,052**	**44,052**
Obligations under PFI contracts	**333,910**	**333,910**
Trade and other payables not including non-financial liabilities	**57,209**	**57,209**
Provisions under contract	**12,732**	**12,732**
Total at 31 March 2012	**447,903**	**447,903**
Embedded derivatives	-	0
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

40.3 Fair values of financial assets at 31 March 2011

As at 31 March 2012, and 31 March 2011, 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 2012	Book value £000	Fair value £000
Non current trade and other payables not including non-financial liabilities	**3,098**	**3,098**
Provisions under contract	**12,732**	**12,732**
Loans	**44,052**	**44,052**
Total 31 March 2012	**59,882**	**59,882**
Fair values at 31 March 2011	Book value £000	Fair value £000
Non current trade and other payables not including 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

40.5 Maturity of financial liabilities	31 March 2012 £000	31 March 2011 £000
In one year or less	**75,480**	58,910
In more than one year but not more than two years	**17,607**	21,686
In more than two years but not more than five years	**36,525**	37,735
In more than five years	**318,291**	317,024
Total	**447,903**	435,355

41. Defined benefit obligations

The Trust did not hold any on-Statement of Financial Position defined benefit schemes during 2011/12 or 2010/11.

42. Transforming Community Services Transaction Details

With effect from the 1 April 2011 a number of Community services transferred to the Trust from Manchester Primary Care Trust. No assets or liabilities were transferred to the Trust in respect of this change.

43. Losses and Special Payments

There were 220 cases of losses and special payments totalling £1,158k paid during the year to 31 March 2012 (year to 31 March 2011 239 cases totalling £749k).

Losses and special payments are reported on an accruals basis, but provisions for future losses are not made.