Central Manchester University Hospitals
NHS Foundation Trust

Annual Report and Accounts
2013/14

Central Manchester University Hospitals NHS Foundation Trust
Annual Report and Accounts – 2013/14.

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

Contents

Our Vision is:

to be recognised as leading healthcare in the NHS, excelling in quality, safety, patient experience, research, innovation and teaching, dedicated to improving health and well-being.

Our Values:

- Pride
- Respect
- Dignity
- Consideration
- Empathy
- Compassion

Message from the Chairman & Chief Executive

Welcome to our sixth 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. It has always been and continues to be a privilege to work in an organisation where so many staff, on daily basis, go that extra mile to ensure our patients receive the very best care.

Throughout the year concerns about the quality and safety of hospital care continued to be in the national spotlight including: the second report of Sir Robert Francis QC into the failings at Mid Staffordshire NHS Foundation Trust (February 2013) followed by the published findings of Sir Bruce Keoghs Review of 14 Hospitals (July 2013) and in August 2013 the Report of Professor Don Berwick.

A common theme from these reports is that there needs to be an organisational focus on the basic standards and components of care. To assure ourselves that we have safe standards of care across all of our hospitals and community services we have introduced our own Quality Reviews, conducted by members of our own staff, visiting clinical areas other than their own, using a process similar to that used in the Keogh reviews.

Our Quality Report provides more detail about how this process enables us to continue to learn and improve and also how we encourage feedback from our patients on their experience of care in Central Manchester.

Trafford Hospital, had in the past, been subject to close scrutiny because of concern about the quality of its services. Last year we were able to report that standards of patient safety had been brought into line with national norms. As a result in this same year we received the decision by the Secretary of State to support the new clinical service model at Trafford General Hospital, which was then implemented towards the end of 2013.

We have worked in close collaboration with doctors, nurses and all partner organisations in Trafford to design future hospital services for the people of Trafford which are safe, affordable and high quality. The new model means that the sickest patients are cared for in specialist hospitals whilst retaining local access to a broad range of high quality services for patients with less serious needs.

In addition to delivering excellent patient services we also aspire to excel in the area of research. We were delighted therefore to have received the news that our Manchester Academic Health Science Centre (MAHSC) had received re-designation as one of only six elite accredited partnerships in the country; we are the only one outside the South-East of England. MAHSC represents a partnership between The University of Manchester and six NHS organisations, including ourselves. The MAHSC accreditation is a quality stamp for the world-class clinical research we do in Manchester which is subsequently translated into cutting edge clinical treatments for patients. This year saw our staff also collect three awards at the first ever Greater Manchester Clinical Research Awards these being Principal Investigator of the year; Research Nurse of the Year and Highest Recruiting Trust into clinical research trials.

We have also received recognition for our excellent services through the numerous television documentary series and programmes. We are proud to observe the care and compassion of so many of our staff filmed at our hospitals as they go about their day to day roles. It is rewarding to know that these programmes are being seen by several million viewers watching the amazing work of our staff.

In terms of specific events this year's Annual Report provides an overview of those which have occurred over the last 12 months. We would like to highlight some of the key ones:

- The opening of a new dialysis unit in Stockport so patients can attend for their dialysis nearer to home.
- Our hospital school based in the Children's Hospital was declared 'outstanding' by Ofsted – the highest grading possible.
- We were the first hospital in Europe to transplant kidneys into a pair of identical 9 year old twin brothers on the same day from the same donor.
- We held our first Equality, Diversity and Human Rights fortnight.
- Our Eye Bank reached it's 20,000th donation.

As part of the regeneration scheme we are also in the process of building a new hospital in Altrincham town centre which will house high quality facilities for a range of clinical specialties. We are also building a new Hybrid Theatre Suite at the MRI, which will transform the care and treatment of patients undergoing minimally invasive procedures; and Citylabs, a building on the site of the old Eye Hospital which will be opening in the summer of this year to provide state-of-the-art laboratory and office space.

Looking further forward into 2014 we celebrate the bi-centenary of the Manchester Royal Eye Hospital which was founded in 1814. We have a programme of activities and events planned throughout the year and we hope you can join us on our open day on 21st October 2014. We are also running a charitable appeal alongside the celebrations to support the future work of the hospital.

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, Many Hands Campaign and the Discovery Ball.

To summarise, this year has not been without its challenges as is the case for many NHS organisations, however the Trust continues to learn, progress and achieve excellence because of our dedicated staff to whom we are indebted.

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 the organisation you have an opportunity, through your elected representatives, to shape our future.

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.

Peter W Mount CBE
Chairman

Mike Deegan
Chief Executive

Strategic Report

Executive Summary

Central Manchester University Hospitals NHS Foundation Trust (CMFT) is a major specialist and teaching hospital providing local acute and community services to the populations of Manchester and Trafford, together with complex specialist and tertiary hospital services to patients from the whole of the North West and further afield.

CMFT is also the Corporate Trustee to the CMFT Charity (registration no 1049274) and has sole power to govern the financial and operating policies of the charity so as to benefit from the Charity's activities for the Trust, its patients and its staff. The Charity is thereby deemed to be a subsidiary of CMFT and has been consolidated into the accounts of CMFT for the first time in accordance with International Accounting Standards. The accounts disclose the Trust's financial position alongside that of the Group which is the Trust and the Charity combined. A separate set of accounts and annual report have been prepared for the Charity for submission to the Charities Commission.

Research and teaching are fundamental components of our organisation. The Trust has a long-established successful relationship with The University of Manchester and both are founding members of the Manchester Academic Health Science Centre (MAHSC), sharing a vision of becoming a leading global centre for the delivery of applied health research and education. An important strand of this is our joint plan to establish a translational technology hub on the Oxford Road campus that brings together clinical academics, precision medicine, clinical diagnostics and bio-informatics in order to make a step change in translational science infrastrucucture in the North West.

Over the past five years the Trust has expanded significantly the scope of its operations, with continuing growth in demand for complex and specialist treatments accompanying the move into brand new facilities. We have taken responsibility for local NHS community services and acquired and re-shaped hospital services in Trafford working closely with local clinical commissioning groups in both cases. We are now in the process of reviewing our vision and strategic aims, and updating our key priorities for the coming year. These are summarised in our plan-on-a-page (see page 14).

Our clinical service strategy remains primarily focused on developing our specialised services, having brought together the expertise, infrastructure and range of co-located services required to care for those with the most complex conditions. We are strongly positioned within the top ten leading providers of specialised services nationally. The 5-year strategy for specialised services is being developed by NHS England and will be consulted upon later in 2014, but the early proposals which emphasise links to research, working at volume and reducing the number of centres, do align closely with our own strategic outlook.

In relation to our local health economy, the challenges around clinical and financial sustainability of the historic service models and configuration of hospitals are well recognised and are being addressed through two significant collaborative programmes of work:

- *Healthier Together* (aimed at improving outcomes for patients treated in hospital services, through hospital reconfiguration across Greater Manchester) and
- *Living Longer, Living Better* (a city of Manchester programme to develop services that are fit for 2020 and which will support shifting the delivery of more care from hospital into community settings, where appropriate).

CMFT, along with our commissioners, local authorites and other stakeholders, is fully engaged in both.

Our quality and service-related key priorities reflect

the areas where we will be focusing our efforts in 2014/15 and 2015/16. They are:

- Delivering safe, harm-free care focusing on evidence based pathways, supervision and clinical leadership.
- Developing, maintaining and consistently deploying nursing and midwifery establishments, which are informed by evidence based acuity and dependency tools and professional guidance.
- Delivering personalised, responsive and compassionate care in partnership with patients and families in appropriate environments safeguarding the most vulnerable.
- Transforming urgent and emergency care for the local populations and beyond with a particular emphasis on frail elderly and developing our community and integrated care services.
- Exceeding all key NHS commissioned standards and deliverables, including access and quality outcomes.
- Developing our specialist services including cardiac, cancer, children's and vascular services.

Detailed operational plans sit beneath each of these priorities and a system for monitoring and managing progress is in place.

The financial position of the Trust remains robust with the Continuity of Service Risk Rating for 2013/14 and the next two years forecast at level 3.

The Trust continues to invest to support the delivery of services, with investment over the next two years potentially up to £100m. This includes investment in the Trust's IT infrastructure and systems, development of a new hospital in Altrincham, Citylabs (a flagship redevelopment of the former Royal Eye Hospital into bespoke-built biomedical facilities), the development of a new hybrid theatre suite and to begin the re-development of the Manchester Royal Infirmary Emergency Department in support of the likely demands flowing from future reconfiguration of services across the Greater Manchester health system.

Annual efficiency challenges for the next two years are forecast in the order of £28m and £34m respectively. These reflect a combination of being paid less in future, for the same range and complexity of services we have delivered to patients in 2013/14, together with further annual cost inflation arising beyond the Trust's immediate control. Robust plans are in place for delivery of the 2014/15 challenge. CMFT fully recognises the challenge we will face in 2015/16 and being well advanced on the delivery of the 2014/15 target means the Trust has started to develop more headroom to respond effectively to this challenge, with four Divisions already making significant inroads into identifying and 'banking' savings for 2015/16 from their work to finalise the 2014/15 plans. It is recognised that the economic challenges facing commissioners means that there will need to be a greater emphasis on service transformation. A number of workstreams are already

in place across Divisions to design and implement transformational service improvements.

The delivery of the financial plans will be managed through well-established corporate processes, developed and operated successfully over recent years.

Our Profile

Central Manchester University Hospitals NHS Foundation Trust (CMFT), established in 2009, is a large teaching hospitals group. The Trust is made up of the hospitals as shown below. The main campus, the Oxford Road site, is located two miles south of Manchester city centre and comprises the following hospitals:

- Manchester Royal Infirmary
- Saint Mary's Hospital
- Manchester Royal Eye Hospital
- Royal Manchester Childrens Hospital
- The University Dental Hospital of Manchester

Trafford hospitals, acquired in 2012, includes Trafford Hospital, a general hospital situated in Urmston and two out-patient hospitals in Stretford and Altrincham.

The Trust also provides community services; adults and children's community services for central Manchester and children's community services for the whole of Manchester.

Each Hospital and Division within the Trust is led by a Clinical Head of Division and Divisional Director.

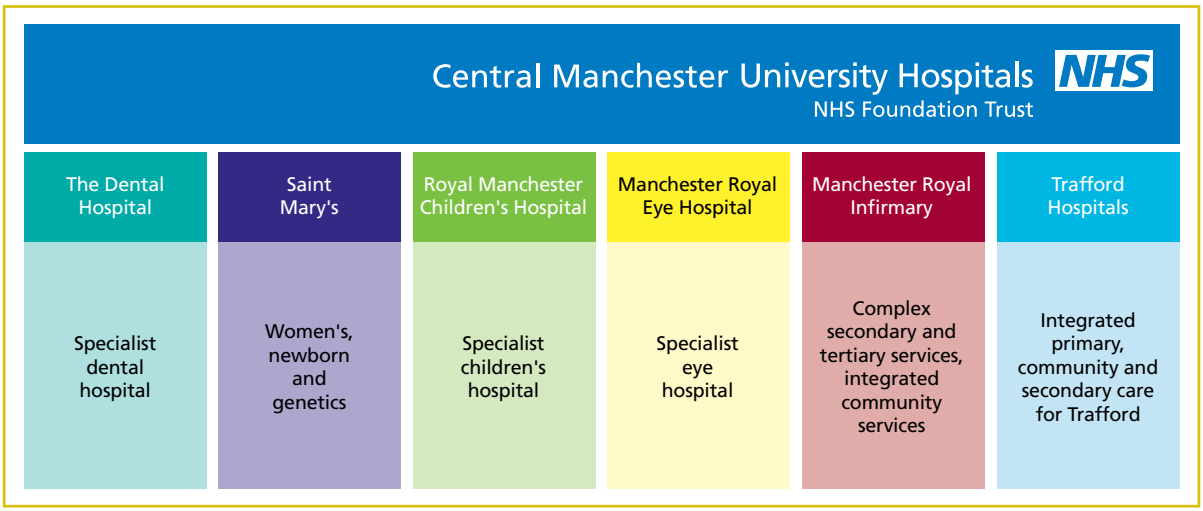
They in turn are supported by a full Divisional Management Structure. Progress and performance is managed at a Divisional level through formal reporting to the Board of Directors via the Trust Management Board; the Operational Managers Group; Bi-annual Divisional Reviews with the Executive Team and Intelligent Board Reporting. The Trust's Governance Structure below Board Level includes representation from all Divisions within the organisation.

Board Assurance

The Board derives assurance on the quality of our services including safety and patient experience, through our internal mechanisms and through the work of external bodies responsible for regulating quality such as the Care Quality Commission CQC.

The following are our key internal governance mechanisms for providing assurance to the Board:

- Leadership Walk Rounds – undertaken by the Board of Directors in all clinical wards and departments and includes talking to patients about their experience at the Trust.
- Intelligent Board – key clinical quality and patient experience metrics are provided to the Board of Directors each month.
- Risk Management Process – all risks are identified and scored. Any scoring above 15 is brought to the attention of the Trust Risk Management Committee which is chaired by the Chief



Executive. All of the executive directors are members and all non-executive members are invited to attend, and do so, with non-executive attendance recorded for all meetings during 2013/14.

- Ward Accreditation – wards are scored based on ward data, observing practice and gathering views from staff and patients and are awarded bronze, silver or gold based on a series of quality metrics. Those awards not achieving the required standard have rigorous action plans to improve standards within a given timescale.
- Board Assurance Framework – maps the key risks associated with achieving delivery to the strategic aims and key priorities. It provides the Board with an overview of the gaps in controls and assurance and the actions required to mitigate them.
- Finance Scrutiny Committee – a committee of the Board established to examine the incidence, nature and potential impact of emerging or identified significant financial risks to the Trust's on-going position and performance, either in-year or forward-looking.
- Clinical Effectiveness Scrutiny Committee - a committee led by the Chairman who will identify areas that require more detailed scrutiny arising from: national reports, patient feedback and public interest issues.
- Quality Reviews - multi-disciplinary reviews of care delivered by our clinical divisions across the whole Trust based on Keogh methodology.

The following are examples of external sources of assurance to the Board in relation to the quality of our service:

- National Patient Survey – this provides feedback in relation to patient experience and clinical quality. It is analysed in depth and the findings are reported to the Board and used as the basis for identifying areas where we need to improve and develop our work programmes.
- Care Quality Commission (CQC) – the Trust must be registered with the CQC who check all hospitals in England to ensure they are meeting national standards.
- The Friends and Family Test - is an important opportunity for patients to provide feedback on the care and treatment they receive with a view to improving services.

Key Priorities and Achievements

Progress against our 2013/14 Key Priorities, as well as the Trust's achievements are shown below, the tables also show where the Trust has identified a significant risk, the details of what constitutes a significant risk together with the detail of each are shown in the Annual Governance Statement later on in the Annual report.

Key Priorities	Achievements	Risks
Achieving the Highest Standards for Patient Safety and Clinical Quality		
Reduce mortality rates to below 100 before re-basing	Mortality: Consistent process for mortality reporting developed for all Divisions, reduction in mortality indices achieved Summary Hospital-level Mortality Indicator SHMI 103.9 and Hospital Standardised Mortality Ratios HSMR 93.1).	Regulatory Framework – Clinical Risk Trustwide HSMR and SHMI – Clinical Risk Patient Records – Organisational Risk Never Events – Clinical Risk Communication of Diagnostic Test and Screening Results – Clinical Risk
Ensure pathways are in use, fully utilised and delivering the right clinical outcomes	Pathways: Trust-wide pathway mapping exercise complete	
Ensure safe supervision is in place for all medical staff	Supervision: Quality framework developed and implemented.	

Key Priorities	Achievements	Risks
Ensure clinical engagement and leadership in all improvement programmes and develop a new consultant development programme	Leadership: Newly Appointed Consultant (NAC) programme - to date, 28 NACs have completed the programme. There are a further 35 still on programme, 9 of whom will complete July 2014 and 26 in December 2014. A new cohort starts in September 2014.	
Ensure the High Level Investigation Process reduces actual harm	High Level Investigations: Review of processes undertaken, electronic monitoring of action plans, reduction in Never Events (8 in 2012/13, 3 in 2013/14) and serious harm achieved (From 33 level 4/5 actual harm last year to 16 - plus 9 pending).	
Ensure medical education improves quality and patient safety	Education: Evidence base for education has been incorporated into electronic Revalidation Management System (Equiniti RMS) and into the Consultant appraisal process and trainer role: We maintain a database of educational and clinical supervisor compliance.	
Improving the Patient Experience		
Maintain high levels of professional leadership	Professional Leadership: Increased number of nurses completed and studying for MRes (Masters in Research) and PhD in nursing. Increased number of nurses on Nursing and Midwifery Council. Florence Nightingale Chair appointed in Nursing Research in partnership with The University of Manchester.	On the basis of an unannounced visit in December 2013, the Care Quality Commission made a finding of non-compliance of minor impact on patients with regard to the choice of food in one of our hospitals (Royal Manchester Childrens Hospital). The Trust has put in place mitigation to the effect that the Trust feels able to declare compliance against this outcome and will monitor this going forward.
Ensure safe staffing levels are maintained	Safe Staffing Levels: Increased nurse staffing levels on wards at night in acute medicine. Introduced a tool to determine safe staffing based on patient need. Increased recruitment to maintain safe staffing levels. Provided visible ward staffing information at ward entry – 'Proud to Care' initiative. Increased Health Visitor workforce in line with the National Call to Action to deliver the Healthy Child Programme and the integrated Early Years New Delivery Model.	
Create a culture of compassionate leadership	Compassionate Leadership: Annual Nursing & Midwifery Conference – launched Values and Behaviours Framework and Clinical Support Workers Code of Conduct.	
Ensure the highest standards of cleanliness	Cleanliness: Increased patient satisfaction on cleanliness	
Ensure patients receive and enjoy good levels of nutrition	Nutrition: Increased patient satisfaction on patient dining	
Ensure the environment is fit for purpose	Environment: New hospital development with a high standard of facilities. Achieved The Commissioning for Quality and Innovation CQuINs for harm-free care and dementia. Introduced Friends & Family test and achieved over 20% response rate. Patient feedback at agreed threshold (over 85%) across quality indicators.	

Key Priorities	Achievements	Risks
Developing Excellent Clinical Services		
Achieve Cancer waiting time standards	Cancer: Cancer 62 day from GP referral - full compliance with Monitor performance framework achieved.	A&E Performance – Clinical Risk Infection Control standards – Clinical Risk
Achieve Access/Waiting Time standards	Access/Waiting Times: full compliance with Monitor performance framework achieved.	
Achieve A&E/Urgent Care Standards	A&E /Urgent Care: full compliance with Monitor performance framework achieved for 3 out of 4 quarters and the year.	
Achieve Infection Control standards	Infection Control: continued reduction in infection rates achieved.	
Robust Emergency Planning	Emergency Planning: Internal and external exercises undertaken with full learning taken back to the Trust Operational Group.	
Maintaining Financial Viability and Stability		
Deliver trading gap (savings) plans	Trading Gap: 2013/14 trading gap target delivered.	Trading Gap Delivery/ future financial challenge – financial risk Commissioning – financial risk
Protect the liquidity position so that the Trust is able to meet its payment obligations as they fall due through management of the capital programme and working capital balances	Liquidity: Targets for liquidity achieved – Continuity of Service Risk Rating of 3 achieved, with liquidity at a rating of 4. Capital expenditure plan achieved.	
Implement the new service model for Trafford	Trafford: New service and financial model at Trafford introduced.	
Developing our specialist and tertiary portfolio		
Specialist Children's Services	Children's: Designation as the centre for paediatric cystic fibrosis services for Greater Manchester and Lancashire. Started provision of children's epilepsy surgical services (under 5s).	Major Trauma – System Readiness – Organisational Risk
Specialist Cancer Services	Cancer: Designation as the single centre for specialist HpB (liver and pancreas) cancer surgery achieved. Designation as centre for specialist gynaecology cancer surgery achieved.	
Vascular Surgical Services	Hybrid theatre installation progressed.	
Major Trauma Centre (MTC) for Adults and Children	Successful peer review for adults and children's MTC Retained accreditation as a MTC for children Retained accreditation as part of the Manchester MTC Collaborative.	
Cardiac Services	Single centre discussions with University Hospital of South Manchester progressed – expect to sign partnership agreement in early 2014/15.	
Dental	Dental strategy progressed and draft strategy document produced.	
Diagnostics	Development of next generation sequencing tests (genomics) progressed.	
Capacity Planning	Review of imaging capacity and capability completed.	

Key Priorities	Achievements	Risks
Implementing the Research and Innovation Strategy		
Develop Partnerships that enhance the research capability of the Trust	Partnerships: Achieved re-designation as Academic Health Science Centre (AHSC). Base for Inflammation and Repair Domain, part of the Manchester AHSC, established at the Trust. One of the 15 Local Clinical Research Networks opened on 1st April 2014 following a successful bid to host.	
Promote research that will improve the quality of healthcare to our population	Promote Research: Campaigns raising awareness of research in 2013/14: - International Clinical Trials Day (May) - We Do Clinical Research (October-December) - Research Conference (December)	
Integrating Trafford Hospitals		
Approval of the new model of care	Approval: Service change proposals approved by Secretary of State and NHS England.	Trafford Diagnostic Review – Clinical Risk Trafford Service Re-design – Organisational Risk Informatics Trafford Hospitals Infrastructure – Organisational Risk
Harmonisation of clinical support	Harmonisation: First phase of organisational change programme completed, including staff consultation and re-deployment process etc.	
Development of clinical services/facilities/infrastructure	Clinical Services: Operational plans implemented, including revised critical patient pathways and working with key partner organisations. Comprehensive communications plan implemented, including information to staff, patients and the public.	
Development of the new Altrincham Hospital	Altrincham Hospital – building work began on the new state-of-the-art healthcare facility in Altrincham town centre.	
Development of organisational capacity and capability		
People Management Practices	People Management Practices: Competence and capability of line managers to deal with employment issues effectively in the workplace developed through specialist training. Case Management Employment Relations Framework in place to provide improved assurance and manage risk.	Failure to meet Equality and Diversity Obligations – Organisational Risk
Organisational Development	Organisational Development: Strategies developed and being implemented for the Trust and Children's Division. The first wave of a major change management programme in the Children's hospital has been implemented for five specialities. Wave 2 will begin in May and future Change Leader capacity being developed.	
Senior Leadership	Senior Leadership: The Senior Leadership programme for 225 of the most senior leaders and clinicians was launched in February and the first Master Class undertaken in March.	

Key Priorities	Achievements	Risks
Developing a work-force that is fit for the future		
Valuing our Staff	Valuing our Staff: The Staff survey – survey completion rate increased by 1%, staff engagement score increased again and is now higher than the acute trust average, significant number of key findings improved. Regular staff engagement sessions held with the Chief Executive. Staff Engagement strategy, incorporating the 'Voices' project, being implemented. Governors Health & Wellbeing Group established.	
The Medical Workforce	Medical Workforce: 217 revalidation recommendations made for doctors. 168 hour consultant labour ward cover agreed and being implemented.	
Safeguarding Employment	Safeguarding Employment: Successful redeployment processes to include Trafford redesign.	
Workforce data	Gap between staff in post and establishment closed by 2.21%.	
Engaging stakeholders, demonstrating leadership for corporate social responsibility		
Working with Manchester City Council (MCC) and the Manchester Health Academy (MHA)	MCC and MHA: The Manchester Health Academy - achieved 2013 targets for attainment, has full enrolment, post 16 provision judged good, surplus for re-investment.	
Green Initiatives	Green initiatives – Sustainability manager and lead recruited, successful application to Energy Efficiency Fund for boiler, system for monitoring energy installed for wards, Green Impact programme launched in November 13.	
Governor Development	Review demonstrated Governors have driven 223 actions over the past year.	
Foundation Trust Membership	Membership: Target membership achieved, events held including new Annual Members' Meeting with Governor Q&A session, Young Persons Event.	

The Trust also monitors its workforce statistics, full details of which can be found on page 34. In line with reporting guidelines, the Trust can confirm that the split of male and female employees in 2013/14 is as follows:
Male - 2667 Female - 10159

Of this number the split for senior managers and Directors is as follows:

Senior Managers – the definition of a senior manager is an individual who reports to an Executive Director
Male - 14 Female - 14

Directors inc Non-Executive Directors
Male - 7 Female - 6

The Trust has considered the impact of its business and in particular any relevant policies and risks in relation to environmental matters, its employees, social, community and human rights. The Trust has identified one significant risk in relation to compliance with Equality and Diversity Legislation, the actions of which are described in detail in the Annual Governance Statement later in this report. With regards to policies, the Equality, Diversity and Human Rights Section of the Annual Report describes the impact and effectiveness of its Equality and Diversity Policy framework. Those policies and strategies that impact on the environment are described in the Carbon Reduction/Sustainability section of the Annual Report.

The Trust has determined its key priorities for 2014/15 together with the key performance metrics and these are outlined overleaf.

CMFT Plan-on-a-page 2014/15- 2015/16

Visions and Values	**Our vision is** To be recognised as the leading healthcare provider in the NHS, excelling in quality, safety, patient experience, research, innovation and teaching, dedicated to improving health.	**Our values:** • Pride • Respect • Dignity • Consideration • Empathy • Compassion
Strategic Aims	1. Improving the safety and clinical quality of our services 2. Improving the experience for the patients, carers and families that we treat 3. Developing our specialist services and providing excellent integrated care to our local populations 4. Increasing the quality and quantity of research and innovation across the Trust, contributing to improving health outcomes 5. Providing the best quality assured education and training 6. Developing our organisation and our workforce 7. Remaining financially stable and generating a surplus	
	Key Priorities	Metrics
Quality	Delivering safe, harm-free care focusing on evidence based pathways, supervision and clinical leadership	HSMR/SHMI less than 100 before re-basing Rates of harm per patient bed day < 0.001 VTE Risk assessment completed >95%
	Developing, maintaining and consistently deploying nursing and midwifery establishments, which are informed by evidence based acuity and dependency tools and professional guidance	Board review of ward establishments twice in year Monitoring of staffing levels in real time achieved and reported to Board
	Delivering personised, responsive and compassionate care in partnership with patients and families in appropriate environments safeguarding the most vulnerable	Friends and family response rate >15% achieved Safeguarding targets achieved
Service/ Operational	Transforming urgent and emergency care for the local populations and beyond with a particular emphasis on frail elderly and developing our community and integrated care services	Reduced A&E attendances Reduced non-elective admissions Reduced Length of Stay Reduced readmissions for frail older people and adults with dementia, adults with long term conditions and adults at the end of life (no actual targets being negotiated between CMFT and commissioners)
	Exceeding all key NHS commissioned standards and deliverables, including access and quality outcomes	Delivery of 4 hour emergency access target Delivery of all other access targets including referral to treatment time and cancer wait times Delivery of quality outcome measures within national guidance including for stroke, trauma and access to emergency surgery
	Developing our specialist services including cardiac, cancer, children's and vascular services	Achieve designation as major arterial (vascular) centre Achieve designation for paediatric neurosciences and burns Achieve designation as specialist cancer surgical centre for head and neck, colo-rectal, gynaecology and urology Single service model for adult cardiac care achieved
	Reviewing and refreshing Trust administrative processes	Modern customer-facing standards pusblished by March 2015 Recognised as a national exemplar by April 2016
Research	Integrating research into patient choice and the treatment pathway	Annual patient recruitment - 6,000 patients to be recruited to clinical trials Percentage of Trust patients entered into trials - 5% total patients Patient research suvey returns - 50% increase in response rate Website analytics - 10% increase in hits on website
Human Resources	Implementing the HR and OD strategies, focusing on: developing leadership capability; accountability and recognition; values and behaviours (inc Equality & Diversity and health and well-being); education and training, in particular for medical staff	E&D objective included in the objectives/appraisal for every member of staff 3% improvement on retention figures compared to 2013/14 level 225 most senior leaders completed senior leadership development over next 3 years 5% improvement compared to 2013/14 staff survey results for self-rated health, perceived managerial interest in personal health and well-being, work-related stress and perceived pressure to come to work
	Implementing Workforce Planning, focusing on the medical workforce	Workforce plans produced that are aligned with the Trust's strategic direction and the delivery of our service development plans, activity requirements and high quality services A reduction on the 2013/14 level for the gap between staff in post and establishment achieved 5% improvement on previous year HR KP and relative to other large acute teaching hospitals achieved for staff survey keyfinding 34: "Staff Job Satisfaction"
Finance	Achieving financial stability and generating funds to re-invest in our services	Capital servicing capacity '2' Liquidity '3' Continuity of service risk rating '3' Operating surplus of £6.5m Capital programme £56.0m 2013/14 and £44.7m 2015/16

Context - Local Health Economies

CMFT is geographically located within two local health economies (LHE)

- The main Oxford Road site is within Central Manchester LHE (Central Manchester Clinical Commissioning Group and Manchester City Council)
- Trafford Hospitals are within the Trafford LHE (Trafford Clinical Commissioning Group and Trafford Local Authority).

Both of these local health economies operate within the context of a broader Greater Manchester health system which is striving to deliver consistently high standards of care for patients across the conurbation.

Our high volume of tertiary and complex specialist services means that Specialised Commissioners (NHS England - Cheshire, Warrington and Wirral Area Team) are our single biggest commissioner.

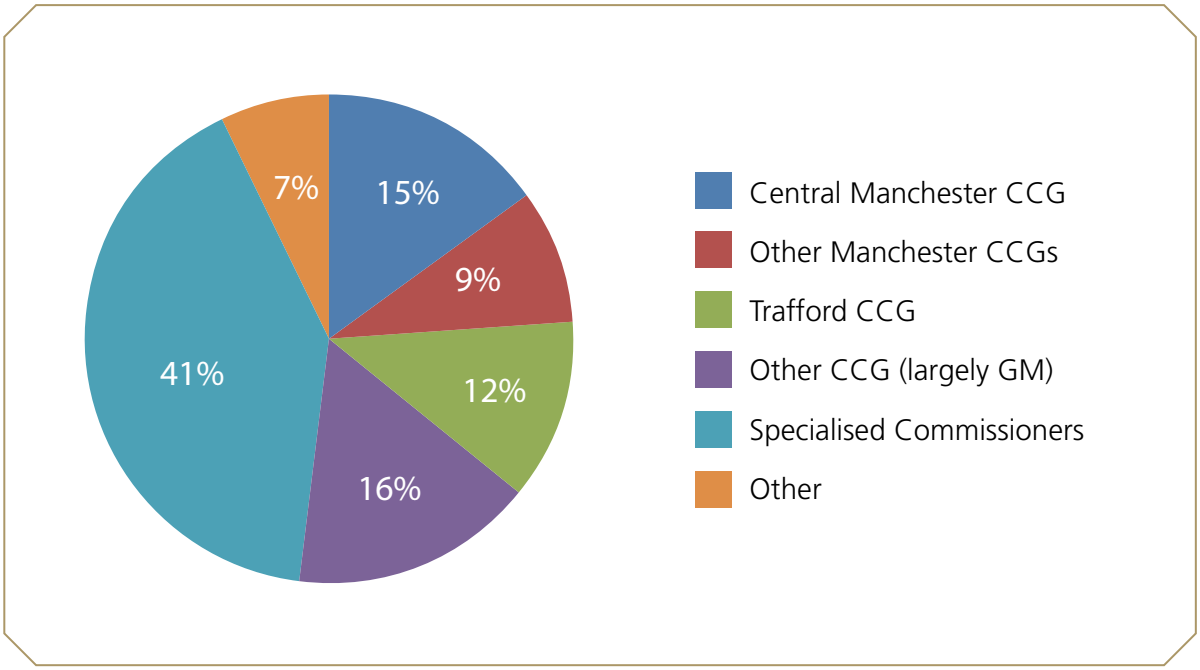
Specialised Services

CMFT is the seventh largest provider of specialised services in England. Our specialised services are commissioned by NHS England - Cheshire, Warrington and Wirral Area team (CWWAT). The Head of Commissioning at CWWAT is one of our nominated governors and we have extensive engagement with the team including regular executive to executive team meetings, contract meetings, ad-hoc meetings related to specific issues such as designation/derogation of services.

Central Manchester Local Health Economy

Manchester is served by three Clinical Commissioning Groups CCGs; North, Central and South CCGs. It is covered by one local authority; Manchester City Council. We have long-standing and well developed engagement arrangements in place with Central Manchester CCG and across the city of Manchester. They include –

- *Central Manchester Integrated Care Board* (CICB) – chaired by the Chair of Central Manchester CCG brings together health and social care providers and commissioners within central Manchester and reports to the Manchester Executive Health & Well Being Group.
- *Manchester Executive Health & Well Being Group* – chaired by Manchester City Council CEO brings together CEOs of the health and social care providers and commissioners across Manchester.



- *Manchester Health & Well Being Board* – chaired by the Leader of Manchester City Council and brings together Manchester CC, Manchester CCGs, and the key health and social care provider organisations in the city.

Trafford Local Health Economy

CMFT has worked extremely closely with Trafford CCG over the last two and a half years on the New Health Deal for Trafford programme. As a result we have well-established personal relationships with senior colleagues at Trafford. More formal engagement mechanisms in place include:

- *Trafford Integrated Care Redesign Board (ICRB)* - oversees the programme to develop integrated ways of providing healthcare in Trafford.
- *Trafford Health and Wellbeing Board (HWB)* - CMFT is represented on the statutory Health and Wellbeing Board which is a sub-committee of Trafford Council.
- *Executive-level Group* – recently established between key partner organisations. This is led by Trafford Council and will sit alongside the HWB, meeting on a quarterly basis.

Key Challenges

The health and social care system is about to face unprecedented levels of demand as people are getting older and those with long term conditions are living longer. At the same time in real-terms, funding is projected to fall. In recognition of this, the key stakeholders in the Manchester health and social care system commissioned a study which showed that the current configuration of services is not sustainable and that income and cost pressures could drive a combined deficit of up to £58m in 2014/15; a gap that could not be bridged by improving productivity alone.

This echoed the findings in other health economies and as a result there has been collaboration at the Greater Manchester health economy level to address the potential gap. Four inter-dependent programmes of work have been established:

- *Healthier Together* – reviewing the configuration of hospitals
- *Integration* – provision of seamless services, irrespective of which organisations provides them, that prevent patients from being admitted to hospital unnecessarily (for Manchester this is called Living Longer, Living Better)
- Primary Care Strategy – further strengthening the role of primary care
- Ongoing Quality, Innovation, Prevention and Productivity (QIPP) programmes in individual health economies

Financial Plans

In the context of overall government finances and the spending review settlement for the NHS, 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.

Financial Out-Turn

The Trust's income and expenditure out-turn for 2013/14 financial year is a surplus of £1.2m which equates to 0.13% of the total income for the year. The Group position reflects the expending of Charitable Funds £2.44m in excess of the income generated by the Charity in the current year.

The year-end cash balance of £75.5m reflects funding held for continuing capital investment projects across the year end and the maintenance of adequate working capital to support continuing operations. The overall Group cash balance was £80.1m including cash holding by the Charity of £4.6m.

Financing

During 2013/14 the Trust received £331k Public Dividend Capital from the Department of Health for capital schemes supporting Energy Efficiency and Improving Maternity Care.

The Trust has continued to maintain an as yet un-utilised working capital 'overdraft' facility of £50m

as required by our terms of authorisation. 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 table shows the Trust's performance against Monitor's mandatory performance measures, which the Board of Directors also uses to track overall financial performance. The Trust's overall financial position remains robust, resulting in an overall Continuity of Service risk rating of '3' (where '4' is the strongest rating and '1' the weakest):

Continuity of Service Risk Rating

Metric	Actual	Rating for the year
Liquidity ratio	4.8 days	4
Capital service cover rating	1.36 x cover	2
Overall continuity of service risk rating		3

The 2013/14 financial year saw increases in the scope of the Trust's activities, including implementing the clinical model agreed for Trafford. With careful management through this transition, the Trust has met the overall financial requirements set by Monitor throughout the 2013/14 financial year. These figures do not include the Group position as neither the Charity nor the Group are subject to the Risk Assessment Framework.

The Trust continues to invest in capital to support the delivery of services with current projects including completion of the final phase of the new Adult Critical Care facilities, the state of the art hybrid theatre suite, the Citylabs project which in partnership with Bruntwood plc is a flagship redevelopment of the former Eye Hospital into a bespoke biomedical facility, delivery of the new Altrincham Hospital and an extensive programme of investments building gradually towards having an Electronic Patient Record in use right across the Trust over the years ahead.

Annual efficiency challenges for the next two years are forecast in the order of £28m and £34m respectively. These reflect a combination of being paid less in future, for the same range and complexity of services we have delivered to patients in 2013/14, together with further annual cost inflation arising beyond the Trust's immediate control.

Robust plans are in place for delivery of the 2014/15 challenge.

CMFT fully recognises the challenge we will face in 2015/16 and being well advanced on the delivery of the 2014/15 target means the Trust has started to develop more headroom to respond effectively, with four Divisions already making significant inroads into identifying and 'banking' savings for 2015/16 from their work to finalise the 2014/15 plans. It is recognised that the economic challenges facing commissioners means that there will need to be a greater emphasis on service transformation. A number of workstreams are already in place across Divisions to design and implement transformational service improvements.

The delivery of the financial plans will be managed through well-established corporate processes, developed and operated successfully over recent years.

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.

Declaration

The Directors confirm to the best of their knowledge and belief that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the NHS Trust's performance, business model and strategy.

Mike Deegan
Chief Executive

Directors Report

The Directors Report has been prepared in accordance with sections 415, 416 and 418 of the Companies Act 2006 where applicable and Regulation 10 and Schedule 7 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008. It also includes additional disclosures required by Monitor.

Detailed below is where the key aspects of the requirements can be found in the Annual Report sections.

The Annual Governance Statement and the Quality Report describes the Trust's quality governance framework in detail and plans to improve quality in the future.

The Strategic Report describes the Trust's principal activities, strategies, performance, resources, partnerships, financial position and instruments.

The Statement of Compliance with the NHS Foundation Trust Code of Governance confirms that so far as each Director is aware, there is no relevant audit information of which the Trust's auditor is unaware and all Directors have taken all the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

Accounting policies for pensions and other retirement benefits are set out in note 1.7 to the accounts and details of senior employees' remuneration can be found in page 215 of the remuneration report.

The Annual Report contains the full declarations of interests for all Board Members undertaken on an annual basis which is available on the Trust's public website.

Full details of all Directors of the Board is contained within the Annual report, the remuneration report also notes changes in Board membership during 2013/14.

The Equality, Diversity and Human Rights Section gives a description of how the Trust delivers professional equality practice in employment, the policy framework and the current workforce profile.

Throughout 2013/14 there have been increased efforts to engage with staff following the results of the National Staff Survey. This is described in detail in the staff engagement update.


PRESS

Working with our Patients and Visitors

This year the Patient Experience team has reached out across the Divisions to enable a range of services to undertake proactive patient and staff engagement.

The examples included within this report describe how meaningful involvement can lead to better outcomes for patients, carers and ultimately the professionals supporting them.

Almost everybody working in the organisation agrees that there is room for improvement. However, it can sometimes be difficult to know where to focus efforts, to secure the most significant improvement.

Listening to our patients, carers and staff as a routine part of the delivery and planning of healthcare helps give us a balanced view.

Working with Patients with Cancer: Listening, Understanding and Responding

The services that provide support to our cancer patients wanted a more inclusive attitude for patients and families, where they are listened to, heard and consulted more closely. The teams involved wanted to balance the needs of both the person with cancer and their carer to enable them to achieve the best outcomes.

The first of two listening events took place in November 2013. The focus for the first event was around Living with and beyond cancer. Patients and carers were invited to join the teams for a series of short presentations and by group discussion in their specific tumour groups. The teams then reflected with their patients and carers on key areas highlighted within the National Cancer Patient Experience Survey (NCPES) 2012/13. The areas discussed included:

- Preparation and support for discharge
- Communication, support and information provision.

Feedback from Event

The event was attended by over 88 delegates, the majority of which were patients and carers. Information discussed within the groups was captured and this information was then collated and circulated to the clinical teams to review at cancer boards and agree appropriate actions.

Analysis of the feedback has identified common themes across all the groups and an example is given right.

The listening event provided useful discussions and insight into the cancer patient and carers experience. The common themes identified around communication, information support and discharge are found in the recent National Cancer Patient Experience Survey 2012/13.

Following on from the event a Cancer patient experience subgroup co-ordinates the different opportunities for us to find ways of achieving better collaboration between the clinician/team/ward, patient and family. The group will also ensure that patients/carers are informed of the outcome of the events and ongoing patient led service improvements.

Healing Environments

The Healing Environments Project has developed across our patient environments over the past two years. Partnership working has enabled us to fulfil our ambition of reaching as many patients, staff and carers as we can – and offering them something

Analysis of feedback

Topic	What went well	Even better if
Communication Good effective communication is vital element for all cancer patients and carers. It underpins many of the categories within the national in-patient survey. Within the NCPES 2012/13 survey there were positive statements concerning the clinicians and nurse specialists who felt they received excellent care during their treatment.	The feedback from the listening event contained positive comments overall, with patients feeling cared for and supported by the clinical teams. Patients reported that they were able to access clinical staff and discuss their concerns around treatment. Patients felt they received the feedback from tests and diagnostic procedures in a timely manner and were involved in decisions around their management and treatment. Specific comments related to continuity of care, they valued being able to see the same consultant at each visit, as they found this less confusing. They also highlighted intentional patient rounding as positive to patient experience. For patients in the group that underwent surgery, they appreciated the telephone call to carers from the surgeon on the day of the operation as good practice. Ward rounds were also a useful opportunity to speak with the specialist nurse and team.	Use of medical jargon - patients commented that descriptions need to be simple and easy to understand when discussing causes of cancer, or its management and side effects. Support provided when English was not the patient's or the medical/nursing staff's first language. Patients felt that continuity was important – seeing the same member of the team and having access to the Clinical Nurse Specialist (CNS) would be of benefit when they attended clinic. This was complicated for many of the groups where care spanned several provider organisations. Co-ordination of diagnostics and tests would also improve continuity and prevent numerous attendances. Attitudes of the ward staff, patients perceived in some areas staff did not have the knowledge or skills, and were not supportive. This undermined the patient's confidence in the care given. Poor communication between primary and secondary care from the multi-disciplinary team to GP and District Nurse. Written communication between departments; GP – ensuring contact details for Keyworker/CNS are included on all correspondence.

unexpected, surprising and entertaining in the process. By formulating a diverse programme of activities, musical performance and special events we share the common aim of enhancing the patient experience.

By working closely with cultural organisations such as Manchester Museum and Whitworth Art Gallery and national charities such as 'Kissing it Better' patients have been exposed to a range of exciting opportunities during their time with us.

Stroke Unit Art Project

The Art project on the Stroke Unit in Trafford General Hospital has been one of the Healing Environment Project's biggest successes. The work is a true example of staff involvement, partnership working and collaboration in practice and we have been pleased to see the project continue to flourish.

By working closely with Manchester Museum, we have been able to provide a series of artist-led sessions in response to the museum collection.

From watercolour painting, printing, collage and textile art – these twice weekly art sessions have enhanced patient wellbeing through their ability to create a relaxed, social environment. These sessions culminated in the production of two beautiful silk banners, designed from work the art group created, which have been displayed in the Museum before being gifted to the day room as a lasting legacy.

One of the patients (Jayson) who was actively involved in the first art group, has highlighted the value of the sessions in his recovery process. Jayson has been very keen to express that this is "exactly the sort of thing patients should be getting involved with" – and the positive effect of participating in the art group resulted in a wonderful art piece that evoked pride and involvement.

These art sessions have continued and we look forward to extending them across more wards to ensure as many patients, staff and carers benefit.

Kissing it Better – Trafford and Manchester College Beauticians

Kissing it Better are a valued part of the Healing Environment project and have introduced a number of successful projects. One of the most popular has been the beauticians from Trafford College and The Manchester College who attend a weekly timetable of wards and Out-patient environments offering hairstyling, hand massage and manicure. The beauticians have been extremely well received by staff and patients.

Forget-Me-Not Focus Group

The work programme for bringing about improvements for people living with dementia continues. The programme has several strands. Supporting carers of people with dementia is a priority. A Forget-Me-Not forum was established for carers of people with dementia during 2013 as the The Alzheimer Society (2013) campaigns for:

- Carers to be supported in their role
- Carers to receive better information and advice
- Peer support networks to be available to all carers of people with dementia
- Carers to be true partners in care, involved in decisions about care and also in designing the care and support that they and the person with dementia receive

The Forget-me-not focus group is where carers of people living with dementia meet on a monthly basis to offer their input on changes to dementia care across the hospitals. With their help we have designed a care plan to meet a person centred approach and provide individualised nursing care for people with dementia.

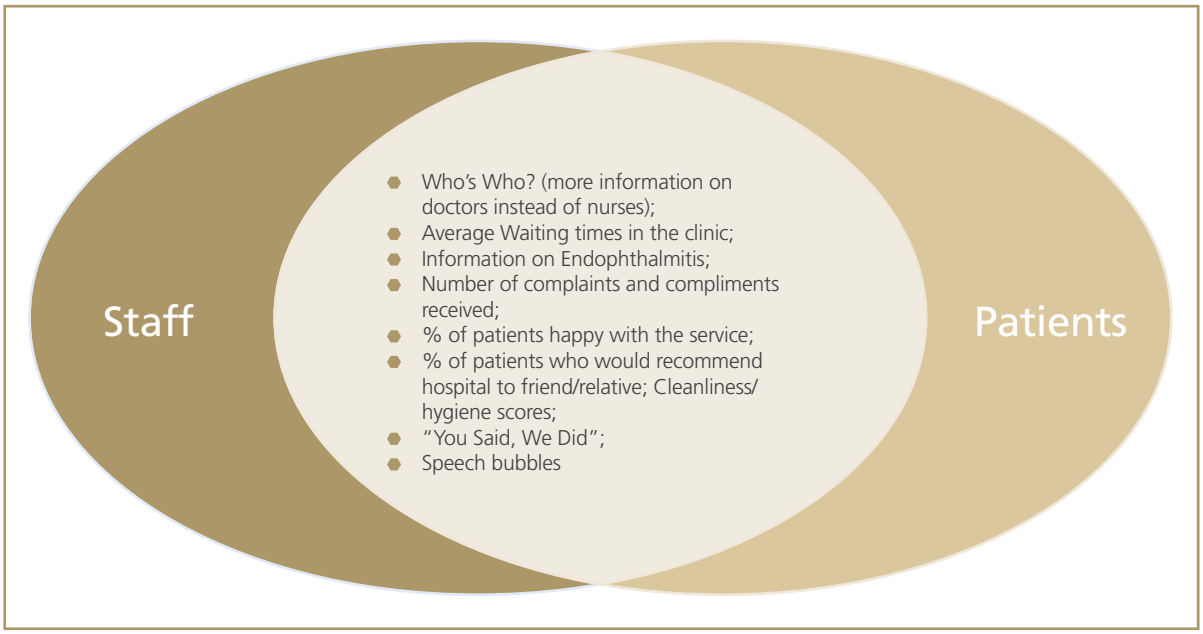
Sharing the Caring - The group have also developed a carers' leaflet to provide information to support all carers of people living with dementia from Manchester.

Memory Lane - The carers from the focus group felt reminiscence activities can have many benefits for people with dementia allowing them to hold on to their sense of identity, while also helping them, their relatives and carers feel that the person they knew is still there. The creation of a memory wall within the hospital has had the input and guidance of the carers forum, this they feel would provide an area for patients with their carers to access to stimulate memories.

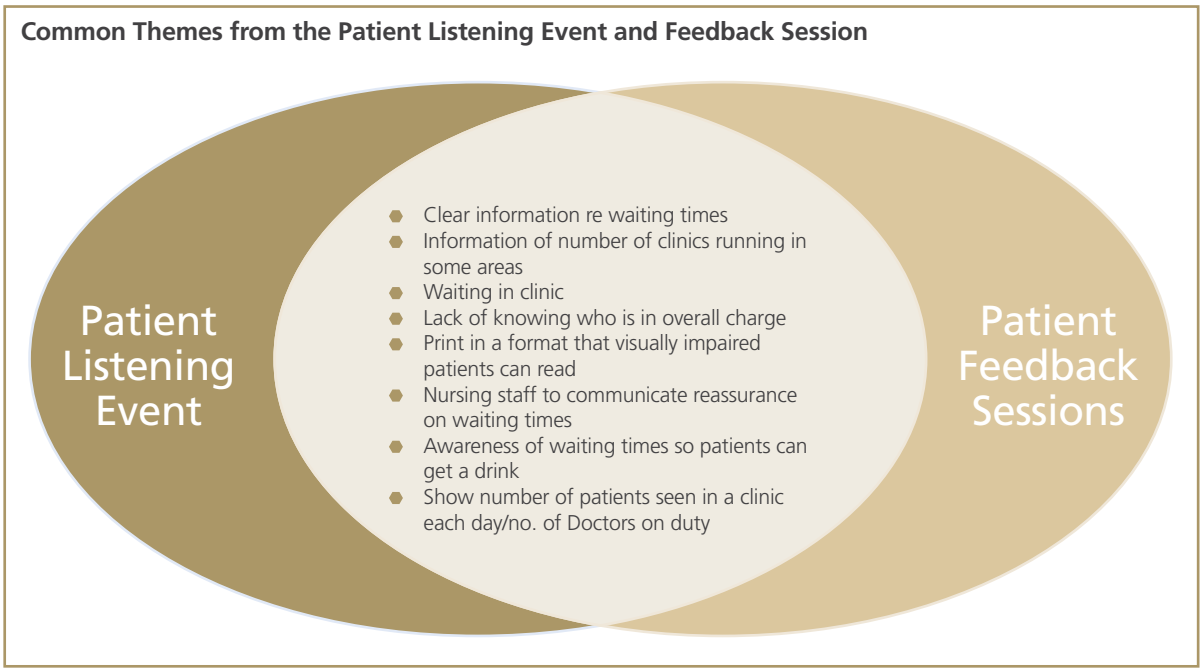
Manchester Royal Eye Hospital (MREH)

The Manchester Royal Eye Hospital's Out-patient Services wanted to know the patients' views with respect to the kind of information they would like seen or displayed in the clinics. The project entitled 'Information for Patients' was an offshoot of the MREH-sponsored Patient Listening Event that took place in October 2013. Patients and carers who were invited were grouped according to the service they accessed, namely: Cornea, Ocular Plastics, Glaucoma, and medical Retina.

A total of 80 respondents (including staff) gave their views of the kind of information that can prove useful and informative for patients and their relatives



Common Themes from the Patient Listening Event and Feedback Session



or carers who wait in the Out-patient Department. Those taken feedback from said that it would be good for the hospital to inform the patients about:

1. Waiting times;
2. Doctors' and nurses' names;
3. Hospital Acquired infections;
4. Cleanliness and hygiene scores; and
5. What the MREH was doing about comments or complaints put forward for their action.

The results of the Eye Hospital's listening event and the Patient and Staff Feedback Session were then compared to find further commonalities. The results are shown above.

Both the Listening Event and the Feedback Sessions provided a wealth of feedback for the Hospital. From the information gathered, the Hospital was able to see what they were doing well and what could be done better. It was also able to gauge what kind of information patients, their relatives, and their

carers felt was informative and how this information could make their hospital experience much better. This in turn can assist the Hospital in their service improvement plans.

Based on the data, the Manchester Royal Eye Hospital were able to identify and define the issues, based on the feedback and agree a number of tests of change (actions) that are currently being introduced. The tests of change included some changes that are consultant specific and some nurse-led changes to reduce the clinic waiting times and improve communication with the patients about any waiting times they could expect to experience, beyond the time of their actual appointment time.

The changes include:

- **Waiting-time transparency:** Staff are to let patients know as close to their arrival as possible how long they will be expected to wait and provide a personal apology if they are expected to wait after their actual appointment time;
- **Waiting-time transparency:** The display of waiting times, apologies and other clinic specific information on the CMFTV screens;
- **Improving the perception of waiting times:** The introduction of the Sodexo refreshment trolley service;
- **Minimising waiting times:** Consultant triage of patients at the start of each clinic to the appropriate doctor will be in terms of seniority and experience. This is to ensure that they can manage the patient consultation without advice, with the aim of reducing the number of times they need to seek advice and interrupt the consultant.
- **Minimising waiting times:** Consultant taken on a 'supernumerary' role within the clinic to enable co-ordination of senior support to junior doctors in a timely manner.

Division of Surgery

We are privileged to support patients at some of the most memorable, and possibly the most vulnerable, times in their lives. Our patients are often frightened, enduring prolonged hospital stays, episodes of depression, and feelings of isolation and loneliness. All this whilst trying to recover both physically and psychologically from serious illness and trauma in a very busy environment.

Our patients have high expectations for the delivery of care. We employ a variety of strategies and methodologies to monitor satisfaction and much of the feedback reflects that it is the 'little things' which can significantly affect the patient experience whilst they are in our care.

We have a responsibility to deliver our duties against a backdrop of patient experience measures and a framework of monitoring by commissioners and other external agencies. The evolution of tariffs for specialist services, and CQUIN deliverables, mean that we must focus on the quality of our service and patient experience feedback.

The introduction of our innovative Hand Rub project was driven, primarily, by our Care and Compassion Agenda. We believe that the work reflects strongly our aim to deliver care based on the six core values outlined in our Nursing and Midwifery Strategy: Respect, Consideration, Empathy, Pride, Compassion and Dignity. The delivery of Hand Rubs in the Division of Surgery was born out of the Healing Environments (HE) project.

There is strong evidence to suggest that a 'healing environment' improves patient experience by stimulating positive emotions, improving clinical efficiencies and enhancing patient safety. Furthermore, distraction therapies have been found to be highly effective when patients are experiencing feelings of confusion, anxiety, nausea or pain - taking their minds off discomfort, unpleasant thoughts and forthcoming procedures.

In order to demonstrate the value and success of the initiative, it has been essential to gather feedback from patients, from the volunteers who deliver the service, from ward staff and from our Patient Experience Team through the use of a guided questionnaire and the Patient Experience Tracker.

Our patients said:

"I didn't expect to have a hand massage. It was heaven. It lasted about seven minutes.'

'It was so relaxing."

"After having the hand rub I noticed a difference in the arthritis pain in my hands."

Our staff said:

"The young man who came is really good. He chats to the patients and they really enjoy his company."

"Sometimes we need to have a rota, so the patients who had the therapy the week before will be asked to wait until next week."

The delivery of Hand Rubs to our patients in the Division of Surgery is a new area of practice and as such has been, and continues to be, subject to close scrutiny. The majority of our Hand Rubs are delivered by volunteers and in order to maintain and extend the current level of service there is a planned programme of training. As this training is also made available to members of our permanent staff we hope to be able to take the service to a wider variety of clinical settings.

In September 2013, the Hand Rub project was showcased at our annual Nursing and Midwifery Conference and received the award for most outstanding contribution in the Arts category. As a result of this success we have been invited to present our initiative at a number of forums and events throughout the organisation. This has been instrumental in raising the profile not only of the Hand Rub project but also the benefits to our patients of all the other Healing Environment projects.

We continue to promote the service at every available opportunity through face to face presentations and the publishing of feedback and data results. Recently, the project was entered for a Patient Experience Network National Award (PENNA 2013) and was voted Runner Up in the Environment of Care category.

Patients and their carers are benefitting from Hand Rubs in the Divisions of Surgery, Medicine, and Community and Specialist Medicine; in the Neonatology Unit; and in the Children's Hospital. Huge benefits can be drawn from a service that comes at minimal cost and requires access to minimal materials.

Community Services

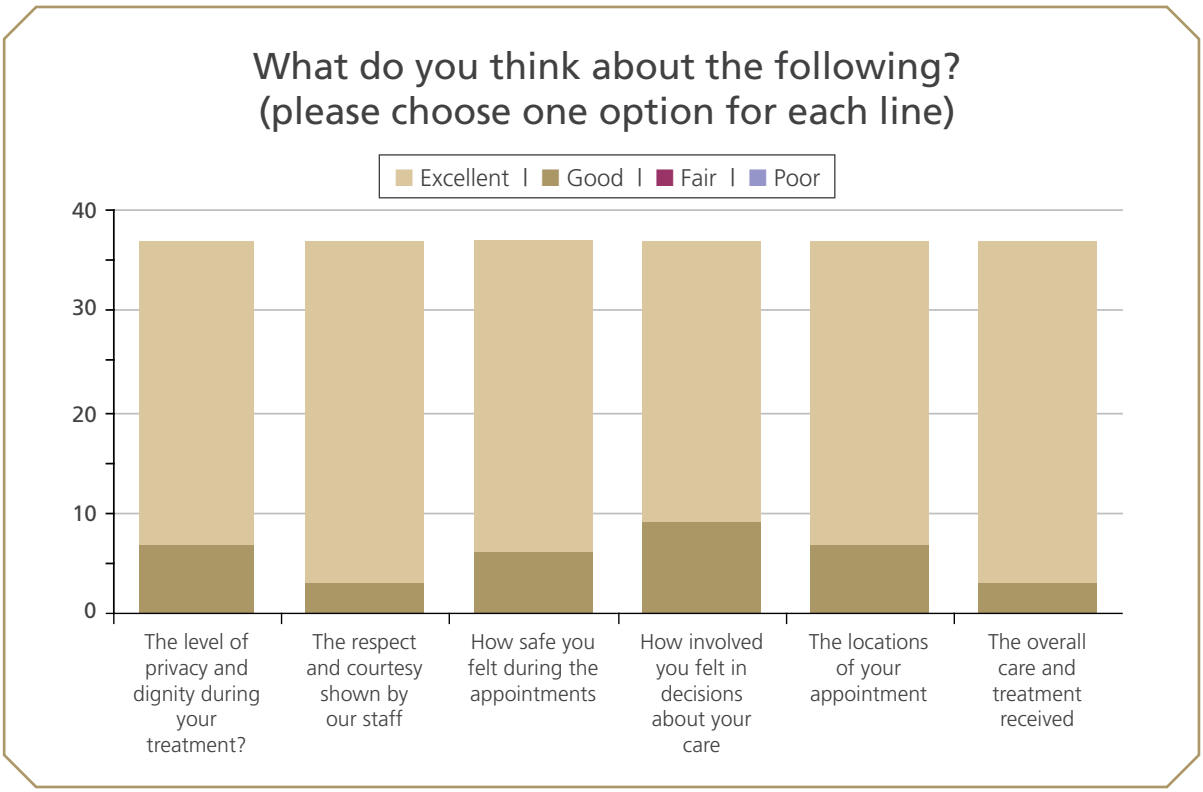
In November 2013 the responsibility of Patient Experience for community services was amalgamated with the Patient Experience and Quality Team for the acute hospitals. This meant gaining a deeper insight into the services provided by our community teams and therefore the information below gives

an overview of some of the work one of our teams within the community undertakes.

The Intravenous - Adult Community Therapy (IV-ACT) team is a new service which was implemented in 2013 to provide patients who required IV treatment the opportunity to undertake this treatment in their home environment or at a clinic location convenient to themselves and the team, thus avoiding the need to be admitted to hospital.

A patient survey was developed in an effort for patients to be able to give an overview of the impact the service has had on them. This considers how they rated the service but also asks the patients to give consideration to the location of where their treatment was provided as the other alternative would have been a hospital stay as an in-patient.

An overview of some of the results is attached for information:



Patients were also asked "**Did the service meet your expectations?**" and "**If needed again is this a service you would consider?**" On both occasions all patients answered 100% yes.

Patients were also asked: Are there any ways in which your care could have been improved? Please let us know how you felt about the visit, both good and bad. The responses below have been analysed by text size to show the eight most important and significant words and phrases received in this feedback:

Care Excellent Good Service Needed
Recommend Staff Team

The team also work with patients with acute medical conditions and those who also require intravenous therapy interventions as part of their clinical procedure. An example of some of the feedback which the team have received following their intervention is provided below from a family member who has witnessed first hand the support the service were able to provide:

"My mother was very ill and weak and when the nursing home suggested the (IV-ACT) team for my mother I had no hesitation in supporting this proposal.

I was keen for her to avoid any unnecessary trauma and the prospect of an admission to hospital with all the attendant issues of transfers between wards, the sea of new faces and her, by then, very limited understanding of what was befalling her was more than she could have endured.

For her to be able to receive the treatment in the nursing home in surroundings she understood and supported by the familiar faces of her carers was the ideal treatment.

At that time I had yet to encounter the IV-ACT team. When I did, I was impressed, very impressed with the care and compassion and understanding that they showed my mother. It's very difficult to gain a ready rapport with a patient as ill as my mother was then and especially with her limited cognition but the gentle, patient and soothing approach of the team achieved that and I was so relieved that it was done without any stress to her.

The team were at pains to ensure that the nursing home staff understood what had to be done in support, that I understood and was content with the treatment my mother was receiving and that, insofar as was possible, that my mother understood too.

In short, my mother could not have received better IV treatment than that administered by the team. Their professionalism was first class, their concern for the patient's comfort and the ease of communication with them made an ordeal very bearable. For that they have my everlasting thanks and I would unreservedly recommend this service to anyone requiring IV therapy at home.

In any service, cost comparisons of service delivery are usually readily discernable but customer valuations of the comparative services are much harder to determine in monetary terms. Suffice it to say that I found the service of a dedicated IV team to be beyond price in terms of relieving what otherwise would have been a very traumatic time for all the family.

I'm so glad that the IV team were able to provide such a necessary service with compassion and care. I am very grateful for the ease that gave my mother. I sincerely hope that you are given the opportunity to repeat that for 1000s in the future and will be pleased to convey my admiration for your service when it is reviewed".

Listening to our patients and their carers is an integral part of the delivery of our services. We can learn what it is like to live with an illness or be the carer of someone who is experiencing their care and treatment through our staff and to learn what it actually feels like to be a service user and the trust is committed to:

- Treating our customers safely, courteously and with dignity and respect.
- Providing care and treatments for patients within state of the art facilities that are clean and free from infection.
- Delivering care, treatment and advice that combines clinical excellence with the highest standards of patient safety, is based upon the best research and employs the latest clinical technologies.
- Offering a unique range of services to the North West treating and managing the simplest to the most complex conditions and diseases.

Volunteers Service

We recognise the unique contribution volunteers play in improving the experience received by our patients, by engaging with them on a personal level, and offering services which are intended to help improve the quality of life of patients during their treatment within the hospital.

Volunteering provides an opportunity for people from a variety of backgrounds to become involved in their local community. We are committed to encouraging and valuing volunteers with differing backgrounds, abilities and needs, to fully represent the communities we serve.

We have around 490 volunteers, working across all our sites. There is good representation across the ages, across all ethnic groups and within those acknowledging a disability.

The value of Volunteers

Volunteers are involved in over 30 different roles. These include welcoming and wayfinding, dining assistants, children's and adult activity volunteer roles and other Patient Experience Projects. They have been involved with hand rub/massage training, helping at the Nurses and Midwives Conference, training as dining companions on elderly wards, and assisting at the Macmillan Coffee Morning.

Their roles have also included assisting at the Patient Listening Event, being a Charity office volunteer, helping with the Multi Faith Event, collecting information for the Anaesthetics Patient Feedback Project, sitting with dialysing patients and wrapping Christmas Presents for Renal patients and children.

What Patients and Staff have said:

"Thank you for sending us such a lovely volunteer. She's an angel and the patients love her;" **(MRI staff)**

"Our volunteer guides our patients to the ticket machine, making the Phlebotomy Department run smoothly and there are noticeably less complaints as a result." **(staff at Trafford General Hospital)**

"I was greeted with a smile and the volunteer walked with me to the ward and told me about the hand-wash machine." **(Patient about volunteer at Trafford)**

"Working at the hospital, I often need to go to various places and yesterday I went to A&E as a patient! I was there four hours so had ample chance to watch (the volunteer) and was most impressed. He had time for everybody, took people to where they wanted to go or gave directions. You would have thought he was being paid to do the job as he was so good at it! He didn't wait for people to approach him; he greeted them and asked if he could assist them……I did tell him I thought he was doing an excellent job." **(MRI staff member)**

A Volunteer Story

"I have now been a ward volunteer at Trafford Hospital since February 2010.

The most important part of the role is chatting to the patients. I have met patients of all ages and they love a chat over a hot drink.

I help out at meal times and get involved with all aspects of the ward. I am currently on Ward 3 (Intermediate Neurological Rehabilitation Unit). I interact with the patients playing board games and quizzes and of course generally befriending them and serving drinks.

As I have been trained in Hand Rubbing I travel between the wards offering this very popular service which men as well as women enjoy.

In order for me to stretch my volunteering duties I have taken advantage of the transport link from Trafford to the Manchester Royal Infirmary. It was arranged for me to do Hand Rubbing on the Maternity Ward and it was well received. It was truly lovely meeting the mums and their babies.

I feel that the transport link has made more opportunities available and if any other volunteers would like to shadow me at Trafford it would be lovely to meet you." Diane Butterworth

Chaplaincy-Spiritual Care

Throughout 2013/14 the Chaplaincy-Spiritual Care Team continued to be involved to support the patient experience. We have made over 17,000 visits to patients during the year, baptised or blessed over 70 babies and conducted funerals for 45 patients. The team is upgrading the Shabbos facilities in the Royal Manchester Children's Hospital for the increased benefit of the Jewish Community. During the year, Rev. Peter Gomm was promoted to Head of Chaplaincy and Rev. Neil Hepworth became the Deputy Manager of the Team.

During 2013/14 the service has:

- Offered training based on the Religious and Spiritual Care of Patients Best Practice Guidelines.
- Held a successful Multi Faith Event at which staff and public shared with community faith leaders from across Greater Manchester as part of our commitment to Equality and Diversity.
- Set up a series of regular Memorial Services to remember adults who have died across the organisation.
- Supported the work of the Specialist Palliative Care Team, the Organ Donation Committee, the End of Life Steering Group, the Children's Quality Forum and represented chaplaincy on numerous Divisional committees and Clinical Effectiveness Committees.
- Been involved in reviewing the spiritual care goals in the new End of Life Care Plan.
- Fed into the 'Living Longer Living Better' Initiative.
- Contributed to public engagement through the Brilliant Basics theme, 'Dying Matters'.
- Improved facilities used by patients and their families, including the Shabbos Kitchen and the Multi Faith Prayer Rooms.

What patients have said:

"My friend's mother is ill and with great confidence I have directed her to the hospital chaplaincy service."

"Thanks for what you have done for my lovely little boy…"

"You don't know how much my partner and I appreciate what you have done; I can't express my eternal gratitude to you enough"

"Mum died…following a long illness. We were provided with wonderful pastoral care by everyone we came across in the (Multi Faith) Centre."

"Thank you for your guidance, friendship and support during my stay in Ward 44…"

The story of a patient going to have surgery.

A patient showing signs of distress and panic asked to see the chaplain assigned to her ward. The patient's nurse told the chaplain that she was fearful of having an operation and worried about what it might reveal. The chaplain sat at the bedside, and used several interpersonal skills to interact with the patient. Through listening, using a calming tone of voice, reflecting back her concerns and offering to spend a moment in prayer, the patient's mood changed. She became calmer and began to be able to trust the skills and experience of those treating her. A few days later after the procedure, she was visited again, and commented on how the chaplain's presence had given her the courage needed to face a difficult outcome. Taking her fears seriously and offering a period of calm reflection had been instrumental in the patient coming to terms with what was taking place.

Equality, Diversity and Human Rights

Mainstreaming Equality and Diversity

Throughout the year we have continued towards making sure that equality and diversity is part of our day-to-day work in everything that we do.

We continue to implement our strategic Equality, Diversity and Human Rights Framework. The current equality and diversity objectives within the framework are:

- Ensuring that all our practice and performance surpassed compliance with equality legislation requirements, human rights law and regulatory requirements.
- Ensuring all practices, procedures and services are free from direct and indirect discrimination.
- Continue to embed equality and diversity in everything that we do.
- Adapting our services to meet the identified needs of our patients, service users and the wider community.
- Working with our main contractors and suppliers to ensure the ethos and values regarding the equality and diversity is embedded within our workforce.

Equality Delivery System

The Equality Delivery System (EDS) is an NHS toolkit designed to support NHS organisations to improve their equality and diversity outcomes. EDS has four goals within which are 18 outcomes. Goals and outcomes related to:

- Better health outcomes for all
- Improved patient access and experience
- Improved, engaged and well supported staff
- Inclusive leadership at all levels

Our belief is that we should take a rigorous approach to the implementation of EDS. During 2013 we completed our first assessment against EDS outcomes and undertook an internal verification exercise. Therefore we would like our internal assessment to be externally scrutinised by our community partners. During the year we have had discussions with a number of organisations representing people with protected characteristics to support us with external verification. Arrangements for external verification of our EDS assessments will be finalised in 2014.

Equality Implementation Group

The Equality Implementation Group (EIG) was established in 2012 and continues to meet during 2013/14. The group is responsible for overseeing our equality and diversity work. It reports to the Board via the Quality Committee on service delivery issues and the Human Resources Committee on staffing issues. It is chaired by a director, and its membership includes a Non-executive director, senior managers from across the organisation, equality and diversity specialists and staff representatives. It meets every two months.

Equality Impact Assessment

We have continued to carry out equality impact assessments for all our new and updated policies. During 2013, 200 equality impact assessments were carried out. The completion of our equality impact assessments helps us to ensure that our policies support the advancements of equality and do not have any negative effects upon any particular groups. Completion also helps us to comply with our duties under the Equality Act 2010.

Supporting Divisions and Corporate Services

The Service Equality Team (SET) is responsible for supporting the divisions and corporate services on equality, diversity and human rights issues at work. SET worked with the divisions and corporate services through their equality and diversity co-ordinator. In 2013/14 SET has:

- Worked with the corporate services to establish an equality and diversity co-ordinator for each corporate service, based on the successful divisional model.
- Provided support to the co-ordinators so they can meet their responsibilities in their areas.
- Met on a monthly basis with co-ordinators to support divisions and corporate services to make progress on their equality and diversity work.

Patient Profiling

Patient Profiling is the process of understanding who uses our services and how they are used in terms of diversity. We have completed and publicised an Annual Patient Profile Report for 2012/13. It identifies that our patients are from a diverse background.

During the year the Patient Profiling Group has continued to meet to ensure that we collect and use good quality patient profiling information.

Our Diversity Calendar

At the beginning of 2014 we published our third Diversity Calendar following the success of the previous calendars. Due to increased demand amongst staff the print run was increased. The calendar contained:

- Notable diversity dates and events
- Religious festival information
- A diversity hero for each month
- An equality quote for each month
- The Service Equality Team also published a series of articles in Wednesday Weekly News (our internal staff newsletter) to highlight certain events featured in our Diversity Calendar.

Equality and Diversity Fortnight 2013

We held our first Equality, Diversity and Human Rights Fortnight in May 2013. The fortnight coincided with NHS Equality and Diversity Week. The aims of the Fortnight were to:

- Celebrate equality and diversity achievements
- Showcase good practice
- Raise awareness and better understanding of equality, diversity, and human rights issues
- Provide learning opportunities for staff
- Demonstrate that equality and diversity can be fun.

The Fortnight was co-ordinated by the Service Equality Team and more than 50 activities took place across the central, Trafford and community sites organised by the divisions, corporate services and the Service Equality Team.

Raising the profile of Equality, Diversity and Human Rights

The Service Equality Team has undertaken a number of events and activities through the year to raise the profile and increase the understanding of equality, diversity and human rights issues. These included:

- **International Day Against Homophobia (IDAHO)**
  The Trust flew the Rainbow Flag, over the MRI

in support of the International Day Against Homophobia during part of May 2013. The day is designed to raise awareness of the impact of prejudice and discrimination on the lives of lesbian, gay, bisexual and transgender people.

- **Manchester Pride**
  More than 30 staff took part in the Manchester Pride parade in August 2013. Manchester Pride is an annual celebration of lesbian, gay, bisexual, and transgender (LGBT) life. We support the event as part of our commitment towards LGBT equality in both employment and service delivery.

- **Men's Health Week**
  Men's Health Week (June) is designed to raise awareness of the health issues that affect the health of men and boys. To mark the week we held a number of stalls within our hospitals. The stalls had information on men's health issues including facts about men's health. Both staff and members of the public visited the stalls.

- **World AIDS Day**
  SET and the sexual health centre organised two World AIDS Day stands (in December). Stands had information on HIV and AIDS. The stands were very popular and had around 180 visitors across both days and included the public and members of staff.

- **International Human Rights Day**
  The Service Equality Team developed an educational human rights display which was placed in the MRI Atrium for members of the public and staff to view. The display outlined what human rights are, why they are important, and how they applied to health care.

- **Manchester Hate Crime Week**
  Manchester Hate Crime Week (in January) is designed to promote better understanding of hate crime and the ways in which it can be tackled and reduced. To mark the week we held an information stall in the MRI Atrium for members of staff and public. The stall was run in partnership with Manchester City Council. The workshop was organised in partnership with Greater Manchester Police for our staff to raise the awareness of hate crime. Both activities had very positive feedback and we will build upon this success over the coming year.

Equality and Diversity Training

- **Corporate Induction and Mandatory Training**
  All our new staff have continued to receive equality and diversity training as part of their Corporate Induction. The Service Equality Team has continued to deliver this element of the induction programme. SET also have updated the Mandatory Training Programme which all existing staff complete once a year.

- **Equality Diversity Training for Governors**
  The Service Equality Team delivered a number of workshops to the Governors on mainstreaming equality, diversity and human rights. The workshops were designed to equip the governors with knowledge and skills to integrate equality and diversity into all aspects of their work. The workshops were very well received.

- **Training for the Equality Implementation Group**
  Two training sessions covering introduction to equality and diversity issues were delivered for members of the Equality Implementation Group to equip them with understanding of the major issues within the Trust's equality and diversity agenda.

- **Equality and Diversity Co-ordinators Training**
  The Service Equality Team delivered a workshop on mainstreaming equality and diversity for the Equality and Diversity Co-ordinators. This workshop was well received.

  SET also delivered a three part Foundation Programme for new Divisional Equality and Diversity Co-ordinators. The programme was also available to our existing Co-ordinators. The programme equipped Co-ordinators with the skills and knowledge that they need to carry out their roles effectively.

Equality and Diversity in Employment

Delivering professional equality practice within employment is led by the Human Resources (HR) Directorate. The Directorate has an on-going programme of work that aims to ensure that equality is central to all employment activities and our work spreads across all areas of the Directorate – Recruitment, Workforce Planning, Organisation Development & Training, Occupational Health & Safety and the day to day management of staff. Our work programme for equality in employment is comprehensive and in late 2013 we developed four revised strategic objectives that sit under a clear strategic (see diagram on page 35).

Work programmes are in progress to achieve against these objectives and will deliver over the coming year. In 2013/14 we have continued to develop and strengthen the equality agenda and we have achieved the following:

Equality & Diversity Employment Policy Framework

Our employment policy framework reflects the employment law provisions in relation to discrimination and advocates best employment practice when managing equality based issues in the workplace. We have a series of specialist policies that cover Equality in Employment, Disability, Special Leave, Flexible Working, Maternity, Paternity & Adoption Leave and Dignity at Work. We also have guidance notes for managers on the observation of religious duties and managing staff with a disability.

Equality Networks

We support three staff networks (Black and Minority Ethnic (BME), Disability and Lesbian, Gay, Bisexual and Transgender (LGBT)) whose aim is to support staff from different equality groups and to enable us to gain a better understanding of issues faced by staff in the workplace.

The networks have been involved in wider equality initiatives within the organisation and have worked hard to increase their membership and create a better understanding of their role. By including the networks in our equality governance mechanisms, they act as a valuable forum for discussing issues of mutual interest with staff from equality groups, contribute to policy development in relation to employment and contribute to staff development. Each network chair sits on the Equality Implementation Group which gives the networks a role in the decision-making process. We will continue to work with the staff networks to promote their role and capacity by giving them the tools and resources to progress their key priority which is to be an effective voice for their members and to contribute to the development of the organisation.

Manchester Equalities Consortium

Over the last 12 months we have worked with Manchester Equalities Consortium to review all aspects of our agenda to ensure that we meet our statutory and professional responsibilities in relation to the operating infrastructure for equality and diversity. The input of this specialist support has been valuable when ensuring that we deliver compliance with the Public Sector Equality Duty and a thorough assessment of our position in relations to the NHS Equality Delivery System. Manchester Equalities Consortium have supported the Board of Directors on the development of their approach to equality leadership and ensured that we have a robust governance framework in place through the operation of the Equality Implementation Group. They have also worked positively with the chair of each Equality Staff Network to support their development and programmes of work.

Manchester Equalities Consortium have also worked closely with the senior Human Resources team to establish the baseline for delivery against the revised strategic aim list on page 35.

Workforce Profile

We published an annual workforce profile for 2012/13 which supports the assessment of the impact of our employment policies and procedures. In 2013, we carried out an analysis of the ethnic make up of our staff by geographical location compared

to the ethnic make up of the population in those locations. The analysis showed that the percentage of black and minority ethnic (BME) staff from Greater Manchester is almost the same as Greater Manchester BME population figure. This is a positive trend because 84% of our workforce comes from Greater Manchester sub-region.

Summary of Workforce Statistics 2013/14

- There continues to be no significant change to the age profile of the workforce with 99% of the Trust workforce aged 22+.
- Approximately 76% of our workforce is White. 16% are from a Black and Minority Ethnic (BME) background. 8% of the staff have not stated their ethnicity.
- The percentage split between male and female staff has stayed the same over the last two years.
- 2% of staff has recorded a disability and this has doubled since the last report. However this data does not truly reflect the number of disabled staff within the organisation as staff do not have to disclose this information.

It is recognised that we need to further understand the equality profile of our workforce and we have developed an online equality information update tool for staff. We are currently running a publicity campaign to encourage staff to update their equality details. This campaign aims to improve the quality of equality data that we hold on our staff which will inform further priorities.

Workforce Statistics 2013/14

(Information extracted from ESR on 31st March 2014)

	Staff 2012/13	%	Staff 2013/14	%
Age				
0 – 16	0	0%	0	0%
17 – 21	130	1%	144	1%
22+	12341	99%	12682	99%
Ethnicity				
White	9653	77%	9783	76%
Mixed	241	2%	262	2%
Asian or Asian British	950	8%	981	8%
Black or Black British	521	4%	587	5%
Other	171	1%	183	1%
Not Stated	935	7%	1030	8%
Gender				
Male	2579	21%	2667	21%
Female	9892	79%	10159	79%
Not Stated	0	-	0	-
Recorded Disability	230	2%	262	2%

Diversity Delivers Conference

On 22nd May 2013 we ran our first equality themed conference 'Diversity Delivers – Be the Difference, See the Difference'. 100 staff attended the Conference providing a representative audience of staff from different groups and backgrounds.

Speakers included Shobna Gulati, Actress and Presenter; Evelyn Asante-Mensah, EHRC (Equality and Human Rights Commission) Commissioner; Paul Martin, Chief Executive of the Lesbian & Gay Foundation; Greg Austin, HR Director of Sodexo UK and Lucy Rowe and Chris Small, speaking about our successful Supported Traineeship programme. Frances Binns, Therapeutic and Specialised Play and Rachel Belk, Genetic Counsellor gave interesting presentations about the service based equality initiatives that have improved our service to patients. All speakers were very well received and the content of the day achieved a representative balance of external learning and the internal sharing of good practice.

Interactive workshops were delivered covering topics such as the NHS Equality Delivery System, supporting staff and managers to see the relevance of equality, engaging staff in the equality agenda and how to see and embrace difference in others. On the day 38 conference delegates signed up to the NHS Employers Personal Fair & Diverse campaign that promotes the role of equality champions in an organisation.

Strategic aim

To ensure the achievement of the overall vision for CMFT by having in place the best workforce to serve the needs of our patients. This means that our workforce will reflect the diversity of our patients as well as being appropriately skilled and knowledgeable and actively demonstrating CMFT required values and behaviours.

Strategic objective 1

Incorporate E&D into the values and behaviours framework and embed into the Trust through the implementation of a systemic change plan

Strategic objective 2

Engage with our patients, staff and local community to identify key issues and create plans to improve

Strategic objective 3

Raise awareness of the Board about where improvement is required and secure board sponsorship for specific improvement ideas

Strategic objective 4

Improve data collection and analysis in order to monitor the progress made

Corporate Social Responsibility

We have an innovative and challenging programme of work to deliver our aims to achieve excellence as a service, employer and corporate citizen.

Local Recruitment

We have maintained our commitment to support the recruitment of local people, encouraging growth and prosperity in Manchester and Trafford. Recruiting locally and in particular ensuring we have a strong employment offer to local young people remains a priority.

Pre-Employment Clinical Programme: This long-standing programme continues to deliver results in relation to offering a real opportunity to local people. Quarterly Open Days provide local unemployed people we an opportunity to learn about life and work in a Health Care setting, hear about roles and vacancies we have and to apply to join the Pre Employment Programme.

Programme candidates participate in a 4-week course that equips them with knowledge and experience in order to apply for Clinical Support Worker roles. A key feature of the programme is a guaranteed interview on successful completion of the programme and work placement.

In 2013/14, 66 people completed the course and entered paid employment with the Trust. This is 76% of the total number of people who completed the programme, with over half being under 25 years of age, the age group currently hit hardest by difficult labour market conditions.

The majority of recruits when established in post join our Apprenticeship Programme to ensure their learning and developments needs are met in order to deliver excellence in the role. Analysis shows that the number of people who leave the Trust and this role is significantly lower for people who have been through the programme.

Pre-Employment Non-Clinical Programme

This year, the Pre-Employment programme has expanded to include non-clinical roles at various levels. This programme offers longer work placements and the chance to undertake NHS specific training. In 2013/14, 16 young and local people accessed paid employment in a variety of roles.

Pre Employment Non-Clinical Programme Case Study - Adam Jones

Adam is 22 years of age and lives in the Withington area. Adam has a good standard of education and previously worked in a variety of roles including: Bar staff, Call Centre Operative and Labourer for a local tiling company. However, for most of 2013 Adam was struggling to find suitable employment. He was unemployed for 8 months before taking up the Pre-Employment Opportunity offered by the Trust. His first placement was at Moss Side Health Centre where Adam demonstrated excellent IT and communication skills. From this, a placement opportunity came up at the Royal Manchester Children's Hospitals in the Management Offices and after 8 weeks Adam successfully gained employment as an Administrator working full time and launching what we hope will be an interesting and rewarding career in the NHS.

"I was struggling to find work and this opportunity has provided me with, not only that, but a career as well".

Supported Internship Programme

This programme is now in its fourth year and continues to go from strength to strength. It is a year-long employment and educational programme for young people with learning disabilities. To date 50 people have benefited from the programme with over 50% (26 people) accessing paid employment on completion.

Strategic partnership, dissemination and communications have led to other employers delivering the programme, benefiting 110 young people to date across Manchester. This includes a newly launched site at Trafford General Hospital in September 2013. This new site offers a unique opportunity to Trafford residents who are making the transition from specialist educational provision to employment.

Both the Manchester and Trafford sites represent innovative partnership working with the local authorities, local colleges, third sector specialists and other employers in the area. This in turn has maximised the educational and employment outcomes for young, local people with disabilities.

External recognition for this programme:

- Winners of the North West National Institute for Continuing Adult Education Project Award 2013
- Highly Commended by the Chartered Institute for Personnel Development, People Management Award (Equality and Diversity Category) 2013.

We are committed to continue this work in the long term and to provide meaningful employment, education and training outcomes for talented young people with disabilities and long term health conditions.

More information on the Programme is available at www.traineeships.cmft.nhs.uk

Manchester Health Academy

As the lead sponsor of Manchester Health Academy, students have benefited this year from an ever increasingly innovative and diverse range of activities to enrich curriculum, learning, personal health, wellbeing, experience and future progression of all students.

Highlights over the last year include (news from the Academy is featured in the 'News Over the Year' section of this report):

- Co-ordination of activities to support the curriculum of the Health and Social Care Sixth Form Students, including visits and practical sessions at the Stroke, Diabetes and Pathology Units.
- Multiple work experience placements for sixth form students for example in Elective Treatment Centre and the Paediatric Unit at RMCH. This in turn has led to enhanced university applications and students successfully accessing opportunities in Higher Education, including Nursing, Health and Science related degree subjects.
- In addition, Two Clinical Support Worker Apprenticeship positions at the Trust have been obtained by students who have been able to demonstrate excellent skills and knowledge at interview.

Engagement with local Schools and Colleges

Work with other local schools and colleges is also a key priority and we have attended several careers fairs and events, including at Trafford College. Work Experience and the innovative 'Taste of Medicine' programme continue to be core activity in order to inspire future generations of Health Care Professionals.

Staff Recognition

Many of our staff receive recognition from external organisations for their achievements and expertise. For 2013/14 these include:

- OBEs for Dr Catherine White, Clinical Director of Saint Mary's Sexual Assault Referral Centre and Kathy Cowell, Non-executive Director.
- The following members of staff received chairs and became Professors: Charles Hay, James Hill, Jarood Homer, Robert Pearson, Anthony Smith, John Walter, Robert Wynn and Zulf Mughal.
- Dr Sujesh Bansal, supported by Dr Steve Benington, Tony Armstrong, Karen Stuart, Dr Anna Kelsey and Professor Simon Carley - Innovative Training and Support Programme for Internationally Qualified Doctors. This work won the Improving Services through Training and Development category at the LEAN Healthcare Academy Awards for 2014.
- Dr Heather Williams - Dr Williams has been recognised as one of the top practising scientists in the UK by the Science Council.
- Miss Gillian Robinson, Consultant Nurse - Acquired Brain Injuries was a finalist at the Nursing Times awards in the 'Patient Safety Improvement' category, for her work in designing age-specific paediatric neurological observation charts.
- Autism Service Improvement Team – Won the Unite Award for Working Together for their work with Autistic patients. The specific focus for this application was on improving investigation procedural pathways for patients with autism in Radiology.
- Rheumatology Services – received national recognition at the British Society for Rheumatology Best Practice Awards. Trafford General's Rheumatology service was one of only five in the UK to have been recognised as 'outstanding'. This recognition focuses on the role of four specialist nurses who work at an advanced level so that patients can be seen and receive treatment quickly for their condition.
- Dr Fred Wu – Consultant Endocrinologist, Researcher of the Year at The University of Manchester. He is an international authority in male ageing and has recently been President of the European Academy of Andrology and an advisor to the US Anti-Doping Agency.
- Procurement Team – nominated for two National Awards; Team of the Year and Initiative for the Year in March 2014. Simon Walsh – Elected as Chairman of the Health Care Supply Association. Mark Stevens – Appointed to Department of Health supply chain resilience advisory panel. Maureen Gallacher and David Basset – won Health Care Supply Association prizes for high achievement at the Annual Professional Development week course.
- Jeanette Murphy – Dental Therapist has been chosen as the recipient of the British Association of Dental Therapists Roll of Distinction Award for 2014.
- Fozia Ahmed - Heart Rhythm UK Young Investigator of the Year (October 2013)
- Robert Tattersall, Specialist Engineer - has been awarded membership of IPEM (Institute of Physics and Engineering in Medicine) for his accredited work in MEAM and achieving Bachelor of Science with Honours in Medical Technologies Management through sponsorship with the Trust.
- Roy Craven and his Team – were awarded runner up in the 2013 Advancing Health Care Awards in the "Award for Improving Quality: Measuring and Demonstrating Impact" for their work on improving the Hysterosalpingogram Clinic.
- Philippa Burns, Stuart Allen and their teams received the 'HCS and AHP's Leading Together

on Health' certificate and trophy at the 2013 Advancing Health Care Awards for their project entitled 'from corridor chats to Catheter Labs'.

- Linda Bailey – led our anti-inflation activity that has been adopted by the Department of Health nationally.
- Fiona Geiger and Siobhan Doolan – runner up in the PENNA awards for a healing hands project.
- Elective Surgery Treatment Unit – nominated by Nursing Times as Student Placement of the Year.
- Ann Jones – Education and Development Manager has been recognised for the Orthodontic National Group for Dental Nurses and Therapists Outstanding Contribution to Orthodontic Nursing Award.
- The CAMHS team were nominated by NHS England for a Patient Participation award, this nomination recognised the work they have done with their EMERGE team (16 -17 year old group) in shaping CAMHS services.
- Dr Leonard Ebah – Specialist Registrar/Research Fellow: Postgraduate student of the year.
- The Vulnerable Baby Service (VBS), (Children's Community Services, Division of Medicine & Community Services), was nominated for the category of 'Patient Safety in Paediatrics' as part of the National Patient Safety & Care Awards 2013.
- Jacqueline Thompson (Advanced Nurse Practitioner, MRI and Florence Nightingale Travel Scholar) was invited to attend the Florence Nightingale Commemoration service, at Westminster Abbey. This annual service celebrates the life and work of Florence Nightingale and gives thanks to nurses, midwives, healthcare workers in the Armed Forces and unqualified staff working in healthcare.
- We collected an impressive three awards out of a possible twelve at this year's Greater Manchester Clinical Research Awards. Dr Rick Body, Consultant in Emergency Medicine and Honorary Lecturer in Cardiovascular Medicine scooped the Principal Investigator of the Year gong. Sarah Thorpe from Manchester Centre for Sexual Health collected: Research Nurse of the Year. We were also named as the highest recruiting Trust in Greater Manchester.
- Manchester Hospital School and Home Teaching Service, based at Royal Manchester Children's Hospital, was declared 'Outstanding', scoring the highest grading in each Ofsted inspected area of school activity.
- Manchester Health Academy celebrated after their toddler group was named one of the best in the UK's biggest parenting competition.
- Communications Team were shortlisted for Best Media Handling and Team of the Year at the Association of Healthcare Communications and Marketing Awards and shortlisted for Best Internal Team at the Golden Hedgehog PR Awards.
- Staff and students from our Supported Internship programme celebrated after achieving a 'Highly Commended' award at the National Chartered Institute Personal Development, (CIPD) People Management Awards, in the category of 'Diversity'. The programme that supports people with Learning Disabilities gain work skills and employment opportunities also won the Regional National Institute Adult Continuing Education (NIACE) Award in the category of 'Partnership'.

- Our BBC1 Documentary 'Rape: The Unspeakable Crime' was shortlisted at the UK Public Sector Communications Awards for 'Community Relations Campaign of the Year'.
- Manchester Health Academy became the first school in the country to receive a new national award for excellence in children's food and nutrition.
- A project led by our Anaesthetic team received nationwide recognition at the Quality in Care Awards. 'Personalised Patient Experience Tracker: innovative use of patient experience to enhance post-operative recovery of gynae-oncology patients after surgery' was judged to be the winning entry in this year's Quality in Care (QiC), Excellence in Oncology Awards.
- Mr Bibhas Roy, Consultant Orthopaedic Surgeon, was the winner of the Healthcare Project of the Year category in the Bionow Awards 2013 for the development and innovative application of a web-based tool, which enables remote monitoring of patients following shoulder surgery.
- Reshma Thampy, a trainee ophthalmologist at the Eye Hospital was named as one of the Health Service Journal's 'Rising Stars' at this year's awards.
- Manchester Health Academy (MHA) picked up the School Catering Award at the Education Business Awards, held in London and sponsored by school online payment provider ParentPay.
- Faye Macrory, Consultant Midwife (Manchester Specialist Midwifery Service) and Domestic Abuse Lead, won the Lifetime Achievement prize at the British Journal of Midwifery Practice Awards.
- Dr Carol Ewing, from Royal Manchester Children's Hospital was appointed Vice President for Health Policy for the Royal College of Paediatrics and Child Health and Dr Lisa Kauffmann was appointed Honorary Treasurer.
- In December 2013 the staff from First Steps Day Nursery received a Silver Award in the Early Years Quality Assurance Framework, awarded by Manchester City Council Children's Services, having been assessed against seven quality standards.
- Joy Worth won the Supporting Others Award at the Diabetes UK's Regional Inspire Awards, held in Bury on 29th March. Joy regularly attends Diabetes UK care events, including residential trips, which are designed to support children, young people and families in the management of their diabetes.
- The Patient Experience Network National Awards – we had several teams who were finalists at these awards and two who were awarded 'Runner Up'. The 'Runners Up' were:
    - Fiona Geiger and Siobhan Doolan (Surgery) for 'Healing Touch' and Naz Khan (Genetics, Saint Mary's) for 'Developing an effective clinical genetic service to engage and communicate with South Asian families affected by autosmal recessive disorders'

    Finalists included:
    - Heather Birds and Louise Weaver-Lowe (Neo-natal Unit, Saint Mary's) for 'The Development of the Neonatal Parent Forum'; Therapeutic and Specialised Play Service (Royal Manchester Children's Hospital) for 'Going the Extra Smile'; Walter Tann (Royal Manchester Children's Hospital) for 'Valuing the Voices of Young People'; Phil Taylor/Out-patients Team (Royal Manchester Children's Hospital) for Avoid the queue - Self Check-in is for you!' and Heather Birds (Saint Mary's Hospital) for 'The introduction of a Quality 'tour bus' within Saint Mary's Hospital to increase staff engagement and level of involvement with service development'

In addition we have many staff who attend events/ conferences due to their professional knowledge and many other who have research papers published.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Carbon Reduction/Sustainability

Sustainable Development Strategy

We recently published our Sustainable Development Strategy and Plan (SDMP), setting out our sustainability programme for the next five years. Our vision is to be a leading green and sustainable hospital, delivering high quality care in a resource efficient and sustainable manner. Our overarching priorities are:

- To reduce our direct carbon footprint by a minimum of 2% year on year, through a combination of technical measures and staff behaviour change
- To embed sustainability considerations into our core business strategy
- To work collaboratively with our key contractors and stakeholders to deliver a shared vision of sustainability
- To comply with all statutory sustainability requirements and implement national strategy

We have a dedicated energy and sustainability team and as a healthcare provider, we are fully committed to engaging across our organisation and beyond to deliver our sustainability strategy. The strategy sets out a framework outlining how we will implement the national Sustainable, Resilient, Healthy People & Places strategy. Our carbon footprint from building energy use is 61,000 tonnes and our plans have focused on where we will achieve the greatest reductions in terms of carbon and cost, as well as improving our wider sustainability and increasing social value.

The following section focuses on some of the key initiatives we have implemented to date.

Staff Engagement

In November 2013, we became the first NHS Trust in the North to deliver the Green Impact programme. It's a pro-environmental behaviour change model, developed by the NUS (National Union of Students), which works by engaging staff in teams to deliver sustainable behaviours. An online bespoke workbook of bronze, silver and gold criteria is completed by the teams, and covers standard housekeeping issues such as energy and water saving and waste management, as well as broader sustainability issues

Sustainability Communications

Communicating sustainable messages in a consistent manner is vital to raise staff awareness and increase engagement. We have a new identity for sustainability and launched the first campaign, at a Green Valentine's Day event on the 14th February 2014. A green heart symbol and a strapline of 'little things, big difference' is now used across all sustainability related communications, and we have a toolkit that is used by staff within our wards and departments. Our first campaign focuses on simple switch off behaviours, associating them with improved patient experience, environmental benefits and cost savings.

Laboratory team members meeting the Green Heart Mascot

such as promoting biodiversity, positive community engagement and wider social impact. We have 70 teams engaged in delivering Green Impact, with a total of 564 members, covering departments with 4,332 members of staff.

We have an active network of over 40 Green Champions, who meet regularly to discuss environmental matters and disseminate information and key messages to their colleagues.

Sustainable Travel

Our Sustainable Travel Plan was updated in 2013 and challenging targets have been set around modal shift. We have been heavily involved in inputting into the proposals around the Oxford Road works in relation to the Bus Priority Package. We continue to facilitate an improved public transport service, through part funding the hybrid bus service, the 147 which links Piccadilly Station with the Universities and Hospitals and we now have the First Bus number 18 service coming onto site.

We are heavily investing in improving cycling infrastructure, with a new cycle hub at our headquarters currently under construction and a second hub to follow in the new car park on Grafton Street. We have also installed electric vehicle charging infrastructure, with dual charging points at our Central and Trafford sites, in accessible locations for staff, patients and visitors.

Staff arriving at the Cycle to Work breakfast event in December 2013

Waste

Over the last year, a new system has been introduced for the disposal of healthcare wastes that are uncontaminated, or non-infectious. This waste stream requires less intensive treatment and has a reduced carbon footprint. We have also increased the proportion of our waste that we send for energy recovery to 20%. We plan to increase this as further Waste to Energy plants are commissioned in the North West.

We have experienced some issues with contamination of our domestic waste stream in certain areas, and are working closely with our partners, Sodexo and staff in those areas to get this resolved so this waste stream can be segregated and recycled, rather than treated.

Investment in Energy Efficiency

A new capital plan for investing in energy efficiency technologies to reduce our carbon footprint has been launched. Significant investment is planned over the next two years to save 1,000 tonnes of carbon. Projects include improving insulation to buildings, plant and equipment, powering down PCs when not in use and optimising our lighting and controls. In 2013, we secured significant investment from the NHS Energy Efficiency fund and have recently installed boiler flue gas economisers (to recover heat from the waste gases) and feed water pumps, which are predicted to save us 485 tonnes of carbon per annum. We are maximising the energy efficiency of the new build hospital in Altrincham and this will generate further carbon reductions when it opens in early 2015. The steam heating system at the Dental Hospital is being replaced by Low Temperature Hot Water (LTHW), generating further savings.

We are also looking at our long term energy planning, currently investigating the feasibility of energy options including geothermal and combined heat and power (CHP).

Biodiversity

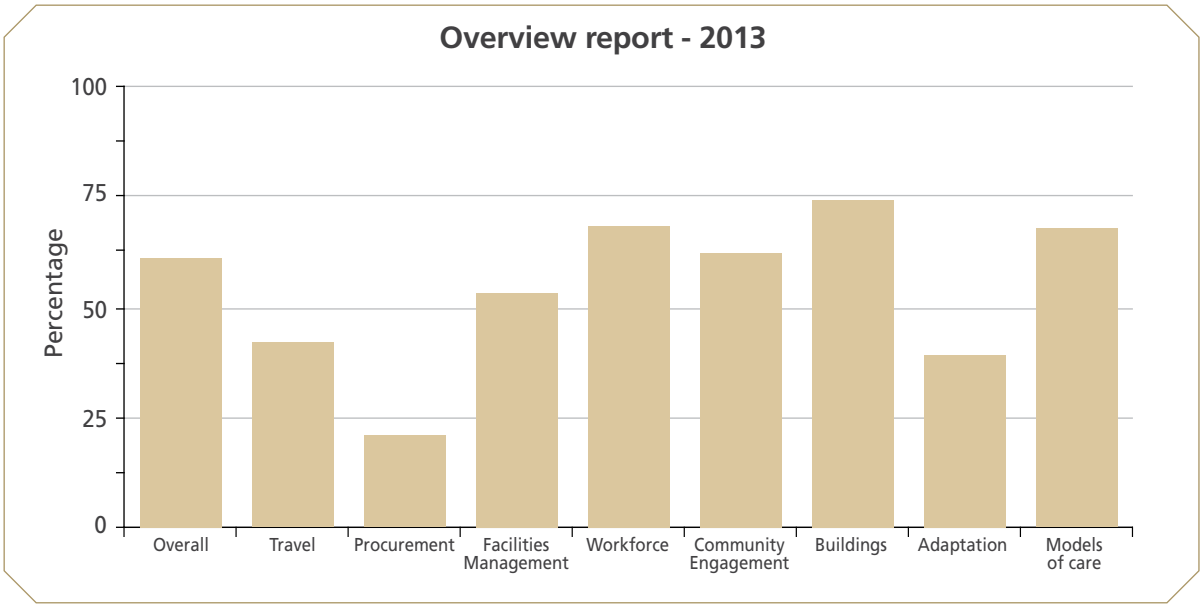
A Gardening Group was set up, along with our PFI provider Catalyst to clean up and replant the Garden of Reflection in October 2013. In March 2014, as part of a series of events for NHS Sustainability Day a wildflower meadow was planted on the Boulevard area to provide food for pollinating insects, as well as a burst of colour. We plan to build on this work in coming years by developing a range of initiatives to promote biodiversity across our Estate, and developing a Biodiversity Action Plan.

The tidied up Garden of Reflection outside Cobbett House

Sustainable Procurement and Food

We recognise the opportunity to influence suppliers of goods and services to develop more environmentally and socially responsible practices. We have a carbon footprint from procurement of 236,000 tonnes, and are utilising the NHS procuring for carbon reduction toolkit to identify our most carbon intensive areas for focused activity to reduce. Sustainability criteria are built into tenders and work is ongoing to develop this further and update our sustainable procurement policy. A number of initiatives are currently underway to improve the sustainability of our procurement. There is a drive towards centralised printing devices and a move away from desktop printers wherever suitable, and increased use of technology to reduce the environmental impact of our paper use, as well as reduce travel to meetings.

We use the NHS Good Corporate Citizenship self-assessment tool to benchmark our sustainability progress. Comparing our recent results with the national averages for Acute Trusts we are performing above average in all categories. We have identified our key areas of improvement as travel, procurement and adaptation and will address these through delivery of the Sustainable Development Management Plan.



NHS Good Corporate Citizen Assessment, October 2013, score of 54%

Performance Data

Energy

Resource		2011/12	2012/13	2013/14
Gas	Use (kWh)	122,566,335	124,680,242	120,353,759
	tCO2e	25,046	25,478	25,532
Oil	Use (kWh)	350,700	638,000	502,760
	tCO2e	112	203	161
Coal	Use (kWh)	0	0	0
	tCO2e	0	0	0
Electricity	Use (kWh)	58,584,974	60,135,192	62,914,821
	tCO2e	32,831	34,326	35,227
Total Energy	**tCO2e**	**57,989**	**60,008**	**60,919**

Waste

Waste		2011/12	2012/13	2013/14
Recycling	(tonnes)	1,698	2,144	2,027
	tCO2e	36	45	43
Re-use	(tonnes)	0	0	0
	tCO2e	0	0	0
Compost	(tonnes)	163	154	113
	tCO2e	0.978	0.924	0.678
Waste Electrical and Electronic Equipment (WEEE)	(tonnes)	34	49	46
	tCO2e	0.714	1.029	0.966
High Temp recovery	(tonnes)	169	132	96
	tCO2e	3.549	2.772	2.016
High Temp disposal	(tonnes)	524	518	589
	tCO2e	11	11	12
Non-burn disposal	(tonnes)	862	917	1371
	tCO2e	18	19	29
Landfill	(tonnes)	751	304	213
	tCO2e	184	74	52
Total Waste	(tonnes)	4,201	4,218	4,455
% Recycled or Re-used		45%	56%	49%
Total Waste	**tCO2e**	**254**	**154**	**139**

Water

Water		2011/12	2012/13	2013/14
Mains	m3	407,834	360,880	372,660
	tCO2e	371	329	339

Infection Prevention and Control

Infection Prevention and Control continues to be a high priority. The reduction of health care associated infection (HCAI) protects our patients against infection. We are proud of all the continued hard work and effort that our staff put into preventing the risk of infection to our patients which are reflected in our success in achieving the HCAI objectives. Our approach was validated by an external assessment undertaken by one of our peers in the Shelford group - The Shelford Group comprises ten leading NHS multi-specialty academic healthcare organisations.

The Infection Prevention and Control team includes both specialist nurses and doctors. The team work closely with all staff and are highly visible in the wards and departments. The team provide advice and support to both staff and patients.

All cases of *Clostridium difficile* infection and MRSA bacteraemia thoroughly investigated and reviewed at weekly multi-disciplinary meetings and any lessons learnt are shared across the organisation. Figures for the year and further information is detailed on page 116.

We have also been challenged by the emergence of Carbapenamase-producing *Enterobacteriaceae* (CPE). We have invited experts from Public Health England (PHE) to review the CPE situation and are actively participating in the regional and national response to the issue.

Key achievements:

Hand hygiene is the single most important practice for reducing the risk of infection. To maintain the focus on good practice we organised a 6 Point 60 Day Hand Hygiene Campaign. The campaign proved to be very successful and will roll over to the 2014/15 infection control programme.

As part of our efforts to continue to raise awareness of infection prevention and control and the simple yet important measures that protect our patients we held a successful campaign which specifically focused on the importance of Hand hygiene. The Infection Prevention and Control Team (IPCT) plan to continue the campaign throughout 2014.

Our recent campaign to vaccinate as many staff as possible against winter seasonal flu has been hailed a great success with 75.4% of staff being vaccinated. We are delighted that our efforts have been recognised by the National Flu Fighter Campaign as we were nominated in the most improved category. Vaccinating staff not only protects staff but also helps protect our patients.

We continue to monitor practice by measuring the incidence of blood culture contamination rates which have remained at a rate of 3%. (There is no UK standard however we base our target on the benchmark of 3% or lower which is set by the American Society for Microbiology).

Research and Innovation

Research and Innovation is central to everything we do. As people's health needs change we need to evolve – using research and innovation to better equip clinicians to diagnose, prevent and treat illness.

From a research perspective, 2013/14 was a particularly successful year, with 15,583 patients participating in clinical studies at our hospitals.

During this period, we were selected as the host for the National Institute for Health Research (NIHR) Clinical Research Network: Greater Manchester, to take responsibility for managing and distributing clinical research funding across the geography, which includes East Cheshire and East Lancashire.

We also played an important role in the accreditation of the Manchester Academic Health Science Centre (MAHSC) by the Department of Health, which recognises the quality of the healthcare, research and teaching of its partners.

As a member of the newly formed Greater Manchester Academic Health Science Network (GM AHSN), we are also working in partnership with other members to transform the identification, adoption and spread of proven innovations and best practice. 2013/14 also marked the final phase of our Citylabs development (on-site accommodation for biomedical companies).

Our achievements over the past year affirm the quality of research undertaken and, in the long term, will help improve people's health.

Excellence in research

Our research is driven by the need to deliver the best healthcare to patients locally and globally. Around 250 consultants, nurses and allied health professionals lead on research and this means that patients can access studies across a diverse range of clinical areas.

In particular, our research is recognised clinically and academically in the following areas: Cardiovascular; Endocrinology and Diabetes; Musculoskeletal Medicine; Hearing and Sight; Women's Health; Genomic Medicine; Paediatrics and Child Health.

Last year, Dr Alex Heazell, Clinical Director of the Tommy's Maternal and Fetal Health Research Centre at Saint Mary's Hospital was awarded a NIHR Clinical Scientist award for his research into the prevention of stillbirth. Our researchers also won a number of awards at the Greater Manchester 2013 Clinical Research Awards, including Dr Rick Body, Principal Investigator of the Year, and Sarah Thorpe, Research Nurse of the Year.

Making a difference to patients

Patients across our hospitals are benefiting from taking part in a wide range of research studies and trials, including:

- A new method that could be used to predict whether a woman in her first pregnancy is at increased risk of developing pre-eclampsia.
- A study to develop a new genetic test to speed up diagnosis for children with cataracts.
- A study to trial a new pacemaker that utilises pioneering technology offering the potential for improved outcomes for patients with heart failure (we recruited the first patient globally into this study).
- An observation study looking at 'real-life' outcomes for a new injection for people with the rare eye condition, vitreomacular traction, where previously surgery may have been the only solution (we recruited the first patient globally into this study).
- A genetics study to better understand cardiac

hypertrophy, a thickening of the heart muscle, which affects the function of the heart (we recruited the first patient globally into this study).

- A study to evaluate two different treatments (scalpel vs. radiofrequency/electrical energy debridement) which are currently used as standard practice in the treatment of wounds/ diabetic foot ulcers (we recruited the first patient globally into this study).

Working together to improve health

We believe that collaboration is key to understanding and solving the growing health needs of our population, and we work closely with partners in universities, industry and research charities.

Last year, the Chancellor, George Osborne, announced a collaboration between Peking University and the Manchester Centre for Genomic Medicine based at Saint Mary's Hospital. The new partnership will deliver cutting-edge translational research that will help our clinicians develop innovative diagnostics and treatments to benefit patients both in the UK and worldwide.

Closer to home, as the new host for the NIHR CRN: Greater Manchester, we will work with Trusts across Greater Manchester to increase the number of research opportunities for patients in the area. The CRN (Clinical Research Network) provides funding to hospitals and surgeries for research nurses, scans and other costs associated with delivering clinical studies.

We are also proud to be a partner in the Manchester Academic Health Science Centre (MAHSC), which was reaccredited from April 2014. MAHSC is a partnership between The University of Manchester and six NHS organisations in Manchester. The accreditation is a quality stamp for the healthcare, research and education the partners provide. MAHSC is the only accredited Academic Health Science Centre outside of London and the South East.

Investment in facilities

We are working to expand the NIHR/ Wellcome Trust Children's Clinical Research Facility into larger accommodation in The Royal Manchester Children's Hospital. This will enable more of our younger patients to play a part in the development of new medicines and diagnostics.

In November 2013, we celebrated the expansion of the MedTech Centre Incubator, a joint venture between ourselves, Manchester Science Parks and TRUSTECH. Since it was established, the MedTech Centre Incubator has nurtured around 20 companies – including spin-outs from ours and other NHS Trusts. Our work with industry is important, because it enables our clinicians to help shape the development of new treatments and diagnostics, to ensure they meet the needs of our patients and hospitals.

Another way which we are strengthening our work with industry, is through the transformation of the former Royal Eye Hospital into Citylabs – an on-site, state-of-the-art, flexible office space and laboratories for biomedical companies. The development, on the Manchester Corridor and at the heart of the city's knowledge economy, is a partnership between: the Trust; Bruntwood; Manchester Science Parks; Manchester City Council; and Corridor Manchester. Supported by the European Regional Development Fund, Citylabs is due to open in September 2014.

Supporting early stage research

Thanks to the generous support of the Trust Charity, researchers with good ideas who need early stage funding have been awarded a total of £211,556 in pump-priming grants over the past 12 months.

Grants were given to:

- Dr Emma Crosbie to investigate the potential use of simvastatin to treat gynaecological malignancies.

- Dr Martin Rutter for the Restoring FavouRablE Sleep to Help patients with Diabetes (REFRESHED) study.
- Midwife, Kylie Watson for a study into the views of antenatal women on being recruited into a study investigating fetal monitoring using telemetry.
- Speech and Language Therapist, Clare Mitchell for an exploratory study to investigate patient and therapist views on the use of new technology to deliver speech and language therapy.

Improving our research figures (April 2013–March 2014)

Over the past year:	
15,583 patients	recruited to participate into research studies
720 research studies	open or in the follow up phase
278 new studies	approved this year with set-up times and recruitment of first patients quicker than ever
88 new external researchers	enabled to conduct research in our Trust via Research Passports

Looking ahead

"I'm delighted at the level of patient involvement in research that we have achieved this year. Our research covers a wide range of clinical areas across our eight hospitals. By getting involved in research, our patients are helping us to gain a better understanding about some of the world's most complex diseases. Clinical research plays an important role in improving people's health through the development of new diagnostics and medicines, and also enables us to attract a high calibre of staff to care for our patients."

Professor Colin Sibley
Head of the Research and Innovation Division

"We recognise that as well as working with others to develop new medicines, our staff are in a good position to spot opportunities to improve our ways of working through the development of new diagnostics and devices. For this reason, we provide a supportive environment to encourage staff to work with the Trust to explore, protect and develop their ideas, and where relevant we help to connect them with industry partners."

Keith Chantler
Director of Innovation

News over the Year

RMCH takes part in World Autism Awareness Day

"Autism affects one child in a hundred and is a lifelong developmental disability affecting communication and relationships. It also affects how they make sense of the world around them." (The National Autistic Society).

Royal Manchester Children's Hospital staff took part in World Autism Awareness Day 2013 by holding an event in the hospital's atrium.

April 2013

MRI patient is awarded Graeme Clark Scholarship Award

On 11th April, Lord Mayor Councillor Elaine Boyes, accompanied by the Lady Mayoress Linda Geoghegan, presented deaf Manchester University student Georgina Grimshaw with a £6,000 Cochlear™ Graeme Clark Scholarship Award at a ceremony in the city. Georgina who has lived in Tameside all her life is currently studying chemistry at university with the dream of becoming a leading British scientist.

Georgina was born profoundly deaf and could hear very little with hearing aids. At the age of four, she was fitted with a Cochlear™ Nucleus® implant which she says changed her life.

April 2013

We pay tribute to Professor Sir Robert Edwards

It is with great regret that we learnt of the passing of Professor Sir Robert Edwards, Nobel Prize winner, scientist and co-pioneer of IVF treatment which has brought joy to more than 5 million couples around the world over the last 35 years.

Bob Edwards lived and went to school in Manchester at Central High, and carried out the pioneering work on IVF with Mr Patrick Steptoe at Kershaw's Hospital in Oldham and Oldham General Hospital, where the first test tube baby Louise Brown was born in 1978.

Professor Daniel R Brison, Scientific Director. Department of Reproductive Medicine at Saint Mary's Hospital says: "Bob was a personal friend of ours and we were very grateful that he did us the honour of opening our new IVF laboratories and stem cell centre in January 2008, to mark the 30th anniversary of Louise Brown's birth. He was a much loved figure in the field of reproductive biology and continued until very recently to be highly influential even at an advanced age.

April 2013

Snooker star Shaun Murphy visits Royal Manchester Children's Hospital

World Championship winning snooker player Shaun Murphy delighted young patients at Royal Manchester Children's Hospital with a surprise visit.

'The Magician', as he is known among snooker fans, visited to present a cheque for £3,000, a sum Shaun had raised by donating £100 every time he made a break of 100 or more in a competitive match since last year's World Championship.

April 2013

MCFC's Patrick Viera opens our new Interventional Radiology facility

World Cup winner and former Manchester City Football Club midfielder Patrick Viera took time out of his busy schedule to open our new Interventional Radiology suite.

The facility will be used for both diagnostic and therapeutic work including minimally invasive treatments for vascular disease, insertion and maintenance of access for dialysis, lines for treatments such as chemotherapy and stem cell transplants, and emergency procedures such as embolisation following trauma.

April 2013

Manchester Musculoskeletal BRU finds 14 new genes which could affect future treatments of childhood arthritis

Scientists from the National Institute for Health Research (MIHR) Manchester Musculoskeletal Biomedical Research Unit (BRU) based at the Trust along with The University of Manchester identified 14 new genes which could have important consequences for future treatments of childhood arthritis.

Childhood arthritis affects one in 1,000 in the UK. It is caused by a combination of genetic and environmental risk factors, however until recently very little was known about the genes that are important in developing this disease - only three were previously known.

April 2013

News over the Year

NAO the robot visits Manchester Health Academy

On 22nd April, Year 7s from Manchester Health Academy involved in a workshop were joined by two highly unusual visitors. The year 7 students were introduced to the robots NAO 1 and NAO 7. NAO, who measures 58cm tall and weighs 4.3kg was soon instructed to start up, and delivered a brief presentation to the group about itself, followed by a mimicked dance to the 'Thriller' video.

The NAO Robots had been pre-programmed to carry out all these actions on command by voice recognition. The NAO has been developed by Aldebaran Robotics in Paris - the founder Bruno Maisonnier first sketched the NAO on paper originally with the vision to develop a humanoid robot for Health Care. It seemed appropriate to incorporate the Academy's specialism into a new curriculum soon to be delivered in their lessons. The session ended with another dance from NAO this time to the hit video 'Gangnam Style'.

April 2013

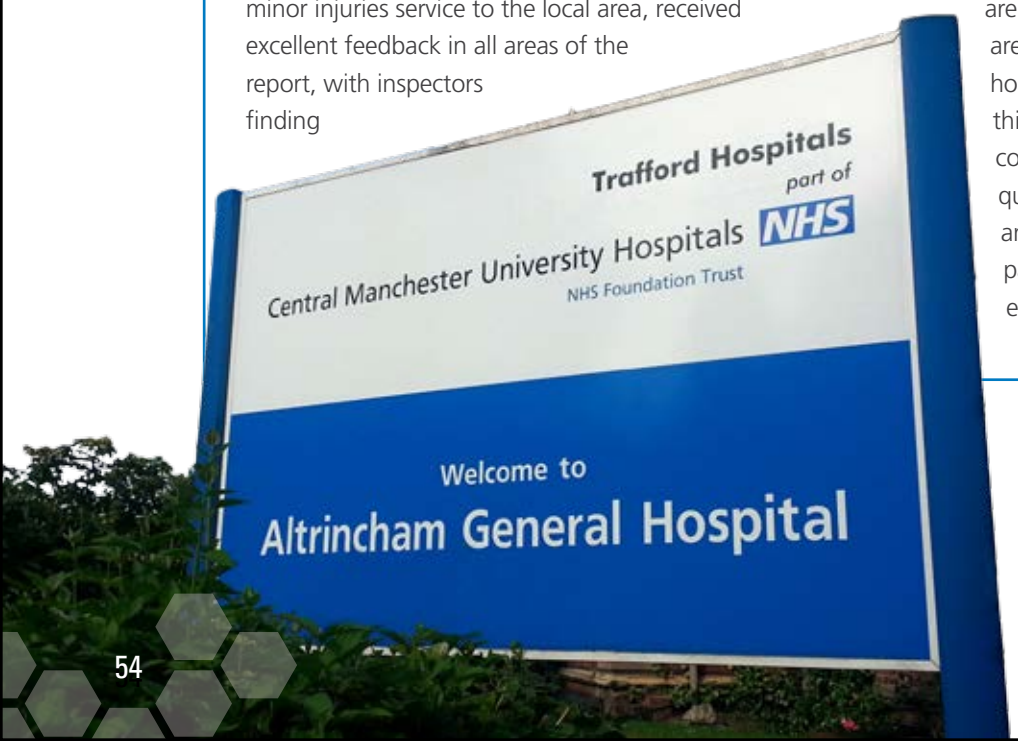
Clean bill of health for Altrincham Hospital

Health inspectors published a glowing report for Altrincham Hospital following an unannounced visit by the Care Quality Commission.

Altrincham Hospital, which provides a range of out-patient clinics, diagnostic services, and a minor injuries service to the local area, received excellent feedback in all areas of the report, with inspectors finding that 'patients were treated with dignity and consideration by staff at all times'.

The report applauded the hospital's 'quality of care rounds'. These are monthly reviews that ensure standards of nursing care and training are being met and that patients are personally asked about their hospital experience. The CQC said this demonstrated the hospital's commitment to providing high quality care and treatment and a positive experience for patients in a clean and hygienic environment.

April 2013

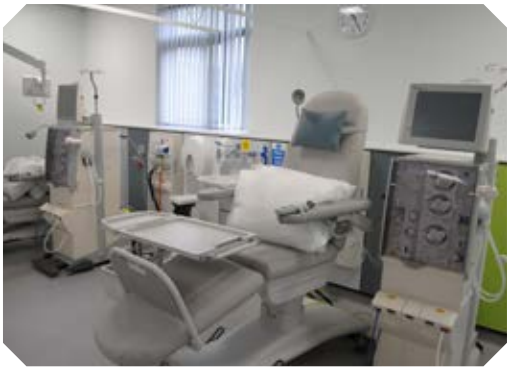


'Green' centre gives patients access to care closer to home

Patients in need of dialysis in Stockport are now able to access treatment closer to home after the official opening of a new centre in Cale Green.

The new unit has been built by renal services provider Fresenius Medical Care, in partnership with the Trust. Previously, patients in Stockport would have had to travel long distances to access dialysis. The new centre reduces travelling time for those living in and around Stockport, ensuring they have more free time.

The new Stockport unit is open six days a week and provides life-saving treatment for up to 96 patients.



April 2013

Go4It - Manchester Health Academy wins the Gold Award

Manchester Health Academy won the latest Gold Go4It Award for all the work that the Academy carries out around developing skills recognised by employers as being key to employability.

This is a prestigious award provided by the nationally recognised HTI (Heads, Teachers and Industry Ltd) - a not-for-profit organisation with over 25 years proven track record working across business, education and government to raise the aspirations and employability of young people. They challenge, stretch and develop leaders of schools, colleges and academies who go on to inspire our next generation. Over 20,000 school leaders have been trained and developed by HTI in 10 years.

April 2013

Building work set to start on new Altrincham Hospital development

A celebratory groundbreaking event took on the site of the new £17 million Altrincham Hospital development to mark the start of building work on site.

The 75,000 sq ft hospital is being developed on our behalf by Pochin Property in partnership with Citybranch. It will be located on Railway Street in Altrincham town centre.

Facilities at the state-of-the-art hospital will include a minor injuries unit, out-patient consultation and treatment rooms, physiotherapy, X-ray, ultrasound and blood testing services, in addition to offices and meeting rooms for staff. The development will replace the current Altrincham Hospital, which dates back to the Victorian era. The new hospital is due to open in early 2015.

April 2013

News over the Year

RMCH recognises World Asthma Day

The Royal Manchester Children's Hospital helped to promote World Asthma Day by hosting a display stand to inform passers-by more about how children and young people with asthma access treatment and support for the condition.

May 2013

International Nurses' Day 2013

Nurses from the organisation celebrated International Nurses Day on 10th May. Nurses across the UK engaged their local communities on the outstanding practice of nurses and their impact on patient care.

International Nurses Day is a great opportunity for us to celebrate the fantastic work of nurses here. It is also a real chance for us to promote nursing as a career option for young people.

May 2013

Keeping Britain Alive

We featured in the BBC series 'Keeping Britain Alive'. Several teams took part including the Manchester Heart Centre, the Manchester Royal Eye Hospital and a third crew filmed across many services, highlighting the work of support services such as linen, domestics, post room, catering, pharmacy and porters that play an essential part in the running of our hospitals.

The Heart Centre allowed the cameras to follow them for almost 24 hours whilst they treated and cared for heart attack patients from across Greater Manchester. Viewers saw how critical early intervention is and how the team works together to ensure patients are given the right care at the right time.

Also in the 8th episode - the last in the series - was a short sequence showing how the medical students use real life scenarios and a high tech, fully responsive mannequin, to prepare for emergencies. The medical students also appeared in the opening titles for the programme meaning they were seen every week for eight weeks.

May 2013

BBC One and Gold Star Productions Secures Unprecedented Access To Rape Centre

For the first time on British television, BBC One and Gold Star productions gained unprecedented access to the St Mary's Centre in Manchester, the leading Sexual Assault Referral Centre, to produce a documentary.

The programme documents the work of this dedicated team of doctors, crisis workers and counsellors at the centre. Each year more than 1,200 women, men and children come to the centre to seek help be that a forensic and medical examination, psychological support or just practical assistance as a result of sexual violence.

As well as following the work of the team, the one-hour programme focused on different aspects of the services available at St Mary's SARC which are shown through the personal stories of two women who have been raped: Juliet was attacked by a stranger on New Year's Eve, while Kellie had known and trusted her attacker for over a decade.

May 2013

Advanced Nurse Practitioner attends The Florence Nightingale Commemoration Service

Jacqueline Thompson (Advanced Nurse Practitioner, MRI and Florence Nightingale Travel Scholar 2012/13) was invited to attend the Florence Nightingale Commemoration service, at Westminster Abbey on the 8th May.

This annual service celebrates the life and work of Florence Nightingale and gives thanks to nurses, midwives, healthcare workers in the Armed Forces and unqualified staff working in healthcare.

May 2013

OK to Ask - International Clinical Trials Day a success!

On 20th May, our activities to promote the research capabilities of the Trust culminated with celebratory events to mark International Clinical Trials Day. Visitors to our hospital sites were able to learn more about research and how to get involved through information stands, interactive activities and public engagement events.

International Clinical Trials Day is on or around 20th May each year and commemorates the anniversary of the very first clinical trial by James Lind. We were one of a number of Trusts celebrating International Clinical Trials day this year, and for the first time under a single theme of 'It's OK to ask', set by the National Institute for Health Research (NIHR). By focusing our efforts on one theme nationally, we hoped to have a greater impact.

May 2013

Launch of the Manchester Centre for Genomic Medicine; a new collaboration bringing research benefits to the bedside

Professor Graeme Black, Consultant in Genetic Medicine and Director of The University of Manchester Institute for Human Development announced the launch of the Manchester Centre for Genomic Medicine (MCGM).

The Centre brings together, in an outstanding collaboration, the NHS Genetic Medicine Service at the Trust and The University of Manchester's Department of Genetic Medicine. It provides an environment for researchers, doctors, genetic counsellors, nurses, computer and diagnostic scientists to translate cutting edge research into new patient services. This is an important development for MAHSC (Manchester Academic Health Science Centre) a partnership between The University of Manchester and six NHS organisations across Greater Manchester.

May 2013

News over the Year

Dementia Awareness Week - Join the conversation!

Worrying changes nothing. Talking changes everything. We're all living longer - and therefore facing a higher risk of one day developing dementia. One thing's certain: the more we know about dementia, the more prepared we'll be to face it.

Dementia Awareness Week is Alzheimer's Society's annual flagship awareness-raising campaign. A number of events took place, including tea parties for patients and visitors where resources from the Alzheimer's Society were shared.

May 2013

Greater Manchester Clinical Research Awards Hat-trick

We collected an impressive three awards out of a possible twelve at this year's Greater Manchester Clinical Research Awards.

Dr Rick Body, Consultant in Emergency Medicine and Honorary Lecturer in Cardiovascular Medicine scooped the Principal Investigator of the Year gong.

Sarah Thorpe from Manchester Centre for Sexual Health collected the final award of the evening: Research Nurse of the Year. We were also named as the highest recruiting Trust in Greater Manchester.

May 2013

New virtual clinics introduced for shoulder surgery patients at Trafford General

Patients who have undergone shoulder surgery at Trafford General Hospital can now have their three month follow-up in the comfort of their own home, office or even on the move.

The new virtual clinics, which are carried out over the phone by a specialist team at a pre-arranged time, are offered as an option to a hospital appointment. All patients are seen in clinic two weeks after their surgery.

The virtual clinics give patients the same support and reassurance that their recovery is going to plan but with the added convenience of being contacted in a place of their choice. The clinics are supported by an assessment which measures the improvement of each patient's symptoms following surgery.

May 2013

Perenbast the mummy comes in for a scan

Older than your average visitor to Royal Manchester Children's Hospital Radiology, Perenbast the 3,000 year old mummy came in for a scan. This was filmed and shown on BBC North West Tonight.

May 2013

Young People's Event

We held our annual open day for young people on 25th June. We began organising engagement events for young people several years ago. Our event this year was our fourth. Over the years, nearly 1,000 young people with their teachers, friends or parents have attended and not only gained an insight into our organisation, but also discovered more about career opportunities in the NHS and work experience in our hospitals.

Trust staff manned stands covering a wide range of careers, including nursing, midwifery, pharmacy and laboratories. There was also information about staying healthy and an opportunity to find out about the latest medical research. ***(June 2013)***

June 2013

Recognising low blood sugars could help prevent brain damage in newborn babies

Researchers from The University of Manchester, and the Manchester Biomedical Research Centre, studying a rare and potentially lethal childhood disease - which is the clinical opposite of diabetes - have made an important discovery.

The team has found newborn babies with transient (also known as short-term) congenital hyperinsulinism (CHI) are at risk of developing, long-term disability or brain damage due to low blood sugars.

Previously it was thought only babies with the most severe form, known as persistent CHI, were at risk of brain damage. The study, published in the journal Frontiers in Endocrinology, will now inform paediatric practice.

June 2013

Relatives of patients hold the key to better understanding the cause of rheumatoid arthritis

Researchers in Manchester launched an innovative new project working with patients and their families to better understand the causes of rheumatoid arthritis (RA). The study, the first of its kind in the UK, will provide vital clues to the early events in the process that leads to someone developing RA and help with prevention measures.

Researchers from the National Institute of Health Research (NIHR) Manchester Musculoskeletal Biomedical Research Unit, a partnership between the Trust and The University of Manchester, will collect data from patients' family members some of whom will be at increased risk of developing the condition themselves.

They aim to create a national database to examine and compare the lifestyle and genetic information in those people who go on to develop RA against those who remain free of the condition.

June 2013

News over the Year

Director of the Institute for Women's Health comes to Saint Mary's

On 28th May, the Maternal and Fetal Health Research Centre, Saint Mary's Hospital, was delighted to welcome Professor Peter Brocklehurst, Director of the Institute for Women's Health, University College London and Chief Investigator for the INFANT study. Professor Brocklehurst spoke about this large national research project investigating an intelligent system to support decision making in the management of labour using continuous cardiotocograph, which is currently running at Saint Mary's.

The presentation was an opportunity to learn more about the background of the study, discuss recruitment and the potential impact that the findings could have on clinical practice in the future. Professor Brocklehurst thanked the hospital and all the staff for their continuous support and commitment to recruitment.

June 2013

UK's first ever study shows early mammograms in younger women at increased risk of breast cancer could save lives

Findings, published in journal Familial Cancer, show women under the age of 40 at higher risk of breast cancer who went for mammographic screening had their breast cancer detected at an earlier, more easily treatable stage, potentially improving their chance of survival.

Leading breast cancer research charity Breast Cancer Campaign, has funded the first ever study into mammographic screening in women under 40 with an increased risk of breast cancer compared to the general population.

Cancer genetics expert Professor Gareth Evans at the Trust and The University of Manchester carried out the study in 1448 women. He retrospectively analysed mammographic screening information from studies among women aged 35-39 with a 17% (1 in 6) or more lifetime risk of breast cancer, to find out whether surveillance with mammography showed any benefits.

June 2013

Our Hospital School is 'Outstanding'

Manchester Hospital School and Home Teaching Service, based at Royal Manchester Children's Hospital, was declared 'Outstanding', scoring the highest grading in each Ofsted inspected area of school activity.

Inspectors commented very positively on the leadership and management of the school, stating that 'excellent teamwork under the inspirational leadership of the exceptional head teacher underpins the effectiveness of this highly successful school.'

The achievement is even more impressive as the rating was achieved under Ofsted's new tougher and more challenging inspection framework, under which it has become even more difficult to achieve an 'outstanding' judgement.

July 2013

The Art of Donation Exhibition Opens

MOSAICS depicting a kidney transplant patient's journey from organ failure to full health went on display at Manchester Museum.

The celebrated works of artist Tracey Walshaw were unveiled to the public, in conjunction with National Transplant Week.

The transplant patient hoped her graphic portrayal of the harrowing process which saved her life will raise awareness about the importance of organ donation. Tracey began to create mosaics that would chart her journey to recovery as she suffered renal failure from polycystic kidney disease in late 2011. The exhibition displayed the mosaics she created before, during and after her transplant operation at Manchester Royal Infirmary in January 2012.

July 2013

Decision secures future of Trafford General

The decision by the Secretary of State to support the new clinical service model at Trafford General Hospital was announced.

The Trust had worked in close collaboration with all partner organisations in Trafford to develop a workable model for the future provision of hospital services to the people of Trafford. Doctors and nurses working in the hospital and in the community have been involved in designing the new model to secure safe, affordable, high quality local health services for the future.

The decision to endorse the new service model means that Trafford General Hospital has a clear future as a vital part of the local network of health and social care services that provide for the people of Trafford. The new model ensures the right balance between caring for the sickest patients in specialist hospitals and retaining local access to a broad range of high quality services for patients with less serious needs.

July 2013

Manchester Health Academy toddler group wins a top award in 'Parenting Oscars'

Manchester Health Academy celebrated after their toddler group was named one of the best in the UK's biggest parenting competition.

The group, which runs at the Academy's Community Facility, was voted the North West's most popular in the prestigious competition, run by Britain's largest parenting site www.netmums.com.

Local mums, dads and child carers praised the MHA staff calling it 'the highlight of our week.' Parents also told how the group was special to them for its 'caring staff, great range of activities for kids and for putting a smile on the face of everyone who attends.' The group, which is open to children aged from birth to 5, has been running for over 5 years.

July 2013

News over the Year

Patient flow management system reduces delays

Our Children's Hospital has reduced out-patient clinic delays by implementing a patient flow management system.

We have fully automated the check-in process, using self check-in kiosks and calling screens when patients arrive for their appointments. Phil Taylor, the Deputy Directorate Manager for Medicine, said: "The wait to check-in for an out-patient appointment was the number one complaint the hospital used to receive.

"By implementing the system, we have significantly reduced clinic waiting times and queues are almost non-existent."

July 2013

Identical twins, 9, become the first in Europe to receive kidney transplants from the same donor at the same time

Jack and Joshua, aged 9, from North Wales were recovering well after undergoing four hour operations in theatres next to one another. The Renal Transplant team at Manchester Royal Infirmary and Royal Manchester Children's Hospital performed the surgery overnight after the call came through that a donor had been identified and the kidneys had been allocated to the twins by a combination of matching and luck.

Surgery began with just over one hour interval between the two brothers. The first transplant started on Joshua and once the kidney was successfully transplanted, the surgeon moved to the theatre next door where Jack's transplant had already started. Soon after the transplant, their appetite and energy levels improved.

July 2013

New Facilities Matron improves experience for patients

Together with Sodexo we appointed a Facilities Matron to help reinforce high standards of cleanliness, patient dining and overall care.

Yvonne Spencer, previously a ward manager at Royal Manchester Children's Hospital, joined Sodexo on a 12-month secondment. The company runs a range of services for the Trust, including cleaning, portering and patient dining, together with site maintenance, security and facilities management.

Acting on feedback about food and ensuring wards achieve the highest cleanliness standards are two key areas which Yvonne is focusing on.

August 2013

Patients benefit from £127,000 music project grant

The National Foundation for Youth Music awarded a grant of £127,000 to our arts charity LIME. The money was used on a unique music project run by Music for Health, based within the LIME charity, to work with young patients at the Royal Manchester Children's Hospital.

August 2013

Manchester Health Academy is first in UK to scoop Children's Food Trust Award

Manchester Health Academy became the first school in the country to receive a new national award for excellence in children's food and nutrition.

Children's Food Trust Award, a new accreditation scheme to help schools and early years settings show parents their commitment to helping children eat well, is only given to schools and childcare providers who can show how they are championing healthy eating and nutrition for children.

It means that the Academy met tough criteria on their food policy, menus, dining experience, staff training, opportunities to learn how to cook, and how actively staff encourage children to eat healthily.

July 2013

BBC Two The Midwives - back for series two!

This documentary series for BBC2 was a moving, revealing and heart-warming look at the work of our midwives.

Filming with our midwives at Saint Mary's, as well as other hospitals across the North West, the series showed the extraordinary responsibility we lay upon our midwives and the difficult situations and decisions they face every day. We saw them juggling NHS resources and the need to meet patients demands.

We saw them dealing with single mums, wealthy families, tearful teens and medical emergencies. From the frontline of one of the busiest delivery units in the country, to helping women get through their high pregnancies against the odds; from protecting babies once they go home, to learning to become a midwife for the first time, this series revealed what it's like to be a midwife in Britain today.

August 2013

Our Commitment to Caring - 2nd Annual Nursing & Midwifery Conference

Hundreds of nurses and midwives came together to celebrate the launch of the recently developed values and behavioural framework which was introduced to ensure a consistent caring approach by all our 5,000 nurses and midwives.

Last year our nurses and midwives developed their core values and commitments to deliver great care with dignity and compassion. During 2013 they have developed a behavioural framework to ensure the delivery of those values and to support them in holding each other to account.

September 2013

News over the Year

Research could lead to a new test to predict risk of pregnancy complications

Researchers from the Trust and The University of Manchester identified proteins in the blood that could be used to predict whether a woman in her first pregnancy is at increased risk of developing pre-eclampsia.

Pre-eclampsia is a complication of pregnancy where the mother develops high blood pressure and protein is present in the urine. In some cases, this can develop into a serious condition for both mother and baby and the only cure is delivery of the baby, often prematurely.

Women who have had pre-eclampsia previously are at higher risk of recurrence and are closely monitored during pregnancy, but there is no way of determining who is at high risk in first-time mothers. The findings will have a significant impact for identifying the condition in first time pregnancies, researchers believe.

September 2013

Appointed as the local branch of the NIHR Clinical Research Network

The Trust was one of just 15 NHS Trusts/ Foundation Trusts in England to be appointed to run a local branch of the National Institute for Health Research (NIHR) Clinical Research Network.

The NIHR Clinical Research Network is the clinical research delivery arm of the NHS. It provides funding to hospitals and surgeries to pay for research nurses, scans, X-rays and other costs associated with carrying out clinical research in the NHS.

As the chosen Trust for the Greater Manchester area, which includes East Cheshire and East Lancashire, we were awarded a five year contract from the Department of Health through the NIHR, to take responsibility for distributing funding to support clinical research across the whole area.

September 2013

New innovative training to improve the care of people with dementia in hospitals

Academics and healthcare professionals from across Greater Manchester as well as people with a diagnosis of dementia and family carers teamed up to devise a new training programme for general hospital staff.

The University of Manchester and Greater Manchester West Mental Health NHS Foundation Trust teamed up with three other NHS Trusts in Bolton, Salford, and ourselves to develop the new "Getting to Know Me" dementia care training programme for general hospital staff.

September 2013

New work experience scheme for youngsters launched at Trafford General

Eleven new recruits were welcomed to Trafford General Hospital at the launch of the new Supported Traineeships scheme. The new scheme helps young people with learning disabilities to have their first taste of work, gain a nationally accredited qualification, and support them ultimately into paid employment.

September 2013

Genetic test speeds up diagnosis for children with cataracts

A blood test for children born with cataracts will allow faster diagnosis and more personalised treatment, according to researchers from Manchester.

The team, from the Centre for Genomic Medicine a collaboration between our Trust and The University of Manchester, have developed a test that checks all genes known to cause congenital cataracts using just one blood sample.

Congenital cataracts are a leading cause of blindness in children, affecting around 200,000 children around the world every year. It is thought around half of cases are due to genetic mutations whilst the remainder are caused by environmental risk factors during pregnancy, for example exposure to infections such as rubella.

Mutations in over 100 genes have been linked to congenital cataracts. Conventional screening methods involve the consecutive testing of each gene separately to determine the precise genetic cause, which is a time-consuming and costly process.

The team are validating the test and it will become available on the NHS by December this year, from which point they will be accepting samples for diagnostic testing.

September 2013

Operation Ouch Hits the Small Screen!

The second series of Operation Ouch, filmed at Royal Manchester Children's Hospital, began on Monday 30th September for 10 weeks on the CBBC Channel.

The series was a great success and went on to win a Children's BAFTA.

September 2013

Central Manchester hospitals participates in NHS Innovation Fellowship video

Manchester Royal Eye Hospital is featured in the launch video of the NHS Innovation Fellowship, a new programme which will draw inspiration from some of the world's leading thinkers in the worlds of health, business, academia and science into the NHS.

At Central Manchester hospitals, we're committed to ensuring that patients get high quality care now, but recognise that it's equally important for us to build better ways of working into our services for the future. This is called innovation. In-line with our mission, we are already using the skills that are inherent within our organisation to improve people's health through clinical research, and identify opportunities to drive continuous improvements, in terms of quality of care and/or efficiencies.

September 2013

Hospital work experience scheme 'Highly Commended'

Staff and students from the Supported Traineeships programme celebrated an excellent start to the new academic year after achieving a 'Highly Commended' award at the National People Management Awards.

The People Management Awards, held by the Chartered Institute of Personnel Development, recognise and celebrate outstanding achievements in people management and development. The Supported Traineeships scheme, which supports young people with learning disabilities into paid work, received the award in the category of 'Diversity'.

October 2013

News over the Year

30 years of screening, counselling and clinical care at the Manchester Sickle Cell and Thalassaemia Centre

The Manchester Sickle Cell and Thalassaemia Centre celebrated its 30th anniversary with a conference and family event on 27th October 2013.

These disorders are commonly found in people of African, Caribbean, Eastern Mediterranean, Middle Eastern or Asian heritage but have been known to affect individuals of any ethnicity.

Haemoglobin disorders are genetically inherited blood diseases that affect how oxygen is carried in the body. The symptoms can include severe anaemia, intense pain, damage to major organs and infections. Although there is no routine cure for sickle cell, patients can be supported to manage their pain, and regular monitoring can help to avoid life threatening complications such as stroke. In England, sickle cell affects an estimated 14,500 people with an estimated 240,000 carriers.

October 2013

Living with Dementia – an interactive training session to improve awareness

A training company from Liverpool helped to raise awareness of people living with dementia at an interactive session aimed at doctors, nurses and allied health professionals.

The company's crew of actors explored a range of scenarios designed to help think about dementia, how it affects families and the challenges it presents. The session consisted of a series of scenes and presentations, interspersed with comments and questions by the company manager to involve the audience.

October 2013

Proud to Care for You: Annual Members' Meeting

Our Annual Members' Meeting took place on 1st October 2013.

The event was open to our members, patients, staff, family, friends and anyone from the local community.

The theme this year was 'Proud to Care for You' and our staff ran information stands about the focus on high quality, safe care across all our hospitals and community services.

Attendees found out more about how we are using feedback from patients, staff and Governors to improve our services, and shared their suggestions for making our Trust a great place to work or be treated.

October 2013

New MAHSC Sino-British health partnership

The Manchester Academic Health Science Centre (MAHSC) formed a partnership with the Peking University Health Sciences Centre to establish an international centre of excellence in genetic medicine.

The new Peking-Manchester Centre for Genomic Medicine, announced by UK Chancellor George Osborne in Beijing, will comprise three separate but interdependent research facilities - the International Centre for Rare Diseases, the Centre for Cancer Genetics, and the Joint Clinical Trials Facility.

MAHSC's involvement is being led by the Manchester Centre for Genomic Medicine at Saint Mary's Hospital, an integrated centre bringing together University of Manchester researchers and our clinical services, to form a world leader in genetic and genomic medicine for research into inherited diseases and delivery of services to families with inherited disorders.

October 2013

An arresting day at the I.M.P.S 'Restart a Heart' programme

Thirty year six children from St Willibrords RC Primary School, Clayton visited the Trust as part of the I.M.P.S (Injury Minimization Programme for Schools) on European Restart a Heart Day.

Unintentional injury is a leading cause of death and illness in young people. On average two million children attend Accident & Emergency Departments every year because of accidental injury and every week five children die. I.M.P.S. aims to minimise the number of accidents that lead to death and disability by working and educating children on the risks.

The programme empowers young people to take personal responsibility for managing their own risk and equips them with the skills to cope in an emergency. The skills that they are taught include CPR and they are also introduced to an AED (automated external defibrillator) to help to address the issues that are being flagged up in the campaign.

October 2013

'Sticky spermatozoa' could hold fertility key

Saint Mary's Hospital took part in a trial led by the University of Leeds, investigating if sticky spermatozoa could hold the key to greater success for couples undergoing IVF treatment.

The largest clinical trial to date aimed at testing this idea was launched on the first day of National Infertility Awareness Week.

The £1.3m trial, funded by the National Institute for Health Research Efficiency and Mechanism Evaluation (NIHR EME) Programme, will be piloting a new IVF method that relies on picking only mature and fertile spermatozoa that stick to a specially coated plate for injection into the egg.

The coating is made of hyaluronan, a naturally-occurring substance that is frequently used in clinical treatments as a lubricant, for example, in joints including the knee, and by the cosmetics industry as a component in rejuvenating products, such as skin creams.

October 2013

National acclaim for Trafford's arthritis service

Trafford General's Rheumatology service was one of only five in the UK to have been recognised as 'Outstanding' for its ground-breaking and innovative practice in treating inflammatory arthritis. This recognition focuses on the role of four specialist nurses in the department who work at an advanced level, meaning patients can be seen and receive treatment quickly for their condition.

News over the Year

'Movember'

For the first time a group of hospitals supported the Movember Campaign!

Doctors who treat health conditions considered to be the biggest killers amongst Manchester men showed their support for men's health campaign 'Movember' at our launch on 1st November. Our health trust was the first in the country to work together with the campaign in promoting awareness of men's health issues.

Movember challenges men to grow a moustache for the 30 days of November, thereby changing their appearance and the face of men's health.

November 2013

Occupational Therapy Week

Occupational Therapy Health Week took place in November and our organisation celebrated along with other Occupational Therapists up and down the country!

We held two events to showcase our work and raise awareness of Occupational Therapy in the NHS.

November 2013

Promoting the health of children and young people of Manchester

Our Healthy Schools team held a Manchester Healthy Schools Health Improvement Awards and Wellbeing Showcase event.

The event was held to award schools for their outstanding work promoting the health of the children and young people of Manchester. It was also a showcase of new public health resources that the Health Improvement Service has created.

November 2013

10 out of 10 Visit to Downing Street for our Head of Procurement as PM's new Enterprise Advisor

Simon Walsh, Head of Procurement and E-Commerce visited Downing Street to meet Lord David Young - former Cabinet Minister and now the Prime Minister's Enterprise Advisor to talk about procurement in the NHS.

November 2013

Orthopaedic centre first step towards new-look Trafford General

Trafford General's new orthopaedic centre opened and was the first major step in a series of changes.

Manchester Elective Orthopaedic Centre brings together specialist orthopaedic expertise from both Trafford General and Manchester Royal Infirmary. All major planned orthopaedic procedures that require an in-patient stay, as well as day cases, for patients from Trafford and Manchester are carried out in modern purpose-built facilities at Trafford General.

These procedures include joint replacements such as hips, elbows, knees, and shoulders. More than 5,500 procedures are expected to be carried out in the first year. Out-patient, rehabilitation and follow-up care will be provided at either Trafford General or the MRI, at the hospital closer to the patient's home. Dedicated orthopaedic theatre lists will mean that the possibility of cancelled operations is reduced.

November 2013

Movember Docs head to Man City!

Our doctors who treat health conditions considered to be the biggest killers amongst Manchester men went to tackle footy fans on 24th November at the ETIHAD Stadium to raise awareness amongst supporters.

Our health trust was the first in the country to work together with the Movember campaign in promoting awareness of men's health issues.

Doctors from Urology, Vascular Surgery, Cardiology and Bowel Surgery answered questions and offered health advice at the Manchester City Vs Tottenham Hotspurs game. A First Stop Health bus provided by Manchester City Council was also at the City Stadium offering free NHS health-check ups and advice to passers-by.

November 2013

National HIV Testing Week

Our Manchester Sexual Health Centre (MSHC) took a leading role in Manchester's involvement in National HIV Testing Week which ran from 22nd - 29th November 2013.

The week aimed to raise awareness particularly among gay men and people from African communities to increase testing. It was initiated by HIV Prevention England, who aim to reduce undiagnosed and late diagnosed HIV by early testing. The event coincided with the first ever European testing week.

November 2013

News over the Year

Trafford General Urgent Care Centre opens

The new Urgent Care Centre replaced the Accident & Emergency (A&E) department at Trafford General Hospital.

The new Urgent Care Centre opened at 8.00 am on 28th November. It continues to be staffed by a highly skilled team of emergency doctors and nurses provides treatment for adults and children who need care for a condition that is not life-threatening but where prompt help, care or advice is required. Its opening hours are 8.00 am to midnight every day.

November 2013

First to Make a Green Impact!

At the end of November we were the first NHS Trust in the North west to sign up to take part in an exciting sustainability behaviour change programme - Green Impact.

Green Impact has been developed by the National Union of Students (NUS) and is an environmental accreditation scheme which helps people improve their working environments whilst gaining recognition for their efforts.

November 2013

Manchester Eye Bank reaches 20,000 eye donors received

On 20th November 2013 the Manchester Eye Bank reached 20,000 eye donors received.

This equates to almost 40,000 corneas processed and stored in the bank.

Dr Isaac Zambrano, Head of the Eye Bank, said: "This is a landmark in our history, and an example of the hard work and commitment of my colleagues in the lab. Needless to say, we are going from strength to strength with every single one of us looking forward to face new challenges as well as developing our service even further."

November 2013

Britain's Got Talent stars Ashleigh & Pudsey bring Starlight's Christmas Panto to Royal Manchester Children's Hospital

Christmas came early in the Teen Zone at the hospital with a visit from Ashleigh & Pudsey, the world famous duo who won Britain's Got Talent in 2012 and will shortly be starring as Alice Fitzwarren and her faithful dog in Dick Whittington at Manchester's Opera House this Christmas.

November 2013

Success for Manchester's Academic Health Science Centre bid

The city's Academic Health Science Centre (MAHSC), a partnership between The University of Manchester and six leading NHS organisations (including ourselves), has been named as one of only six elite accredited partnerships in the country by the Department of Health, and the only one outside the South-East of England.

MAHSC brings together NHS and University staff across six key areas of health: cancer; cardiovascular health; human development; inflammation and repair; mental health and population health.

November 2013

Research Conference a success

The 2013 CMFT Research Conference, held in association with MAHSC, was a great opportunity to share ideas and promote research findings with colleagues. Oral and poster presentation competitions were run throughout the day, celebrating excellent multi-disciplinary research. Prizes were awarded for 1st, 2nd and 3rd place for both forms of presentation.

December 2013

Childhood cataracts: A new genetic test offers better diagnosis and treatment for patients

Our Manchester Centre for Genomic Medicine, based in Saint Mary's Hospital launched a unique genetic testing service for children born with cataracts.

About 200 children are born with cataracts each year in the UK and 200,000 worldwide. The new test will give many more of these children and their families a definitive diagnosis of their condition, a process which used to take months or years before the introduction of this test. The new test will be available to all families across the UK upon request from their NHS clinician.

A definitive and quicker diagnosis, made earlier in a child's life, will help those suffering from severe diseases in which cataracts are an early symptom by allowing correct surgical and medical management and treatment. For those families with no history of children born with cataracts a diagnosis can inform the family of the risk to future children.

December 2013

Key 103 and Coronation Street Stars Switch on Christmas Lights

OJ Borg from Key 103 was joined by Coronation Street actors Katie McGlynn, Jenny McAlpine and Alan Halsall (aka Sinead, Fizz and Tyrone) at our Christmas Lights switch on event at Royal Manchester Children's Hospital.

December 2013

News over the Year

Work starts on Manchester Royal Infirmary's new state-of-the-art hybrid theatres

Building work began on the construction of a new Hybrid Theatre suite that will transform the care and treatment of patients undergoing minimally invasive procedures, especially in the specialties of Vascular and Cardiac Surgery. The facility is being built in the Elective Treatment Centre of Manchester Royal Infirmary.

Minimally invasive procedures are fast becoming the preferred technique for patients and for surgeons, cardiologists and radiologists and our Trust has many acknowledged leaders in this field. Procedures are performed through tiny incisions rather than one large opening and avoid the need for open surgery meaning a lower chance of infection, a quicker recovery time and less risk of blood loss, pain and scarring for patients.

The two theatres will provide a dedicated facility with state-of-the-art technology, including high definition imaging with a robotic arm for increased mobility, and facilities for traditional surgery all in one place. They will not only offer better facilities for existing techniques, but will also enable new innovative techniques and treatments to be carried out that are not currently possible.

The hybrid suite is believed to be the first of its kind in the UK and one of only a few existing internationally that offer the same facilities.

The new hybrid suite will be used primarily for vascular and cardiac surgery but will also be used for other specialties such as urology and increasingly complex major trauma.

December 2013

Citylabs: Crane removal marks start of final phase 10

The 100,000 sq ft Citylabs development, a partnership between the Trust and Manchester Science Parks, began its final phase of construction, with the dismantling of the imposing tower crane.

Work on the new build element is due to completed in Summer 2014 following the restoration of the former Royal Eye Hospital.

Biomedical companies choosing Citylabs will benefits from its location, at the heart of Europe's largest clinical academic campus. Companies based at Citylabs will be able to access expertise from within our hospitals and the wider Manchester Corridor.

Citylabs is supported by the European Regional Development Fund (ERDF) and Manchester City Council.

December 2013

National Recognition for our Anaesthesia Team

A project led by our Anaesthetic team received nationwide recognition at the Quality in Care Awards. 'Personalised Patient Experience Tracker: innovative use of patient experience to enhance postoperative recovery of gynae-oncology patients after surgery' was judged to be the winning entry in this year's Quality in Care (QiC), Excellence in Oncology Awards. Judges said that the project demonstrated "an impressive multi-disciplinary team approach, and a well though-out initiative demonstrating significant improvements in peri-operative care".

The team led by Dr Sujesh Bansal, Consultant Anaesthetist, tracked individual patients' experiences during whole of their in-patient stay by an innovative use of hand-held 'patient experience tracker', which reviews existing obstacles to timely discharge of gynae-oncology surgical patients.

December 2013

Father Christmas gives the Children's Hospital a flypast!

Following a visit to the Children's Hospital the RAF, along with Father Christmas, buzzed the Children's Hospital. Just before 1.00 pm, he flew past crowds gathered on the boulevard, and on the outdoor Children's play area before being taken back to Lapland by helicopter.

December 2013

Researchers explore how mothers' blood sugar levels influence child fat

Researchers from Manchester have begun a new study to determine whether blood sugar levels during pregnancy, lower than the level used to diagnose gestational diabetes, influences later levels of body fat in children and development of diabetes in mothers after giving birth.

The team from the Trust and The University of Manchester are trying to trace mothers and children who took part in an earlier research project 12 years ago.

The original study, the Hyperglycemia and Pregnancy Outcomes (HAPO), looked at 2,400 mothers from Manchester who were part of 23,316 mother-child pairs worldwide. They found that a mother's blood sugar levels, even short of diabetes, were associated with how heavy or fat her baby was.

December 2013

News over the Year

Manchester's Premier League stars pay a Christmas visit to the Children's Hospital

Patients were over the blue moon when Manchester City players came to visit and hand out presents at the Children's Hospital.

Manchester United stars weren't far behind, coming to wish Merry Christmas to patients the day after.

The players took time out of their hectic festive schedule to spend the afternoon with children across the wards, and to see first hand how the hospital continues to provide specialist healthcare services for children and young people.

December 2013

Researchers find potential new treatment approach for pancreatic cancer

Scientists from the Trust - part of Manchester Cancer Research Centre - believe they have discovered a new way to make chemotherapy treatment more effective for pancreatic cancer patients.

Pancreatic cancer is an aggressive cancer with poor prognosis and limited treatment options and is highly resistant to chemotherapy and radiotherapy.

But researchers believe they have found an effective strategy for selectively killing pancreatic cancer while sparing healthy cells which could make treatment more effective.

Dr Jason Bruce, from the Physiological Systems and Disease Research Group, who led the research, said: "Pancreatic cancer is one of the most aggressive and deadly cancers. Most patients develop symptoms after the tumour has spread to other organs. To make things worse, pancreatic cancer is highly resistant to chemotherapy and radiotherapy. Clearly a radical new approach to treatment is urgently required. We wanted to understand how the switch in energy supply in cancer cells might help them survive."

The research, published in The Journal of Biological Chemistry, found pancreatic cancer cells may have their own specialised energy supply that maintains calcium levels and keeps cancer cells alive.

December 2013

Consultant wins innovation award for virtual orthopaedic

Mr Bibhas Roy, Consultant Orthopaedic Surgeon, was the winner of the Healthcare Project of the Year category in the Bionow Awards 2013 for the development and innovative application of a web-based tool, which enables remote monitoring of patients following shoulder surgery.

Musculoskeletal problems are one of the most common reasons for seeking health care, with estimates of up to 20 per cent of adults annually consulting their general practitioner. Isolated shoulder problems affect around 2.5 per cent of adults.

Around 80 per cent of Mr Roy's surgery is performed using keyhole surgery techniques. This often means that procedures can be performed as day case surgery, enabling patients to return to their daily activities more quickly than would be possible following conventional surgery.

The web-based tool, Patient Reported Outcome Measures (PROMS) 2.0, enables patients to be monitored in real-time remotely after surgery, reducing the number unnecessary clinic visits for the patient and health service. PROMS 2.0 collects information submitted by patients after surgery, either online or via telephone

consultation, and uses the feedback to tailor follow-up care to an individual patient's needs. PROMS 2.0 was developed in collaboration with other clinicians and, company, Amplitude Clinical Services Ltd, which provided the technical solution.

The tool has been adopted by 12 NHS organisations, primarily in the North West of England, for use in a variety of clinical areas, including major trauma, orthopaedics, mental health, chronic obstructive pulmonary disease (COPD), stroke, diabetes, smoking cessation and urology. By informing a patient's ongoing care, PROMS 2.0 goes beyond the level of sophistication currently offered by other tools.

December 2013

Work begins on £6 million state-of-the-art surgical facility

Work began on a new £6 million state-of-the-art hybrid endovascular theatre suite set to transform the treatment of patients undergoing minimally invasive cardiovascular procedures.

This will be the first hospital in the UK to have two adjacent fully hybrid theatres utilising a robotic imaging system with fully flexible theatre table. Only a few such facilities exist world-wide.

Situated in Manchester Royal Infirmary, the two theatres will provide a dedicated facility with state-of-the-art technology. This includes high definition imaging with a robotic arm as well as facilities for traditional surgery all in one place. The hybrid suite will provide better facilities where existing techniques can be performed more efficiently and safely.

January 2014

News over the Year

Congratulations to Dr Cath White, Clinical Director of SARC, for her OBE in the New Year Honours List

Dr Catherine White, Clinical Director at the St Mary's Sexual Assault Referral Centre (SARC) was awarded the Order of the British Empire (OBE) in The Queen's 2014 New Year's Honours List.

Dr White has been Clinical Director for the St Mary's SARC since 2003 and a Forensic Physician, specialising in the examination of women, men and children since 1995.

During her career, Dr White has constantly sought to drive up standards in the quality of care for rape and sexual assault victims and has been instrumental in delivering comprehensive training and teaching of practitioners working in this field.

St Mary's Sexual Assault Referral Centre was the first Sexual Assault Referral Centre to open in the UK. It provides a comprehensive and co-ordinated forensic, medical, counselling and aftercare service to men, women and children living in Greater Manchester or Cheshire who have experienced rape or sexual assault, whether this has happened recently or in the past.

January 2014

Trainee ophthalmologist is named one of HSJ's 'Rising Stars'

Reshma Thampy, a trainee ophthalmologist at the Eye Hospital was named as one of the Health Service Journal's 'Rising Stars' at this year's awards.

January 2014

Healthy Schools Manchester is 'relentless' in tackling energy drinks

Healthy Schools launched a campaign to try to combat the surge of energy drink consumption by children and young people in schools all around the region.

The campaign, The Big Health Challenge, is an 'Apprentice' style project, where young people in schools are being asked to work together to come up with a healthier drink option, whilst getting the chance to make money from the enterprise initiative.

After being contacted by several high schools, who are struggling with energy drink issues, Healthy Schools decided to start up a project to tackle issues and put the young people in charge of combating these issues.

January 2014

New Menu for Children's Ward

From January patients on Ward 84 at the Royal Manchester Children's Hospital had more choice on the menu.

This formed part of the new Patient Dining Experience and followed extensive research into what the patients and parents wanted to see improved in the provision of catering on the ward.

January 2014

Helping Staff and Visitors Get Their 5 a Day

Staff and visitors now have a greater opportunity to buy fresh fruit when a new fruit market barrow opened at the entrance to Royal Manchester Children's Hospital.

Its launch has been made possible through the Estates and Facilities team and will be manned by paid staff who responded to an advert placed in the local Job Centre.

January 2014

On track to exceed target for patient recruitment into clinical research studies

Thanks to our patients and staff, we announced that we are on track to exceed our National Institute for Health Research (NIHR) target for patient recruitment into clinical research studies.

Between April 2013 and November 2013, we recruited 11,401 patients into NIHR portfolio studies. This achievement builds on our success last year, as the second highest recruiting Trust in the UK.

As one of the largest providers of tertiary and specialist services in the UK, we have a key role to play in identifying new and better ways to do things, to ensure that our patients continue to receive cutting-edge care. In-line with our mission, we use the skills that are inherent within our organisation to improve people's health through clinical research.

January 2014

New cause identified for children and adults with joint, skeletal and skin problems

Scientists from The University of Manchester and the Trust identified the cause of a rare condition called Leri's pleonosteosis (LP).

Dr Sid Banka (a former Manchester BRC Clinical Fellow) from the Manchester Centre for Genomic Medicine at Saint Mary's Hospital, led a team of researchers on the study which was published in Annals of Rheumatic Diseases journal.

LP is an inherited condition in which children are born with contractures of multiple joints and then develop difficulty of joint movements that progress in severity with age. The research team showed that extra genetic material on chromosome number 8 caused the condition in two families from Manchester.

Some patients with LP also develop thickening of their skin, similar to that seen in patients with a more common disorder called scleroderma. Using their new knowledge, the research team showed that the genetic cause of LP is linked to whether people get scleroderma or not.

This work opens opportunities to understand scleroderma and explore new treatments.

January 2014

News over the Year

Manchester Health Academy student wins Diana Award for Syrian relief work

Sham Mamoun, a Year 10 student at the Manchester Health Academy, spent her Christmas holiday visiting the homeless who have fled from the conflict in Syria or are victims of the effects of the bombings of towns in the ongoing conflict in the country.

Sham travelled into the war zones with charity Syria Relief on a humanitarian mission and arranged to take with her over 200 letters written by students at the Manchester Health Academy to children in the refugee camps. Once in the camps Sham distributed the letters and brought back replies from the Syrian children.

In September Sham won the Diana Award, (National Citizen of the Year) which was presented to her in London by Prime Minister David Cameron. The award was established as a lasting legacy to Princess Diana's belief that young people have the power to change the world.

Sham is now working as an ambassador for the Diana Award and hopes to one day work for the United Nations to raise awareness of international issues and support actions to change lives for the better.

January 2014

Trust hosts a national event for international doctors

Our Trust collaborated with General Medical Council hosted 80 international doctors from all over the UK in a national event at our Postgraduate Centre.

The delegates were new international doctors qualified from India, Syria, Afghanistan, Nigeria etc who have recently started clinical practice in the UK. The theme of the event was 'Challenges for International Doctors: Practical solutions for promoting professionalism and patient safety'.

January 2014

Manchester Health Academy wins prestigious school catering award

Manchester Health Academy (MHA) picked up the School Catering Award at the Education Business Awards, held in London and sponsored by school online payment provider ParentPay.

February 2014

Stars help raise £130k for RMCH!

It was a night of starry surprises as a massive £130,000 was raised at the Discovery Ball for the Royal Manchester Children's Hospital.

Elbow's Guy Garvey and Craig Potter astounded revellers when they performed a surprise acoustic set of spine-tingling songs at the Discovery Ball at the Hilton Hotel on Deansgate.

And the night, hosted by TV legends Richard Madeley and Judy Finnigan, was brought to a close with a star turn from homecoming pop icon Mick Hucknall.

Elbow also helped to raise more than £13,000 on the night by donating unique musical items auctioned by radio stars Mike Toolan and Hugh Ferris.

February 2014

Work Begins on Grafton Street Car Park Extension

Work started on an extension to Grafton Street multi-storey Car Park. This will provide an extra 900 spaces.

February 2014

Our 'International Programme' wins national award

Our Trust's 'International Programme' was awarded the first prize for 'Improving Services Through Training and Development' during the national Lean Healthcare Academy Conference and Awards 2014.

This programme was introduced in August 2012 and in the last 18 months, 42 international doctors have completed the programme with an increasing number registering and completing the online induction. 95% of doctors have found the training useful in enhancing the patient care they provide.

February 2014

News over the Year

Michael Owen sets his sights on London Marathon to help the Eye Hospital

Footballer Michael Owen announced he will run the London Marathon to support Manchester Royal Eye Hospital and scientists from The University of Manchester in their mission to find new treatments for families with genetic eye disorders.

The former England striker who played for Liverpool, Real Madrid, Newcastle United, Manchester United and Stoke City said he hoped his support would help scientists and doctors develop new treatments for patients with inherited eye disorders - where currently there is no available cure.

Manchester Royal Eye Hospital, in partnership with The University of Manchester is making a major contribution to the future of genetic medicine through the Manchester Centre for Genomic Medicine.

February 2014

Staff Asked to Swap Red Hearts for Green Ones on Valentine's Day!

A new sustainability campaign launched on Valentine's Day to help our staff change their behaviour and become more 'energy aware'.

The campaign launched with a day of activities across the sites, including visits to departments by the new Green Heart mascot. Campaign posters and stickers have been produced to encourage staff to take action and reduce their energy use through sustainable behaviours, such as switching off equipment and lighting when not in use and to take the stairs instead of the lift when possible - to save energy and reduce our carbon footprint.

February 2014

ITV1 – Bedpans and Bandages

New documentary series on ITV1 began in February featuring our student nurses - Training to be a nurse has changed dramatically since the early days of the NHS. Greater demands and added responsibility make it harder to qualify than ever before. At universities all over the country, a new generation of nurses is being born.

The series offered an insight into what it takes to become a nurse in the 21st century, uncovers the motivation behind the student nurses' dreams and showed the challenges they face on a daily basis juggling academic study with home life and work on the wards. Audiences averaged at around 3 million and peaked at 5 million.

February 2014

Manchester patients first to take part in global eye study

The study, led by Mr Niall Patton, Consultant at Manchester Royal Eye Hospital, aims to build on existing safety and effectiveness data for ocriplasmin, a treatment for some people with the rare eye condition, vitreomacular traction.

Vitreomacular traction (VMT) occurs when the vitreous, the gel-like substance in the eye, pulls abnormally on the retina, the light-sensitive layer of tissue at the back of the inner eye, which is responsible for processing visual images. The pulling of the gel disturbs the retina, causing swelling and distorted vision, and sometimes a hole in the macular area. It can occur as a result of ageing and may result in the loss of central vision. In 2009/10, there were around 16,000 vitrectomy hospital admissions in England.

The Manchester Royal Eye Hospital recruited the first patients in the world to take part in the study. The patients taking part in the study are those who have been offered treatment with ocriplasmin, as part of their routine care. They will visit the hospital four times within a 12-month period and undertake the usual assessments.

February 2014

Saint Mary's Midwife Wins Lifetime Achievement Award

Faye Macrory, Consultant Midwife (Manchester Specialist Midwifery Service) and Domestic Abuse Lead, won the Lifetime Achievement prize at this year's British Journal of Midwifery Practice Awards.

This award, chosen by the editors in chief, recognised the massive contribution made over a number of years by Faye, was presented to her at a ceremony in London, attended by over 130 guests.

The awards are now in their 11th consecutive year, and have become a prestigious and important part of the midwifery calendar in recognition of outstanding achievements in midwifery practice.

Faye said: "I am absolutely overwhelmed to have received this award and being shortlisted came as a complete surprise. Thank you so much to all my colleagues, my team and friends for their support and best wishes.

"I'd like to especially say thank you to the many women who have shared the stories of their lives with me and inspired me to try to make a difference."

March 2014

News over the Year

New £17m Community Hospital Set to Open in Altrincham Next Year

We announced in March that construction work is well underway on the new £17 million community hospital development in Altrincham which is due to open to patients a year from now.

The new four-storey development on Railway Street in the town centre will replace the current Altrincham Hospital which dates back to the Victorian era. It is regarded as a major step in the town's regeneration. The town centre location will be very convenient for patients who use public transport and the building itself will be much more accessible and user-friendly for all visitors, including those with mobility problems.

A wide range of high quality general and specialist out-patient and diagnostic services including the rapid treatment of minor injuries will be provided in the new hospital. Discussions are underway regarding the possibility of providing additional services.

The hospital is expected to open to the public in March 2015.

March 2014

New Cardiac Parents' Coffee Morning a Success

A coffee morning organised and arranged by the Specialist Nurses in Paediatric Cardiology based at Royal Manchester Children's Hospital, and supported/attended by the Children's Heart Association, has been set up to provide support to new parents of children with cardiac conditions.

Aimed primarily at the parents of babies under the age of 6 months, this is an opportunity to meet other mums and dads in a similar situation, learn about the Children's Heart association and chat to the paediatric cardiac specialist nurses.

The morning was a huge success, and more coffee mornings are set to take place later in the year.

March 2014

Greater Manchester Neonatal Transport Service celebrates new purpose-built neonatal ambulance

The Greater Manchester Neonatal Transport Service (GMNeTS) celebrated the arrival of a new specially adapted ambulance for transporting sick or preterm babies from across the north-west region, thanks to the fundraising efforts of the Red Sea Pedestrians, supporters of Saint Mary's Hospital Charity.

A Valentine's Ball was held and attended by over 400 people who helped to raise an incredible £136,000 on the night. The money was raised through a number of fundraising activities including an auction, raffle and a Stand for a Grand game, hosted by Saint Mary's Hospital Charity patron, actor and comedian John Thomson.

The new vehicle, a bespoke specialist neonatal ambulance, will be the only vehicle of its kind operational in the region and will be utilised by the GMNeTS team, in partnership with North West Ambulance Service crews.

March 2014

Activity and Performance

Accident and Emergency Attendances

	2012/13	2013/14
First Attendances	259,348	284,115
Follow-up attendances	7,153	6,390
Total	**266,501**	**290,505**

In-patient/Day case Activity

	2012/13	2013/14
In-patient (emergency)	76,125	78,148
In-patient (elective)	18,789	19,703
Day cases	76,028	79,226
Total	**170,942**	**177,077**
Day cases as a % or elective activity	80.18%	80.08%
Day cases as a % of total activity	44.48%	44.74%

In-patient Waiting List

	31st March 2014		
	In-patient	Day case	Total
Total on Waiting List	2,971	7,30	10,274
Patients Waiting 0-12 weeks	1,825	4,242	6,067
Patients Waiting 13-25 weeks	571	1,454	2,025
Patients Waiting over 26 weeks	575	1,607	2,182

Out-patient Activity

	2012/13	2013/14
Out-patients first attendances	274,375	273,494
Out-patients follow-up attendances	733,959	748,509
Total	**1,008,334**	**1,022,003**

Bed Usage

	2012/13	2013/14
Average in-patient stay	2.9	2.7

General Information

	2012/13	2013/14
Number of babies born	8,318	8,642
Total number of operations/procedures	174,974	178,700
Renal Transplants (including kidney/pancreas)	241	369
Number of Cataract Procedures	3,837	4,590

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.

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 2013 was updated to incorporate details of all resilience planning activities across all hospitals and community services which fall under our organisation.

As part of our statutory requirements under the Civil Contingencies Act 2004 and the NHS Commissioning Board Emergency Preparedness Resilience and Response Framework 2013, 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.

During 2013/14 we continued to carry out a programme of training and exercising which included Business Continuity exercises for evacuation of critical areas, lockdown of estate, Senior Manager Major Incident Training, decontamination training and exercising around COMAH (Control of Major Accidental Hazards) planning and a number of in hours and out of hours communication exercises to test Major Incident call in lists and contacts. We also form part of the Health Economy Emergency Planning Community, working closely with colleagues in health and with multi-agency colleagues as part of the Local Resilience Forum, representing the organisation at regional forums.

To ensure we are prepared to respond to internal or external incidents and emergencies during 2013/14 and beyond we will include Major Incident Training on the Mandatory Training and Induction programmes and continue to implement a robust annual review process of all emergency plans.

Quality Report

PART ONE –
Welcome and Overview

1. Statement on Quality from Mike Deegan, Chief Executive
2. Welcome from Professor R C Pearson, Medical Director
3. 2013-2014 The Challenges continue
4. CMFT Quality Review

PART TWO –
Statement of Assurance from the Board and Priorities for Improvement

5. The NHS Outcomes Framework
6. Overview of Priorities
7. Patient Safety
   - Acutely Unwell Patient
   - Patient Harm Events/Learning from incidents
   - Medication safety
   - Harm free care
8. Clinical Effectiveness
   - Hospital mortality
   - Infection Prevention and Control
   - Advancing Quality
   - Urgent care
   - Fractured neck of femur
9. Patient Experience
   - Improving quality programme (IQP)
   - Real time patient experience: Friends and Family Test
   - Commissioning for quality and innovation scheme (CQUINS)
   - End of life care
   - Single sex accommodation
10. Other News
    - Brilliant Basics
    - Hospital at night team
    - Health Foundation project 'Safer Clinical Systems'
    - Safeguarding (Adults)
    - Safeguarding (Children and Young People)
    - Compliments, Concerns and Complaints

PART THREE – Other Information

Part 1. Welcome and Overview

Statement on Quality from the Chief Executive

We are committed to continually improving the quality of the services we provide to our patients. Our quality report provide an annual report of how well we are doing against national and local quality targets, comparing our performance year on year to demonstrate continuous improvement; how we benchmark our outcomes against other healthcare providers and where we need to improve. The report also sets out our priorities for the coming year.

This Quality Report provides us with an opportunity to describe the work that we have done during the course of the year in 2013/14 to demonstrate the good work that has been done and progress that has been made in improving the quality of patient services that we provide and to describe what we are doing in those areas where further improvements are needed.

We have carefully considered the findings of the Sir Robert Francis public enquiry into the Mid Staffordshire NHS Foundation Trust, the reviews and findings of a number of NHS Trusts led by Sir Bruce Keogh, the national review of patient safety led by Donald Berwick and the national complaints review led by Ann Clwyd and Patricia Hart. In addition we have considered the guidance on nurse staffing set out by the National Quality Board. As a result we have made a number of changes to the way we deliver, monitor and manage care and importantly how we provide assurance to the Board of Directors on the quality of care for patients and families who use our services; much of which is set out in this report.

The Trust has yet to be inspected using the new Care Quality Commission process that was led by Sir Bruce Keogh in 2013 and therefore the Board of Directors commissioned a series of internal Quality Reviews led by our Medical Director and Chief Nurse. The series of internal Quality Reviews were led by a very senior Doctor, Nurse and Manager from a different division or hospital supported by a group of staff from different divisions to provide a level of independent scrutiny of the care provided. The visits were completed during October 2013 - January 2014 and have provided an in-depth picture of the quality of care across all of our services. The purpose of the Quality Review is first to ensure that the organisation can be fully assured of the quality of care being delivered and that it can identify, quickly, and respond effectively where improvement is required. The results of the reviews will inform our work plans for 2014/15.

We are committed to keeping our patients safe and cared for. All doctors that are registered with the General Medical Council have to undergo Revalidation every five years (for us, the figure is 906). Revalidation is a means of assurance that doctors are up to date and fit to practice. I am pleased to report that we are on target to have all of these doctors complete their first Revalidation cycle by 2016. In addition we have invested in 267 more nurses providing direct care to patients and we will continue to regularly review our nurse staffing as a Board of Directors.

We were visited in the summer by Ann Clwyd MP as part of the national review of complaints and were proud to be mentioned as an area of best practice for our introduction of the role of critical friend and the complaints scrutiny group led by one of our non-executive directors which focuses on lessons learnt

from complaints. In January 2014 we have started a complete review of our processes to ensure that our complaints and PALS service are accessible, responsive and patient focused.

We continue to invest in our estate and will be one of the first hospitals in the UK to have a state-of-the-art hybrid endovascular theatre suite set to transform the treatment of patients undergoing minimally invasive cardiovascular procedures, only a few such facilities exist world-wide.

The final steps this year were taken to introduce the New Model for Trafford Hospitals in November 2013. The delivery of the new model has been challenging but has been well supported by our staff, patients and commissioners and we look forward in 2014/15 to establishing Trafford as a centre of excellence for elective Orthopaedic surgery as well as the core services that are provided.

In November we received the excellent news that our Academic Health Science Centre (MAHSC) had received re-designation as one of only six elite accredited partnerships in the country. Manchester is the only one outside the South-East of England. We were also recently successful in being designated as the host for the National Institute for Health Research (NIHR), Greater Manchester Clinical Research Network (CRN).

Our staff and our services continue to be at the forefront of clinical research, innovation and technology and we treated the first patient in the world as part of an international study, identifying which patients will benefit most from receiving ocriplasmin as a treatment for a rare eye condition known as, vitreomacular traction causing a loss of central vision. The delivery of the study was supported by the National Institute for Health Research Clinical Research Network. In addition the new Peking-Manchester Centre for Genomic Medicine was established: Announced by UK Chancellor George Osborne in Beijing, it will comprise three separate but interdependent research facilities – the International Centre for Rare Diseases, the Centre for Cancer Genetics, and the Joint Clinical Trials Facility. Manchester Academic Health Science Centre's involvement is being led by the Manchester Centre for Genomic Medicine, an integrated centre bringing together The University of Manchester researchers and our clinical services, to form as a world leader in genetic and genomic medicine for research into inherited diseases and delivery of services to families with inherited disorders. These are just two examples where we are world leaders in research for patient benefit.

As with previous years the Trust continues to grow and expand services and our challenge is to ensure that with growth we continue to focus on quality, safety and patient experience putting patients and service users at the centre of all that we do.

We recognise where we need to improve our services and the importance of delivering consistently great care every day and we have been inspected by the CQC three times during 2013/14 against the delivery of the essential standards. They have reviewed Manchester Royal Infirmary/Royal Manchester Children's Hospital and Trafford General Hospital against 10 of their essential outcomes for quality and safety. The Trust was found to be compliant against eight of these and many of the services reviewed received positive comments. I was particularly pleased to have reported by them many positive comments from our patients.

We were disappointed to be given non-compliant reports for two of the outcomes. The first related to the choice of food in the hospitals, the CQC found that the choice was limited and whilst only considered a 'minor impact on people who use the service' we will work hard this year to improve choice and ensure our patients are satisfied with the food in our hospitals. The second non-compliance related to the health care record. We have recognised this as a problem and we have invested in the design and development of a new electronic patient record system which has already been piloted in the Royal Eye Hospital. We will continue to work hard to improve the management of the paper system and minimise the risk to patients whilst the electronic record is being developed and implemented. As with nutrition this was judged by the CQC as having a minor impact on people who use the service.

We also had two unannounced inspections by the

Central Manchester Clinical Commissioning Group in February 2014 who reported both as 'hugely positive' visits, with no major problems identified.

Our challenge for 2014/15 continues to be maintaining and improving the quality of care while becoming more efficient.

Finally in March this year we celebrated our staff's contribution to patient care at our annual Proud of You awards ceremony. This ceremony has become the highlight of our year as it provides the opportunity to celebrate the many achievements of our staff across all of our services. Each year I am humbled by the lengths that staff go to in order to improve the care and treatment of our patients at home, in schools, in the community and in our hospitals.

I am pleased to confirm that the Board of Directors has reviewed the 2013/14 Quality Report and confirm that it is a true and accurate reflection of our performance.

Mike Deegan
Chief Executive
Central Manchester University Hospitals
NHS Foundation Trust

Statement from Medical Director

Achieving and maintaining high standards of Clinical Quality and Patient Safety is central to what we do and remains one of our key priorities. Our aim is to continue to provide high quality care that is free from harm and provides excellent patient experience and satisfaction.

As I reported last year, patient safety and clinical quality remain absolutely at the top of the organisational agenda and the focus of my work this year is that we continue to deliver safe, high quality care that meets and exceeds the needs and expectations of our patients.

Last year I reported on the acquisition of Trafford hospitals. These hospitals are now fully benefitting from being part of our organisation. This year we have successfully completed the reconfiguration of clinical services in both the Trafford and Central site hospitals to ensure patients continue to get a high standard of care and benefit from the expertise on all sites.

As usual we started the year with a challenging work programme with ambitious targets. I am pleased to say we were able to achieve many of these and where we have not, we continue to work hard to ensure we do. Our Quality Report sets out all of these achievements in detail but here are some of the headlines:

- This year we reviewed the recommendations from the Francis report into the failings at the

Central Manchester University Hospitals NHS Foundation Trust

Mid Staffordshire NHS Hospital Foundation Trust. We developed an action plan to address the recommendations. I am pleased to say good progress continues to be made to address the actions and in many cases the actions are complete.

- This year for the first time we have implemented a Trust wide quality of care review which involved around 200 staff of all grades, patients and governors. This new process of reviewing quality has been invaluable and has created learning opportunities across the organisation.
- The 'New Consultant Leadership' programme continues to be successful. This is a programme designed to support newly appointed consultants within the first 12 months of starting in post, focusing primarily on the development of leadership and management skills. The programme aims to support newly appointed consultants to the organisation and in the transition from a 'learning' doctor to a 'leading' consultant.
- I am proud to say that during 2013, research activity reached an all-time high, with over 20,000 patients recruited to clinical studies. This means we were the second highest recruiting Trust in the UK. We continue to be committed to giving patients the choice to take part in clinical trials and have run several successful communication campaigns, including International Clinical Trials Day, to raise the awareness of research and its benefits, amongst staff and patients. Our researchers won a number of awards at the Greater Manchester 2013 Clinical Research Awards.
- With regards to Postgraduate Medical Education, an enhanced induction and support programme developed for internationally qualified doctors recruited to the Trust has been recognised by a number of Royal Colleges and won the LEAN Health Academy Awards in February 2014. With the appointment of key Associate Directors for Postgraduate Medical Education, support for our trainees and trainers continues to be strengthened.
- Maintaining and improving patient safety continues to be one of our priorities. This year we have seen an increase in reporting of incidents by 15%. We continue to be a high reporter to the National Patient Safety Agency when compared to similar Trusts. What this shows is that our staff feel confident to report when things go wrong. Without reporting an organisation cannot learn. We promote a safety culture to ensure that lessons are learned and harm is prevented in the future.
- We have managed to reduce harm from serious pressure ulcers by more than half.
- Infection rates – the management of infection is the responsibility of all staff and remains a priority for the organisation.
- We continue to support doctors through the revalidation process and have now provided them with a web based revalidation system. This system records every doctor's appraisal electronically, making it easier for them to store documents that will help to show that they meet the required standards of the General Medical Council (GMC).

In 2014/15 there will be many challenges ahead. We have again agreed a detailed and challenging work programme which will focus on many areas including:

- Mortality
- Safe Supervision (including ward rounds and handover)
- Leadership
- Patient Safety
- Dementia
- Sepsis
- Education
- Research and Innovation

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

Professor R C Pearson
Executive Medical Director

2013 – 2014 The Challenges Continue

The NHS has had a difficult year. Reports arising out of inquiries such as the Mid Staffordshire Hospitals and Winterbourne View remind us all again that the patient must be absolutely at the heart of everything we do. Here in Central Manchester, we again set out at the beginning of the year, to make improvements across many areas of care. Some of the key achievements are listed below:

- Increased performance on venous thromboembolism risk assessment to 96.58% at year end of 2013/14.
- Maintained low levels of serious harm and reduced the number of 'Never Events' reported and have continued to embed the processes we have put in place to further improve these.
- A further improvement with a 4% increase on the number of incidents reported by staff. We continue to be the highest reporter of incidents to the National Patient Safety Agency (NPSA) when compared to similar Trusts. This indicates that staff are confident to report and willing to learn when things go wrong.
- Successfully accredited all wards using the Improving Quality framework assessment.
- Reduced serious harm from medication incidents whilst maintaining a strong reporting culture.
- Received both praise and constructive criticism from the CQC on the quality of a number of our services.
- Trained more staff in Patient Safety (Human Factors) techniques.
- Implemented an assessment process and electronic flagging system to identify patients who have dementia or cognitive impairment.
- Improved our participation scores on our staff survey.
- Our researchers won a number of awards at the Greater Manchester 2013 Clinical Research Awards.
- We were nominated as a finalist and won an award in the LEAN Health Academy Awards in February 2014.
- We were a finalist at the CIPD awards for our work in supporting young people with learning disabilities to access work.

Quality Review

Darzi 2008, Francis February 2013, Keogh July 2013 and Berwick August 2013 all share one key finding; that we must constantly seek to improve the quality of care being delivered. Boards must drive that quality of care by fully understanding clinical outcomes and addressing problems as soon as they arise. The purpose of the Quality Review is first to ensure that the organisation can be fully assured of the quality of care being delivered and that it can identify, quickly, and respond effectively where improvement is required.

With this purpose in mind, the Board of Directors commissioned an internal Quality Review to strengthen clinical quality assurance information. This review has been led by the Medical Director and Chief Nurse/Deputy Chief Executive.

The CQC has helpfully set out five questions against which they intend to review clinical care going forward:

- is care **safe**?
- is care **effective**?
- are staff **caring**?
- is the organisation **responsive**?
- is the organisation **well led**?

The process for the Quality Review was aligned with those questions and sought to provide organisational assurance on quality of care. The Quality Review was also designed utilising the Trust values and behaviours framework and this very much formed part of the training and the ethos for the review.

Most importantly, the findings and resulting action should provide confidence going forward to all patients and service users that they will receive the best experience and the best care at the right time.

Terms of reference

These were simple and designed to give an understanding and balanced view of the way we deliver care to patients. The approach is straight forward and largely based on that used by Professor Keogh:

- to understand how care is delivered
- to identify areas of good practice and share these
- determine whether there are any sustained failings in quality of care or treatment
- identify whether these problems are known to the Division and whether appropriate action is planned and underway
- identify and advise on any additional remedial action required
- identify and escalate any areas of serious concern relating to safety or quality of care.

The visits were completed during October 2013 - January 2014.

Outcome of the Quality Reviews

The reviews have provided an in-depth picture of the quality of care across all of our services; we have found evidence of excellent practice in different areas, such as:

- learning from harm to improve safety
- use of the safe surgery checklist in Dental Services
- great patient feedback on friendly and caring staff
- staff working well together as multi-disciplinary teams and being proud of what they do
- reduction in falls and pressure ulcers
- improvements in the risk assessment of patients for venous thromboembolism
- excellent school and education facilities for children in hospital
- teams working well with the safeguarding team to protect vulnerable adults and children from harm

However, as expected, the reviews have also provided information on areas where improvement is required. These include:

- the use of paper records and the need to improve standards of record keeping
- changes to out of hours working to ensure consistency of care 24 hours a day, 7 days a week
- the transition of care from the Children's Hospital to the adult services
- consistent use of pathway documents and checklists across all clinical areas
- making sure incidents and complaints are properly fed back to all staff following investigation
- improvements to signposting across all of our hospitals
- making sure patients and visitors are happy with the choice of food available

The findings from the reviews have been used to inform our work plans for 2014/15 and they will also be repeated next year.

Part 2. Statement of Assurance and Priorities for Improvement from the Board of Directors

Priorities for improvement in 2013/14 and summary of progress

In 2013/14 we sought to improve performance across many areas of care. In the following section we present those areas of work with performance data. To provide the reader with an 'at a glance' view of performance we are using, as in previous years, our tick, dash, cross system. A green tick (✓) indicates that we met our objectives for the year, a dash (–) means we made good progress but did not quite reach our objective and a cross (✗) means we did not meet the objective and further work is required and will be undertaken.

We have set these out in the following table and the detail is contained over the following pages.

Statement 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 place in each Division. Action plans are developed where performance becomes unsatisfactory and regular reports are received at Board meetings and through the Board sub-committees e.g. the Clinical Effectiveness Committee and the Risk Management Committee.

During 2013/14 the Central Manchester University Hospitals NHS Foundation Trust provided and/or sub-contracted all services as set out as Mandatory Services under the Terms of Authorisation relevant health services.

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 relevant health 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 the Board of Directors to drill down and interrogate data to local level when areas of concern are identified or review is required. Therefore all the services fundamentally involved in the generation of NHS service income in 2013/14 were subject to a review of data quality. The Board is currently developing improved metrics for clinical reporting to further enhance the understanding of clinical outcomes.

The income generated by the health services reviewed in 2013/14 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2013/14.

Board of Directors Key Priorities for 2014/2015

In 2013/14 we set out our three key clinical priorities as Mortality, Harm Free Care and Dementia Care. We have worked with staff and patient groups to identify these as our priorities and have chosen them to reflect both national and local issues of importance. Our priorities for 2014/15 are Mortality, Harm Free Care, Dementia Care and Sepsis. We have chosen these because:

Mortality is one of the overarching indicators of quality of health care. The two key measures of mortality are HSMR and SHMI which should both be at 100 or below. Whilst the Trust HSMR is now below 100 in year the SHMI is not and therefore it remains a key priority. Information on measurement and previous performance is detailed within the report.

Harm Free Care provides us with a focus on four actual harms and allows us to develop improvements that are applicable across the whole patient safety agenda. We aim to have at least 95% of patients receiving harm free care, we have not yet been able to achieve that for pressure ulcers and have therefore kept this as a priority. Information on measurement and previous performance is detailed within the report.

Dementia Care is a specific condition which is a current national and local concern. We aim to ensure at least 90% of patients aged 75 or over are assessed and referred for support if required. Whilst performance is good and over 90% of emergency in-patients have been assessed we believe we still have some work to do and want to make this a priority for this year. Information on measurement and previous performance is detailed within the report.

Sepsis is a specific condition which is a current national and local concern where opportunities to improve care have been identified. Information on measurement and previous performance is detailed within the report.

These priorities have been set on the basis of Trust quality assurance metrics, the outputs from the Trust Quality Reviews (which included patient discussions) and discussion with our Governors. We have also taken into account wider public discussions and concern relating to Dementia in particular.

Alongside these we will present in this Quality Report other clinical priorities set for 2013/14 and the progress made as set out in the table over.

NHS Outcomes Framework

In this report you will see performance figures and, where possible, comparative information so that you can see how well we are doing alongside our other NHS colleagues. There are some indicators which are measured as part of the NHS Outcomes Framework and we are presenting those here. This is so that all organisations are clear about performance in these areas and that comparisons can be made.

The Outcomes Framework is a set of indicators designed to improve standards of care in five key areas:

The indicators presented here all directly inform the five key areas of the NHS Outcomes Framework above.

Summary Hospital - Level Mortality Indicator (SHMI)

The Central Manchester University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons.

The Summary Hospital-level Mortality Indicator (SHMI), introduced during 2011, is a method to measure hospital mortality. It is based on all patient deaths including those which happen up to 30 days following discharge from hospital. It relies heavily on accurate record keeping and coding. The patient case note is examined by clinical coding staff who reflect what doctors have written in relation to any existing conditions the patient has, such as diabetes, as well as their diagnosis for their current hospitalisation episode and any procedures undertaken. The patient's risk of dying is calculated using these measures. The baseline is 100, so a score below 100 means that mortality rates in an organisation are low (better) than expected.

We have carried out an extensive programme of work over the last few years to ensure that clinical coding accurately reflects the quality of care given. This work includes the coding team working closely with clinicians to ensure what is recorded in relation to patient care is accurately coded.

Indicator	Outcome/s	CMFT 2011/12	CMFT 2012/13	CMFT 2013/14	National Average 2013/14	Highest Performing Trust 2013/14	Lowest Performing Trust 2013/14
SHMI	To be confident that our mortality rate accurately reflects clinical practice, coding and data quality	110.6	110.5	103.90	100	62.6	115.6

Patient Reported Outcome Measures

The Central Manchester University Hospitals NHS Foundation Trust considers that this data is as described for the following reason; all patients undergoing these procedures have the opportunity to complete quality of life assessment questionnaires before and after surgery, the figures represent the percentage of patients reporting improvements in their health outcomes.

The Trust has supported fully the process for gathering patient feedback prior to surgical procedures as part of the pre-operative process. This is collected by surveys which are then returned to our survey providers, the questionnaires which are sent to patients following their surgery are co-ordinated by an independent survey organisation. By sharing patient level detail with clinicians we will ensure learning and development. We will also continue to promote the completion of the surveys and continue to work with our survey providers to achieve high quality data which allows comprehensive review.

Indicator	Outcome/s	CMFT 2011/12	CMFT 2012/13	CMFT 2013/14	National Average 2012/13	National Average 2013/14	Highest Performing Trust 2013/14	Lowest Performing Trust 2013/14
Groin hernia surgery	To improve health outcomes following each of the 4 procedures	64.50%	67.54%	TBC*	68.32%	TBC*	TBC*	TBC*
Varicose vein surgery		66.70%	61.29%	TBC*	74.72%	TBC*	TBC*	TBC*
Hip replacement surgery		85.70%	87.83%	TBC*	88.75%	TBC*	TBC*	TBC*
Knee replacement surgery		76.50%	85.82%	TBC*	83.95%	TBC*	TBC*	TBC*

The percentage of patients readmitted to a hospital within 28 days

The Central Manchester University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; as it is nationally standardised data which allows us to draw comparisons against the NHS as a whole. The Trust has in place a group of senior clinicians whose continual work programme is to develop schemes across hospital and community based services that aim to reduce the number of unnecessary repeat admissions into hospital. For example, bespoke management plans for some of our most complicated patients. Often these patients are unaware of alternative community based services which they could use instead of coming to hospital. Within our community services we have a very proactive team of Active Case Managers who have developed strong links with nursing and residential homes in the local area and now offer advice and assistance to those homes with the aim of keeping patients out of hospital in situations where this is most appropriate. Patients within nursing and residential homes had been identified as a group who were at a higher risk of emergency readmissions, and there is now demonstrable evidence in a reduction.

The Trust in collaboration with its primary care colleagues have participated in a further roll-out of the Practice Integrated Care Team (PICT) model within Central Manchester. PICT teams are multi-disciplinary teams with a membership from a wide clinical background and are centred around General Practice Surgeries in the locality. The primary function of the PICT teams is to review the care given to those patients who are most at risk of hospitalisation (or re-hospitalisation) and to develop care plans for these patients with the aim of keeping them as well as possible and in their own homes.

Indicator	Outcome/s	Relative Risk 2012/13	Relative Risk 2013/14	Actual 2013/14	Expected 2013/14	Super Spells 2013/14	Rate 2013/14
Aged 0-14	To reduce readmissions and improve health outcomes	94.2	94.6	2,640	2,791.48	34,832	7.58%
Aged 15 or over		96.9	97.7	6,502	6,652.62	96,808	6.72%

Trust responsiveness to the personal needs of its patients

The Central Manchester University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; the data is a direct extract from data provided by the Care Quality Commission based on scores from patients who participated in the national patient experience survey having spent at least one night in our organisation in July 2013.

Although the overall score for the five questions has fallen in 2013/14, compared to 2012/13, improvements have been seen in relation to the two discharge questions. This can be linked to programmes of improvement such as the friends and family test and improving discharge information. Following analysis of the separate questions it is noted that the lower score was caused by responses to the question 'did you find someone to talk to about your worries and fears?'. Internal monitoring of patient feedback each month, using electronic devices, shows a sustained improvement in scores for this question during quarter 4.

Indicator	Outcome/s	CMFT 2012/13	CMFT 2013/14	National Average 2013/14	Lowest Performing Trust 2013/14	Highest Performing Trust 2013/14
Amalgamated and adjusted scores from the 5 key questions in the national adult in-patient survey	To demonstrate continuous improvement in our responsiveness to the personal needs of our patients	67.1	65.6	TBC (not yet published)	54.4	86.0

The percentage of staff employed who would recommend the Trust as a provider of care to their family or friends

The Central Manchester University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The data below is taken from the 2013 NHS Staff Survey. Questions 12a, Q12c and Q12d feed into Key Finding 24: "Staff recommendation of the Trust as a place to work or receive treatment". This is weighted by the number of respondents who "agree" or "strongly agree" with each statement and are then given a score of between 1-5, 1 being the lowest and 5 being the highest.

For the 2014/15 Quality Report, data will also be taken from the Staff Friends and Family Test, which will be launched in April 2014.

The Trust has undertaken a number of actions to improve staff engagement and satisfaction, which is considered to be directly linked to the quality of service delivery. This is explored later on in the report in the 'staff engagement update' section. Actions have included Trust-wide focus groups and a brand new Staff Engagement approach, which will be launched throughout 2014.

Indicator	Outcome	CMFT 2012/13	CMFT 2013/14	National Average Acute Trust 2013/14	Highest Performing Acute Trust 2013/14	Lowest Performing Acute Trust 2013/14
Staff Survey Key Finding 24 – staff recommending the Trust as a place to work or receive treatment - an indicator of the Friends and Family Test	Staff report that they are treated with the appropriate values and behaviours by colleagues and by the organisation and that they would recommend the Trust.	3.66	3.71	3.68	4.25	3.06

The percentage of patients who were risk assessed for venous thromboembolism (VTE)

The Central Manchester University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. Patients are assessed, unless part of the agreed group of exclusions. This is documented and then checked by the coding team. All patients who have a correctly completed VTE assessment are coded accordingly and this is the figure presented.

The Trust has taken the following actions to improve this percentage and so the quality of its services by continuing a project to ensure electronic completion of this assessment for all patients as part of the Harm Free Care work. The aim is now to maintain a minimum of 95% compliance throughout the year.

Indicator	Outcome/s	CMFT 2012/13	CMFT 2013/14*	National Average 2013/14**	Highest Performing Trust 2013/14**	Lowest Performing Trust 2013/14**
VTE assessment	To risk assess 95% of appropriate patients (in previous years this has been a 90% target)	90%	96%	96	100	78

** Quarter 4 2013/14 ** Quarter 3 2013/14 NHS England*

The rate, per 100,000 bed days of cases of clostridium difficile infection in patients aged 2 or over

The Central Manchester University Hospitals NHS Foundation Trust considers that this data is as described for the following reason; as it is nationally standardised data which allows us to draw comparisons against the NHS as a whole.

The Trust has undertaken a comprehensive programme of work to achieve our objectives for this measure which has resulted in considerable improvements; many of these are described in this report.

Indicator	Outcome/s	CMFT 2012/13	CMFT 2013/14	National Average 2013/14	Highest Performing Trust 2013/14	Lowest Performing Trust 2013/14
Clostridium Difficile infection per 100,000 bed days	To reduce C Difficile infection	18.8	15.0	17.3	15.3	23.5

The rate of patient safety incidents reported and the number and percentage of such incidents which led to severe harm or death

The Central Manchester University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; increased reporting at low level of incidents, improved data quality checks.

The Trust has taken the following actions to improve incident reporting via the National Reporting and Learning System (NRLS), and so the quality of our service:

- Data quality management
- Awareness raising of need to report near misses
- Patient Safety Training which includes Human Factors
- Patient Safety Initiatives
- Harm Free Care initiative

Indicator	Outcome/s	CMFT Oct 11-Mar 12	CMFT Apr 12-Sep 12	CMFT Oct 12-Mar 13	CMFT Apr 13-Sep 13	Compara-tor Group Average 2013/14	Highest Performing Trust* 2013/14	Lowest Performing Trust* 2013/14
Rate of incidents per 100 admissions	5a Patient Safety incident reporting	10.7	12.12	13.7	12.84	7.98	12.84	4.87
Percentage of severe harm or death	5b Severity of harm	0.2	0.2	0.3	0.3	0.3	0.0	0.9

*This is based on the Acute Teaching Organisation cluster under the National Reporting and Learning system.

Priority	Page	2011/12	2012/13	2013/14
Patient Safety				
Acutely Unwell Patient	103	✓	✓	✓
Patient Harm Events	104	✓	✓	✓
Medication Safety	108	✓	✓	✓
Harm Free Care (key priority)				
• Venous thromboembolism	112	Not applicable	✓	✓
• Falls	112		✓	✓
• Pressure ulcers	113		✗	✓
• Catheter acquired urinary infection	111		✓	✓
Clinical Effectiveness				
Hospital Mortality (key priority)	115	–	–	✓
Infection prevention	116	✓	✗	–
Advancing Quality				
• Acute myocardial infarction (heart attack)	119	✗	✓	✓
• Coronary artery bypass graft (CABG)	120	✓	✓	✗
• Heart failure	120	✓	–	✓
• Hip and knee replacement	120	✗	–	✓
• Pneumonia	120	n/a	–	✓
• Stroke	121	–	✗	✓
Urgent care	121	✓	✓	✓
Fractured neck of femur	122	✗	✓	✓
Patient Experience				
Improving quality programme (IQP)	123	✓	✓	✓
Real time patient feedback	124	✓	✓	✓
Commissioning for quality improvement scheme (CQUINS)				
• Local	126	✓	✓	✓
• National	126	✓	✓	✓
End of life care	131	✓	✓	–
Single sex accommodation	131	✓	✓	✓

Patient Safety

The Acutely Unwell Patient

We continue to focus on ensuring that the care of our patients is safe and that patients who experience deterioration in their condition are promptly recognised and treated to ensure the best clinical outcome.

We are currently implementing an electronic system 'Patientrack', which allows ward staff to input clinical observations into an electronic system alerting the appropriate staff where the patient requires review or treatment based on their Early Warning Score (EWS). EWS is a 'track and trigger' tool which allows staff to recognise from patients clinical observations changes that indicate the patients clinical condition is deteriorating. We have completed implementation of 'Patientrack' within all adult areas on the Central site, and plans are in place to complete implementation Trust-wide by March 2015.

A key component to ensuring our staff have the right skills and knowledge to care for our acutely unwell patients, is the comprehensive programmes of education and ward based support that is provided by the Acute Care Team and our education teams within our clinical areas. Training is multi-professional; scenario based and allows staff to develop the vital skills and knowledge for managing the acutely ill patient.

In 2009, we began a process to review all cardiac arrests, emergency calls and incidents related to patient deterioration. These review meetings continue to be held weekly chaired by the Associate Medical Director and Deputy Director of Nursing. This has enabled us to identify any themes from these events and develop appropriate strategies to address these. It has also created a learning culture and enabled improvements in care to be made. This year has seen an increased focus on sepsis, with several Trust-wide audits undertaken and from these a Task and Finish; group set up to address the issues that were raised. The Ombudsman Report (2013) utilised patient stories to highlight poor recognition and treatment of sepsis across the country and has supported the work that we are doing.

Key themes and lessons learned from this year have been the following:

Problem	How was this identified	Intervention/on-going work
Lack of recognition in change of observation trend	Emergency bleep meeting cases	Training for staff by divisional educators and acute illness management courses
	Incidents	Feedback and training for junior doctors
	Analysis of readmissions to ICU	On the 'Patientrack' system there is a quick view for the charts and the new version of 'Patientrack' introduced in January has improved this function.
		E – learning altered for clinical mandatory training for all staff
		Divisional action plans have been created to address the issues

Problem	How was this identified	Intervention/on-going work
Fluid Balance not being accurate or completed and lack of timely escalation and response when abnormal	Emergency bleep meeting cases	Policy being re-written and re-launched
	Incidents	Training for Health Care Support Worker being reviewed
	Analysis of readmissions to Intensive Care Unit (ICU)	Training for staff by divisional educators and acute illness management courses
		Feedback and training for junior doctors
The evidenced based practice of instigating the sepsis six in severe sepsis is not always happening in a timely manner (the sepsis six is the six immediate care requirements including oxygen, fluid replacement and antibiotics)	Audit	Task and finish group set up
	Emergency bleep meeting	Case reviews with divisions
	Analysis of readmissions to ICU	Analysis of processes
		Review of interventions and change
		Pilot of interventions in 3 different clinical areas which will review the use of a sepsis trolley and increase training.
		Policy review
		Feedback and training for Foundation Year Doctors in their first year (FY1's)
		Training for staff by Divisional Educators and acute illness management courses

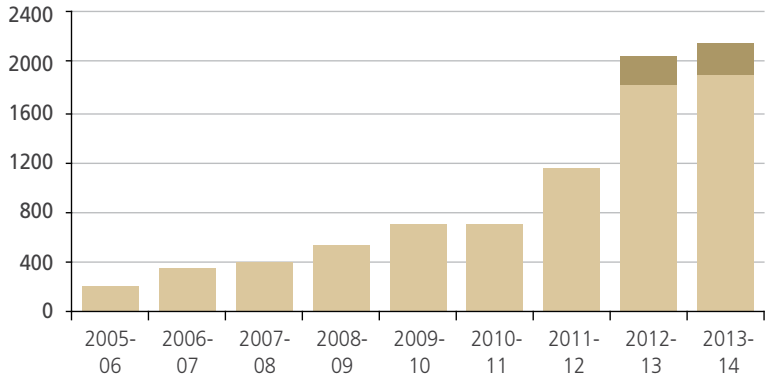
The learning and on-going development of our practice in acute care continues, which allows us to learn, improve and ensure safety and the best care for our patients. The continued use of information from our staff through incident reporting to raise the issues at the Emergency Bleep meetings, allows discussion and learning when we review the cases. This ensures that we do not become complacent but learn and transform our care.

Patient Harm Events/Learning from incidents

Our aim for this year was to increase reporting of Patient Safety Incidents (PSI) by at least 5%.

We have succeeded in achieving a 4.5% increase in Patient Safety Incident reporting this year. This shows that we have continued to raise the importance of reporting incidents and near misses, which has resulted in increased reporting this year. We increased our patient safety incident reporting by 4.5% and, although not 5% our originally set target, this is still an achievement as we remain the highest reporter of incidents to the NPSA when compared to similar Trusts.

Figure One - Average patient safety incidents reported per month



Note as of 1st April 2012 the Trust merged with Trafford Hospital their data is highlighted in the darker colour

Figure Two

Financial Year	Patient Safety Incidents	Average PSIs per month
2005-06	2311	193
2006-07	4115	343
2007-08	4691	391
2008-09	6378	532
2009-10	8322	694
2010-11	8354	696
2011-12	13787	1149
2012-13	21857	1821
2013-14	22826	1902

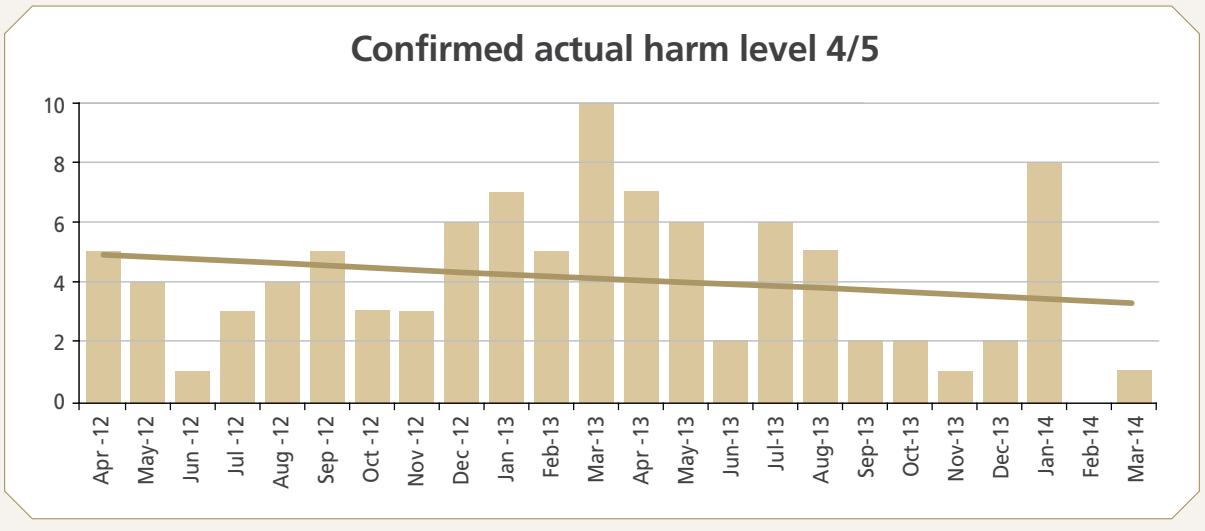
For an organisation to learn and improve it is vital that staff feel comfortable to report when things go wrong. Trusts that report more incidents usually have a better and more effective safety culture.

We have seen a yearly increase in reporting which is good as whilst the numbers of incidents reported has increased, the serious harm that patients experience has gone down (as seen in the graphs below). This is because our staff are reporting more near misses which means we can learn from these and put things right before more serious incidents occur.

Actual Harm level 4/5 incidents

Whilst our aim is to increase incident reporting it is also to reduce the levels of serious actual harm, the graph below demonstrates all actual harm incidents at level 4 and 5 which are the most serious incidents. It can be seen that a reduction in these was achieved over the last year.

Figure Three



NB. Please note the figures presented now include fractured neck of femur as a result of a fall, previously these were presented separately.

Examples of Learning from Incidents

We undertake Patient Safety Training to help staff understand how errors can occur and after every incident we review what happened and where possible make changes to prevent the same thing happening again, examples of some of the actions following incidents are given below.

- Work has been done in out-patient settings to improve safety of procedures undertaken
- Changes to the style of site marking for procedures
- Implemented a Task and Finish Group for safe procedures
- Work within Trafford division to ensure the adoption of consistent procedures across the Trust
- Implementation of acute kidney injury tracking and employment of specialist nurse to support this
- Education on fluid balance
- Training and development linked to patient safety incidents for example AIMS course
- Further rollout of electronic observation and alert system
- Review of paediatric EWS system
- Implementation of hoist alert and checklist

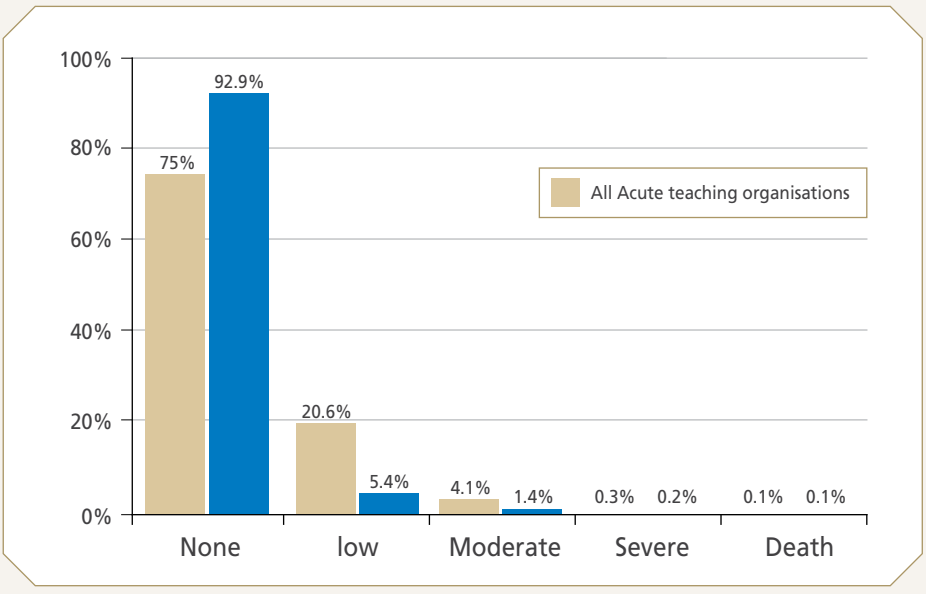
Planned work programmes include:

- Task and finish group for communication of test results
- Collaborative work with other organisations on management of acute kidney injury
- Task and finish group for safe procedures
- Development of electronic patient record

Comparison with other Trusts

We report all our Patient Safety Incidents to NHS England (NHSE) and they use this information to compare us with other Trusts that are similar to us.

Using the information from them we can see that we are the highest reporter of incidents when compared to similar NHS Trusts. The Trust reported 13.7 incidents per 100 admissions in period October 2012 to March 2013.



The graph from the NHSE above shows that 93% of incidents reported by us are at no harm compared to all other organisations level of 75%. This shows that the increased reporting of incidents is those at the lower level.

Shelford Group

The Shelford Group describes a selection of hospitals that are very similar to us, this makes them ideal for us to compare our services with. We have done this for actual harm levels as shown below.

% of Incidents Resulting in Harm	None	Low	Moderate	Severe	Death
Central Manchester University Hospitals NHS Foundation Trust	92.9	5.4	1.4	0.2	0.1
Imperial College Healthcare NHS Trust	90.0	7.1	2.7	0.1	0.1
Cambridge University Hospitals NHS Foundation Trust	83.8	13.9	2.0	0.3	0.0
King's College Hospital NHS Foundation Trust	84.5	11.9	3.2	0.3	0.1
University College London Hospitals NHS Foundation Trust	80.7	10.8	8.0	0.5	0.1
Sheffield Teaching Hospitals NHS Foundation Trust	78.4	18.9	2.4	0.3	0.1
University Hospital Birmingham NHS Foundation Trust	77.2	21.7	0.9	0.2	0.0
Guy's And St Thomas' NHS Foundation Trust	74.0	23.8	1.9	0.1	0.2
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	65.2	32.4	1.8	0.6	0.0

Type of Incidents Reported

Laboratory testing remains our highest reported incident however this is now closely followed by access, admission and discharge and treatment/procedure both of which have increased this year. Falls, Medication errors, Pressure Ulcers and infrastructure incidents have decreased.

Type of Incident	2012/13	2013/14	Change
Laboratory Tests	2877	3016	▲
Access, Admission, Transfer, Discharge	2032	2773	▲
Treatment/Procedure	1974	2509	▲
Falls	2475	2290	▼
Medication Error	2113	2079	▼
Infrastructure (Staffing/Environment)	2371	1724	▼
Documentation	1292	1312	▲
Communication	945	1309	▲
Pressure Ulcers	1303	1140	▼
Clinical Assessment	747	1112	▲
Medical Device, Equipment	755	909	▲
Maternity/neonatal	797	882	▲

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' and we have risk assessments and measures in place to prevent these, however despite this we have had 8 in 2012/13 and a further 3 in 2013/14 all of which are related to safe surgery/interventional procedures in all settings.

Following these events full investigations were undertaken and actions completed which included changes to style of site marking, implementation of checking procedures and checklists for procedures undertaken in out-patient settings.

Being Open

Being Open refers to communicating honestly and sympathetically with patients and their families when things have gone wrong. Our policy is that following any incident resulting in harm information must be given to the patient and or their relatives as soon as possible after the event including the investigation findings and actions planned. This year we have implemented a new monitoring process to ensure this process is completed in a timely manner.

Medication Safety

The organisation has worked hard to improve all areas of patient safety over the last few years and medication safety is no exception.

We set out to reduce serious harm (level 4 and 5) and maintain a strong culture of reporting medication safety incidents and we have done that. Below is a table comparing medication incident severity from last year and this this year 2013-2014).

Medication Error Incidents

Actual Impact	2012-13	2013-14
1 No Harm	2080	2014
2 Slight	20	41
3 Moderate	10	24
4 Major	2	0
5 Catastrophic	1	0
Total	**2113**	**2079**

A high number of reported patient safety incidents is a sign that there is a fair and open culture where staff learn from things that go wrong and serious incidents occur rarely. The Trust is one of the higher reporters of patient safety and medication safety incidents compared with other similar organisations.

We have seen a reduction in overall reported serious harm from medication safety incidents in 2013/14. If serious incidents occur they are fully investigated and measures put in place to prevent similar incidents occurring again and we continue to strive to prevent all such incidents.

There were no medication-related Never Events reported in 2013/14

Progress

We use a number of strategies to improve medication safety and some of these are listed here:

- Piloting and introduction of the Medicines Safety Thermometer a national tool that is designed to give a snap shot on one day each month to help us understand more about medication safety and harm from medication error. It focuses on key medication safety themes such as allergy and omitted medicines and high risk medicines such as anticoagulants and insulin
- Work on the reduction in the number of incidents for some high risk medicines and key incident themes including Insulin and Penicillin Allergy
- Trust-wide Medicines Safety Bulletins on safe administration of oral medicines and prefilled syringes to raise awareness of key medication safety issues
- Updated Mandatory Trust Medicines Safety Training

- New E-learning Prescribing Competency Tutorial and Assessment Tests for new doctors
- Improvements in the safe and secure handling of medicines
- Expansion on the provision of Pharmacy services at evenings and weekends and a pharmacist available in the hospital at all times
- Introduction of a Home Intravenous Antibiotic Service to allow patients to receive treatment at home instead of staying in hospital
- Expansion of the Homecare medication service to reduce the need for patients to be admitted to hospital solely for medication administration
- Improved access to information about medicines and prescribing on our staffnet (intranet)

But we want to do more so this year we will:

- Implement an Electronic Prescribing and Administration System for Chemotherapy
- Obtained funding for a Trust-wide Electronic Prescribing and Administration system that can deliver improvements in medicines safety. (This money has been successfully obtained following a bid for to the 'Safer Hospitals Safer Wards Technology Fund)
- Pilot access to the medication information on the National Summary Care Record to improve timely and accurate prescribing and administration of medicines on admission to hospital
- Introduce a needle-free reconstitution device for intravenous antibiotics to help with timely and safe administration
- Our Medicines Safety Steering Group will lead on initiatives to improve safety with opioid medicines and reduce omissions of medicines
- Use the Medicines Safety Thermometer to develop improvement plans for medication safety and participate in other Medicines Safety initiatives in the North West Region

Harm Free Care

We have been committed to the national Harm Free Care (HFC) campaign since 2012 when the NHS Safety Thermometer was introduced. The NHS Safety Thermometer provides information about harms and the proportion of patients that are 'harm free' during their period of care. National requirements involve collecting the data once per month from patients in the acute hospital and within community settings. We implemented an electronic recording system within the nursing handover, in 2012, to enable collection of this information on all patients, every day within the hospital setting.

As part of our Harm Free Care campaign a launch event took place in July with a specific focus on reducing both the incidence and prevalence of pressure ulcers (grade 2-4) and falls with harm (Grade 2-5).

We continue to submit monthly data via NHS Safety Thermometer as required for the three specified harms: falls with harm, pressure ulcers (category 2-4), and catheter acquired urinary tract infections (CaUTI).

What

- To submit monthly harm free care data to the NHS Information Centre
- To support staff to use the Improvement Methodology (Improving Quality Programme) to focus improvement work on Falls and Pressure ulcers as indicated
- To develop information systems at Trafford so that staff can access the electronic nursing handover allowing them to record harm free care every day

- To develop the electronic nursing handover to include documentation nursing risk assessments for falls and pressure ulcers. As a result risks of harm can be automatically displayed on the nursing handover sheet

How Much

- All in-patient wards and community district nurse teams submitting data every month using the NHS safety thermometer
- All divisional Heads of Nursing to ensure attendance at the harm free care meeting, where progress in relation to reducing harms from falls and pressure ulcers is monitored and support in focused improvement work is identified
- All Trafford wards to use the electronic nursing handover system to complete real time recording of harms each day in line with the acute in-patient wards on the central site
- All wards on central site to have access to electronic risk assessments for pressure ulcers and falls within the electronic nursing handover

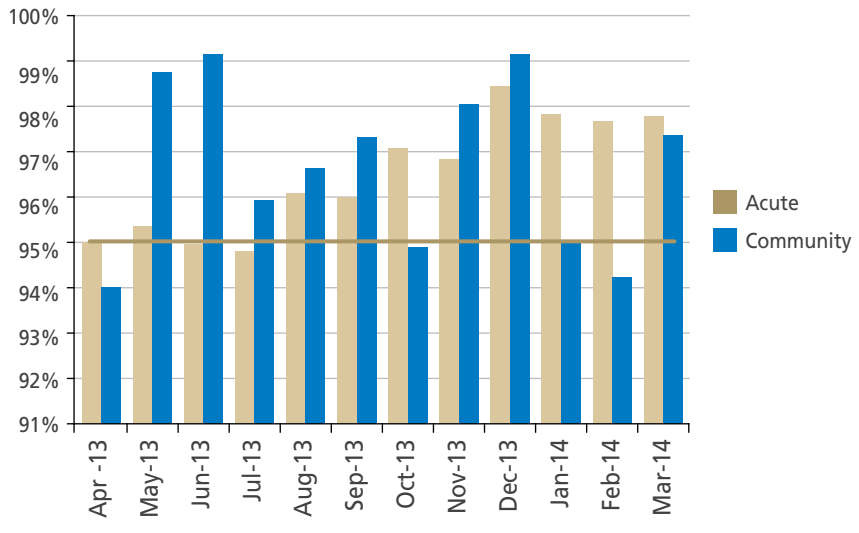
By When

- March 2014

Outcome

- All acute hospital wards and district nursing teams submit data to the NHS information centre on set day each month via the NHS Safety thermometer
- Harm free care meetings have been established quarterly and are chaired by Director of Nursing. These have been well attended by all Divisions. Using the Improving Quality Programme, additional support has been given by the Deputy Director of Nursing, the Corporate Lead nurse and the service improvement team to ward teams as identified
- Further development of the electronic nursing handover has been completed to enable access from the Trafford site. This has been successfully tested in one ward area. Plans are now in progress for the roll out of this across the remaining wards at Trafford following the service reconfiguration
- Electronic risk assessments for falls and pressure ulcers have been developed within the electronic nursing handover at the central site. These were launched in October, allowing risks of falls and pressure ulcers to be highlighted on the nursing handover sheet

% patients receiving harm free care based on monthly prevalence data submitted via NHS safety thermometer



Catheter Associate Urinary Tract Infection (CaUTI)

This is defined as a urinary tract infection acquired whilst a patient has a urinary catheter in situ.

What: To establish a 12 month baseline of the number of catheter associated urinary tract infections. Monitoring began in September 2013.

By when: March 2014

Outcome Achieved ✓

Progress

We have revised the policy for patients with a urinary catheter and aligned this policy to include the policy for the community patients so that patients receive a consistent standard of care based on best practice including alternatives to urinary catheterisation.

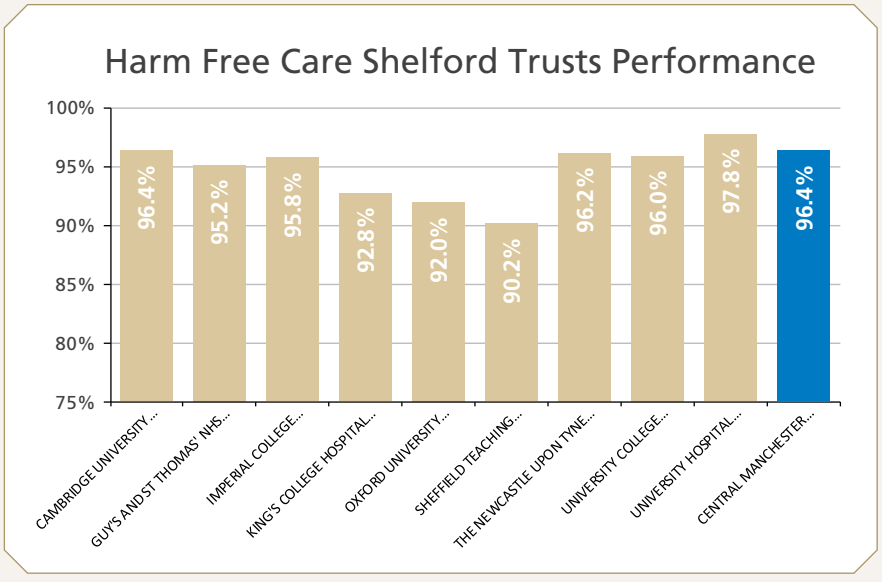
Specialist nurses have conducted local training sessions for staff that care for patients with a urinary catheter. This training took into account selection of catheter type as well as catheter insertion and maintenance.

An electronic data base is being established to record the incidence of CaUTI. All clinical teams are aware that the performance in this area of practice must improve and each clinical division will be responsible for implementing a structured process for reviewing and monitoring the incidence of catheter associated urinary tract infections and use improvement methodology to support their improvement plans.

The monitoring of the incidence of CaUTI has been identified as one of the key preventables in the harm free care programmes. Zero tolerance to the acquisition of CaUTI will form the basis of the following work programme for 2014/15:

- Each incident of CaUTI will be reported, investigated and lessons learned will be disseminated through our harm free care group.
- An audit has been undertaken of in-patient urinary catheters of which the results are being collated. The results will be used to identify themes and additional work streams.
- Following on from the revision of the urinary catheter policy we will implement the integrated care pathway and new patient information leaflets.
- Continue our programme of education and training to staff working in both hospital and community services.

The following graph shows Central Manchester University Hospitals NHS Foundation Trust performance alongside similar organisations (known as the Shelford Group).



Venous Thromboembolism (VTE)

The organisation has worked to improve on the achievement of 90% of all appropriate patients being assessed for their risk of developing a VTE and move to 95%. We can report that we achieved this in year. This year we have been continuing the work to reduce significantly the incidence of VTE as part of our 'Harm Free Care' programme of work.

A process of local investigation has been established to review each individual case when a hospital acquired thrombosis is diagnosed. This has given us some valuable information and enabled us to target improvement work to improve performance in this area.

Electronic systems for the capture of VTE information have been developed and are in place in some areas in the Trust. We are looking to roll this out Trust wide by the end of next year.

What: Achieve 95% performance on risk assessment by end quarter 4 of 2013/14

Achieve 95% compliance with root cause analysis investigation on identified hospital acquired VTE by quarter 4 of 2013/14

How much: Minimum of 95% for both measures

By When: During 2013/14

Outcome: At least 95% of appropriate patients risk assessed every month and 96.3% of investigations complete

Progress: ✓

Reduction in Harm from Falls

What: To reduce the overall number of falls and the number of serious harms caused to patients as a result of fall

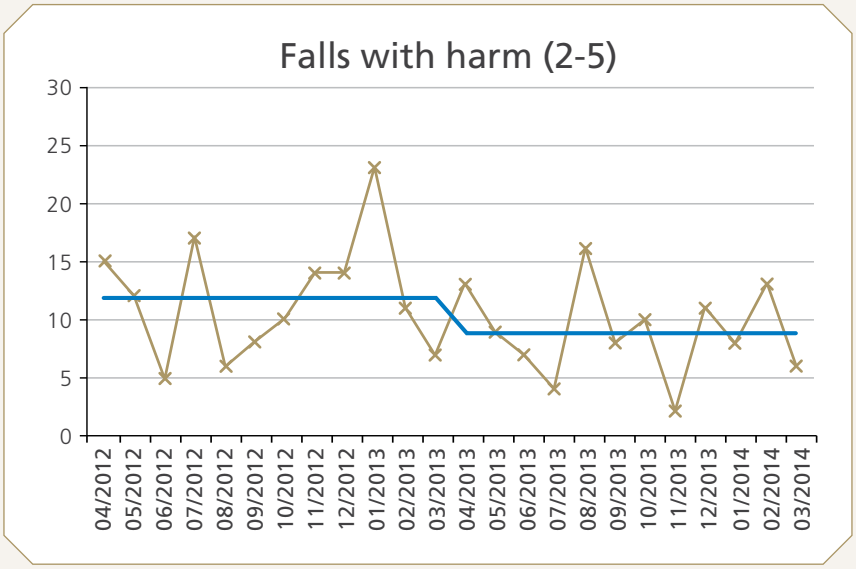
How much: To reduce overall the number of falls and serious harm below that of 2012/13 in 2013/14

By when: March 2014

Outcome: There has been an overall reduction of 8% of all patient falls. There has been a reduction of 25% of falls recorded with harm (severity 2-5)

Progress: ✓

We are committed to improving the reduction of patient falls and have seen an overall reduction of 8% of all patient falls and a reduction of 25% of falls recorded with harm (severity 2-5).



Severity of Harm from Falls

Actual Impact	2012-13	2013-14
No Harm	2335	2186
Slight – Moderate (level 2-3)	111	81
Major Harm	29	23
Total (level 4-5)	2475	2290

Each clinical division has established a structured key performance indicator (KPI) process for the monitoring of the incidence of falls and the use of improvement methodology to support their improvement plans. The Harm Free Care Monitoring Group has been established to monitor the progress of these groups.

A revised electronic falls risk assessment has been introduced following NICE guidance (2013) identifying all patients over 65 years as at risk of falls. The electronic risk assessment together with an electronic flagging system ensures all patients are assessed and identified at risk of falls within six hours of admission and placed on an appropriate plan of care.

The organisation is committed to improving performance and reducing patient falls, particularly those with harm. To support Divisional improvement plans and analysis of falls incidents, an electronic root cause analysis tool is to be introduced to support the investigation and learning from all patient falls. Divisional trajectories will be set for 2014/15 with a focus on reduction of falls with major harm (level 4-5).

Reduction in Harm from pressure ulcers

What: To reduce harms caused to patients from pressure ulceration

How Much: To reduce the number of acquired pressure ulcers from 2013/14

By When: March 2015

Outcome: We have achieved a reduction in all pressure ulcers graded 2 to 4.

Progress: ✓

Following the progress of 2012/13 to reduce the number of acquired harms from pressure ulceration we have continued to focus on improving care and reducing the number of pressure ulcers across community and hospital services. There has been a specific focus on raising awareness and the organisation took part in the 'Stop the Pressure' awareness day. This is a worldwide event to raise awareness of pressure ulcer prevention and management to patients, carers and staff. The day was well received. The event enabled staff, patients and carers to look at equipment, dressing products, obtain advice with regards to pressure ulcer management and gain an insight into our goal of reducing pressure ulcer harms.

Work has focused in four specific areas. Achievements in these areas are identified below:

1. Systems and processes to identify and report pressure ulcers

There has been a further revision of the pressure ulcer policy to incorporate national guidance and to cover acute, community and children's services. This policy has been implemented within all Divisions. New documentation including a skincare bundle has been introduced which includes risk assessment through a purposefully designed tool called the Waterlow Score and guidance on the appropriate care of skin and management of pressure ulcers.

All pressure ulcers are now reported on a single unified system and identified as new or existing. Improved reporting systems enable senior nurses to access real-time information about the number, grade and location of pressure ulcers. This has supported the identification of any trends within Divisions and improved the management of pressure ulcers and reduction in incidence.

2. Best evidenced-based practice

Increased investment in the tissue viability team has enabled all grade 3 and 4 pressure ulcers to be reviewed, in person, by the specialist team within 48 hours. A telephone and triage advice service has been implemented to support the management of all other pressure ulcers.

Harm Free Care meetings have been established within the hospitals divisions which are attended by a specialist tissue viability nurse. For all pressure ulcers graded at level 2 and above, a root cause analysis (RCA) is undertaken to establish improvements in care at a local and organisational level. Each RCA is presented at divisional harm free care meetings which ensure every patient with a pressure ulcer has the correct management plan. These meetings also identify trends and hotspots within divisions and develop specific evidence-based strategies to reduce incidence.

3. Knowledge and skills of staff

The tissue viability/infection prevention and control team has been expanded to ensure that specialist clinical advice and support is available within each of the divisions. Education and training has been on-going throughout the year via study days, divisional induction programmes and ward based training. These have increased the knowledge and competency of nursing teams.

4. Equipment

There has been a Trust-wide review of the provision of all equipment and devices such as mattresses and cushions used to prevent pressure ulcer and an increase in the provision of equipment.

A new equipment contract started in April 2014 improving accessibility to pressure relieving equipment.

Further Improvements Identified for 2014/15

- Continuous engagement of staff across the organisation
- Trust documentation will be reviewed to incorporate practice developments
- Development of standard patient information leaflets
- Further reduction of all grades of pressure ulceration

Clinical Effectiveness

Hospital Mortality

There are a number of key mortality measures and these are reported publically. Two of the main indicators are Summary Hospital–level Mortality Indicator (SHMI) and Hospital Standardised Mortality Indicator Ratio (HSMR). Both of these indicators have a standard expected of 100 or below. Patients, the public and ourselves must be assured through SHMI/HSMR of less than 100 that clinical quality is high and that mortality is at the expected rate.

The key differences between HSMR and SHMI are:

- SHMI includes all deaths, while HSMR includes only a compilation of 56 diagnoses (which account for around 85% of deaths)
- SHMI includes post-discharge deaths while HSMR relates only to 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 sources. These 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 such as national audits, confidential enquiries and in particular the contribution of adult and children's critical care to national data sets.

As detailed at the beginning of this Quality Report, it is of paramount importance that documentation and accurate coding support these data, but most importantly that the care delivered is of the very best standard.

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 93.10 and SHMI 103.90)

By When: March 2014

Progress: ✓

Action

This year we have improved our system for reviewing deaths, a mortality review tool is used and an online system has been developed to make sure doctors have easy access to information that they need to review.

There are continued efforts to improve our clinical records to make sure that all our data on care quality is correct. This enables us to then look at all the information needed and ensure we are delivering the best possible care.

We are also working to understand all of our other 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 continues to be to reduce both our HSMR and SHMI scores to below the national average.

Infection Prevention and Control

Infection prevention and control remains a high priority in our organisation. Protecting our patients against infection is a key priority and one which we consider to be the responsibility of all staff. We have a highly experienced infection prevention and control team including specialist doctors and nurses who are highly visible to provide support and education.

Methicillin Resistant Staphylococcus aureus (MRSA)

Healthcare associated infection presents a huge problem to hospitals and contributes significantly to patient morbidity and mortality (BMA 2006).

It is estimated that 3% of the population carry MRSA harmlessly on their skin, but for our patients the risk of infection caused by MRSA may be increased due to the presence of wounds, or invasive treatments. MRSA may result in blood stream infections (bacteraemia).

What: To reduce the number of cases of MRSA bacteraemias (bloodstream infections)

How Much: Zero avoidable infections

By When: March 2014

Outcome: 8 of which 4 were avoidable and 4 were unavoidable

Progress: 

The total number of reportable MRSA bacteraemia is eight. It was disappointing that four of these were judged to be avoidable infections by the review panel.

These cases are investigated with all staff involved using a detailed root cause analysis. We aim to learn from these situations and share the lessons learnt through the Infection Control Committee.

Clostridium difficile Infection (CDI)

Clostridium difficile infection can cause serious illness. It usually affects elderly and very unwell patients who have received antibiotics (Department of Health 2010). We are pleased to be able to report that we have achieved a further continued reduction in the number of cases of *Clostridium difficile* infection.

What: To reduce the number of cases of CDI

How much: No more than 51 cases

By when: 31st March 2014

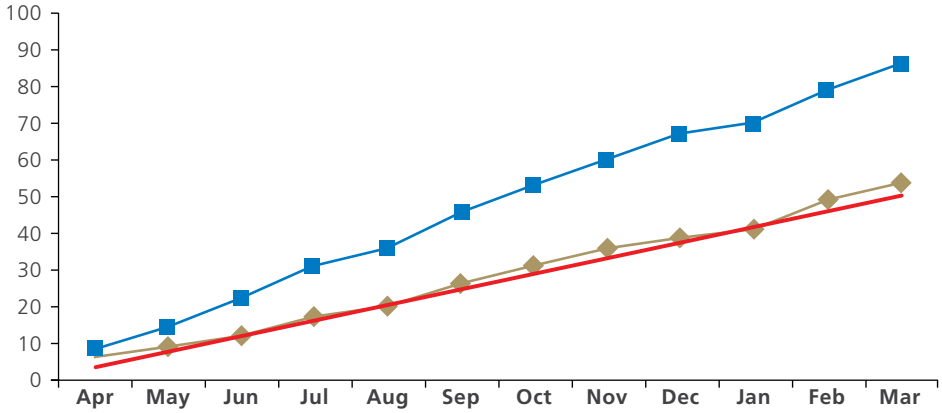
Progress: 

Outcome: 54

Reducing numbers of cases of Clostridium Difficile Infection

- All cases are investigated and reviewed weekly at a multi-disciplinary meeting. The themes identified from the weekly reviews have demonstrated that antibiotics have been appropriately prescribed and there has been no evidence of cross transmission.
- From February 2013 all patients with Clostridium difficile infection are seen on a weekly ward round by a microbiologist and the antibiotic pharmacist.
- For all our suspected and confirmed cases strict infection control measures are put in to place to minimise the risk of spread of infection to other patients.

Incidents of *Clostridium difficile* Infection April 2013 – March 2014



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Apportioned	6	9	12	17	20	26	31	36	39	41	49	54
Reported	8	14	22	31	36	46	53	60	67	70	79	86
Trajectory	4	8	13	17	21	25	29	33	38	42	46	51

Carbapenemase-producing Enterobacteriaceae (CPE)

Carbapenemase-producing Enterobacteriaceae (CPE) is the name given to bacteria in the gut which have developed resistance to a group of antibiotics called carbapenems. Infections caused by CPE bacteria can usually still be treated with antibiotics. However, treatment is more difficult and may require combinations of drugs to be effective.

Actions to Control and Manage the Incidence of CPE at the Trust

- The first CPE was identified at the Trust during 2009/10, however despite strenuous efforts the numbers have increased since then
- We have worked closely with experts at Public Health England both nationally and locally to develop policies to overcome this emerging problem
- Our screening programme is broader than any other UK organisation and we actively screen patients for CPE in order to identify those who may be at risk of a clinical infection in a timely fashion so that if necessary they can be treated with appropriate antibiotics
- The majority of patients that we find are carrying CPE and do not require further treatment. However; we isolate all cases in either single rooms or in cohort bays

Blood Culture Contamination Rates

What: To continue to maintain low contamination rates for blood culture sampling

How Much: Overall compliance no more than 3%

By When: March 2014

Outcome: Achieved

Progress: ✓

All clinical staff who undertake blood culture sampling are trained and Assessed in Aseptic Non Touch Technique (ANTT) (the technique used for inserting and handling invasive devices, such as intravenous lines).

Further Improvements Identified

Our continued works include:

- Continuous engagement of staff, patients and visitors
- Continue to investigate and review all CDI, MRSA bacteraemia and CPE cases
- Additional joint microbiology/antibiotic ward rounds
- As part of our efforts to keep the high profile of infection prevention and control importance we will be holding rolling hand hygiene awareness campaigns every quarter
- To support staff in preventing central line catheter (CVC) associated infections we are updating our policy for CVC policy, devising care pathways and information leaflets for patients

We will be participating in trials of technologies to reduce the risk of environmental contamination.

Focus on Infection Prevention and Control

Infection Prevention and Control remains one of the top priorities for our organisation.

The Infection Prevention and Control team, which includes both specialist doctors and nurses, are highly visible in the clinical areas to provide advice and support to both patients and staff.

We are proud of all the continued hard work and effort that our staff put into preventing the risk of infection to our patients. We ran a Six Point 60 Day Hand Hygiene Campaign to emphasise the importance of hand hygiene from October to December 2013.

As part of the campaign awareness events stands were displayed in each atrium and several out-patient departments and were manned by the Infection Prevention and Control team and staff from each division. The launch was successful with positive feedback being received with staff, patients and visitors.

During December the Manchester Royal Eye Hospital encouraged all patients, visitors and staff to pledge that they would practice appropriate hand washing by asking them to sign their names on a green paper hand which they then displayed in the form of a Christmas tree.

Staff Flu Vaccination Campaign

Our recent campaign to vaccinate as many staff as possible against winter seasonal flu has been hailed a great success, resulting in the Trust being nominated in the most improved category of the NHS Employers Flu Fighter Awards 2013/14.

This year's Flu Campaign saw the highest uptake rate we have ever achieved with 75.4% of frontline healthcare workers coming forward to be vaccinated. Because of this we were invited to an awards ceremony in February 2014 which members of our Flu Fighter team attended.

The programme was co-ordinated and developed by a multi-disciplinary planning group consisting of members from the Infection Prevention and Control team, Occupational Health, Pharmacy, Communications, and senior nurses from all parts of the organisation.

With support from the Heads of Nursing, over 80 senior nurses from all divisions volunteered as key staff vaccinators and attended update training in administering vaccines to staff. Vaccination clinics were provided at local work bases across the organisation by the key vaccinators, with additional flu clinics provided by the Occupational Health Department.

This campaign was not just about protecting our staff but also about protecting patients.

Advancing Quality

Advancing Quality (AQ) is a North-West quality initiative introduced in 2008. AQ aims to improve standards of healthcare provided in NHS hospitals across the North West of England and reduce variation. Every NHS acute and mental health trust across the North West of England participates in Advancing Quality (AQ).

Focusing on several clinical areas which affect many patients in the region – acute myocardial infarction (heart attack), coronary artery bypass graft (heart bypass surgery), heart failure, hip and knee replacement surgery, pneumonia, and stroke. Advancing Quality works with clinicians to provide NHS trusts with a set of quality standards which define and measure good clinical practice.

Focus Area	2013/14 Target	2013/14 Performance *(April to Dec)
Acute Myocardial Infarction (AMI)	79.87	81.86%
Coronary artery bypass graft (CABG)	92.94	76.57%
Heart Failure	62.15	62.89%
Hip and Knee	82.02	83.60%
Pneumonia	61.07	76.41%
Stroke	53.64	59.61%

**Please note that as of April 2013 the scoring system by which the advancing quality measures were assessed was revised. 2012/13 performance was measured against the composite process score (CPS) which used an aggregate score that reflects the number of opportunities to 'do the right thing' and the proportion that were achieved.*

Whilst 2013/14 performance utilises the appropriate care score (ACS) which measures the proportion of patients that received all of the relevant interventions and is therefore a measure of 'perfect care'. This means that direct comparison of figures with the previous year is not possible.

Acute Myocardial Infarction (AMI)

Over 600 patients who suffer Acute Myocardial Infarctions are treated annually at Manchester Royal Infirmary. All patients are treated with primary percutaneous coronary intervention (pPCI). This means we treat by balloon angioplasty and stenting rather than using clot busting drugs. The current AQ standard is that patients should receive pPCI within 90 minutes of hospital arrival. The current average time to pPCI at Manchester Royal Infirmary is 55 minutes. We are also achieving the AQ standard in a number of other measures including giving patients smoking cessation advice, referring to cardiac rehabilitation services, measuring function of the left side of the heart prior to discharge and discharging patients on the best drug treatments including ACE inhibitors, Beta-blockers, Statins and Aspirin.

Coronary Artery Bypass Graft

Over 700 heart operations are performed each year at Manchester Royal Infirmary, the majority of which are coronary artery bypass operations. The current AQ measures include patients receiving appropriate antibiotics within one hour of surgery, use of internal mammary artery during surgery and patients being discharged on Aspirin and Statin treatment, all of which are being achieved. Considerable work has been done to ensure completion of the surgical checklist which has resulted in achieving the AQ standard since November. In addition, there is a CQUIN to ensure in-patients receive coronary artery surgery within seven days of referral and acceptance for surgery which is currently being achieved.

Heart Failure

Over 500 patients in hospital are seen annually by the Heart Failure service at Manchester Royal Infirmary. The current AQ standard includes measurement of left ventricular function, pre-discharge advice about diet, activity, follow-up, medication and weight monitoring and smoking cessation advice if needed. For patients with severely damaged heart pumps, there are also AQ standards for review by a heart failure specialist in hospital and use of the best medications (ACE inhibitors and beta-blockers) at discharge. We are currently achieving all AQ standards for heart failure.

Hip and Knee

The Advancing Quality Programme for Hip and Knee Replacement in Orthopaedics has been going on for six years. We have performed 456 hip and knee replacements in the first eight months of the financial year 2013/14. We have achieved 83.59% success for the first eight months compared to our target of 82.092% for the whole year.

The Advancing Quality in hip and knee replacements looks at six standards:

1 Prophylactic antibiotic administered within one hour prior to skin incision
2 Correct antibiotic regime chosen
3 Antibiotics stopped within 24 hours after surgery
4 DVT prophlylaxis given within 12 hours of surgery
5 Proper DVT prophylaxis regime chosen
6 Appropriate duration of DVT prophylaxis

We have designed an A4 size form for prospective data collection. We have two nurses who gather data about patients from MRI and Trafford respectively. We have also designed stickers for prescribing antibiotic and DVT prophylaxis after surgery. All junior doctors are informed about the AQ criteria at the time of induction. We regularly audit our results to improve our standards.

Pneumonia

The number of patients seen with pneumonia within Manchester Royal Infirmary is on average 61 patients per month. Currently we are on target to achieve the Pneumonia AQ standards for the year 2013/14.

The areas assessed for pneumonia AQ standards include appropriate selection of antibiotics, antibiotics initially given within six hours and smoking cessation advice. To support this, the information is collected on a sticker that is placed within the patient's notes and this enables accurate auditing and reporting processes.

To ensure that this standard continues to be achieved, education sessions will take place for new doctors. In addition the Emergency Department team will have regular training sessions so that the treatment can be started as soon as possible on attendance which significantly improves patient outcomes.

Stroke

The Stroke Service and Unit at Manchester Royal Infirmary see around 100 patients each year who suffer a stroke. It implemented a number of improvement initiatives in 2013 that have resulted in the achievement of the AQ target from July to November 2013. The current AQ measures for Stroke include direct admission to a stroke unit within four hours of hospital arrival, brain scan within 24 hours of admission and the administration of Aspirin within 24 hours of admission.

The Stroke Assessment Team was introduced in February 2013, with an established service from June 2013 available 14 hours a day, seven days a week. The team works alongside the Stroke IT system which means live information of all suspected patients with a stroke can be accessed anywhere in the hospital. Health and social care discharge planning documents are also placed on this system. Weekly meetings are held to provide the opportunity to review every patient in detail to ensure that all sections have been completed and any exceptions to this are noted. It also provides real time review on performance so issues can be highlighted and improved immediately.

An awareness month was held in May 2013 with education and training sessions in all relevant clinical areas which highlighted the presence of the stroke assessment team in the Emergency Department and Acute Medical Unit and the existence of stroke champions in clinical areas.

Urgent Care

Delivered under Manchester's Health and Well-being Board, Living Longer Living Better (Healthier Manchester) describes an ambitious programme of work aimed at ensuring that local people receive high quality, personalised services which support them to manage their own health and well-being as effectively as possible. This will be enabled by the organisations responsible for improving health and well-being in the city working together to develop and deliver integrated out of hospital services with the capacity and expertise to offer support closer to home.

In 2010 a Clinical Integrated Care Board was established to lead on the integration agenda in Central Manchester. Since the beginning of 2013 we have been working with Manchester City Council, Manchester Mental Health and Social Care Trust, University Hospital of South Manchester NHS Foundation Trust, Pennine Acute Hospitals NHS Trust and the three Manchester Clinical Commissioning Groups (CCGs) to create a vision for integration in Manchester. Our shared ambition is for the Manchester population to be living longer and living better, and this is the name given to our integrated health and social care programme.

New care models have been developed by the health and social care commissioners in the city for a number of population groups to ensure that all patients across Manchester can expect the same care outcomes. In Central Manchester the new integrated delivery models which have been prioritised and developed are:

- Adults with long term conditions
- Frail older adults and adults with dementia
- Patient at the end of life.

The main components of the new delivery models include:

Co-production with patients, their carers and the community.

Co-ordination. A central service point providing an overview and point of contact for all services in the design to enable the models to be delivered across multiple providers.

A known and consistent generic team in each locality that can care for a person throughout their illness.

A joined up specialist team(s) that will be able to give care to a patient and their carers in the community.

Unpaid Carer Support - A physical and virtual service giving advice and information with identification of the carer and their needs at a generic team level.

A new delivery model for children between 0 and 4 has also been developed and this is now being implemented as part of the Living Longer Living Better programme.

Accident and Emergency

What To ensure that patients attending the Accident and Emergency Department are seen, treated and discharged within 4 hours.

How much 95% of patients to achieve this standard each quarter and for the year.

Outcome Achieved standard for the full year

Progress ✓

Improvements Achieved

System and process improvements identified across the following areas are:

- Emergency Department – Consultant staffing has been enhanced to ensure at least 16 hours cover per day 7 days a week.
- Medical Wards further work on discharge planning and bed allocation, working on standards for Transfer and accepting patients from the Acute Medical Unit.
- Complex Discharge – we have continued to strengthen the team and intermediate care provision.
- We opened an observational Medicine Unit in October 2012 to support the Emergency Department in reviewing patients requiring a short length of stay. The unit includes a GP assessment area which is open week days from 9 to 5.
- The 55 medical assessment beds opened in October 2012 and have helped to reduce length of stay in key areas.

Further Improvements Identified

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 focusing on the following key priorities:

- Supplementing 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.
- Map nursing requirements when most patients are attending.
- Rapid Improvement Events taken place in February/March 2014 to further improve our clinical and managerial processes for safe and effective patient flow both within the Emergency Department and on the broader ward footprint of the MRI.

Fractured Neck of Femur ✓

Over the last three years, a key priority for the Trust has been to improve the care pathway for patients admitted to the Manchester Royal Infirmary (MRI) for surgery after suffering a broken hip, sometimes known as a fractured neck of femur. During the past 12 months, there have been important changes in the management of adult patients admitted with a fractured neck of femur, in order to improve clinical outcomes and patient experience. Some of the key changes include:

- **IT support** – an electronic form, which records the details of all patients with a trauma fracture, has been developed to help the surgical and medical teams ensure that these patients are treated in a timely way. The form holds information such as admission time, lead consultant, most recent blood results, diagnosis and treatment decisions/plans and is discussed in daily trauma meetings in order to organise patient lists for surgery.
- **Staffing** – a part-time fractured neck of femur Specialist Nurse has been appointed to co-ordinate the care and admission of patients with a fractured neck of femur, ensuring that they are fast-tracked through the Emergency Department (ED) and that they are suitably prepared for surgery. The results of a recent staff survey, which evaluated the Specialist Nurse role, showed that staff in the ED and adult MRI wards considered the role to have made a positive difference to the pre-operative care and management of patients admitted with a fractured neck of femur. In addition, a full-time Occupational Therapist has also been appointed as the fractured neck of femur Key Worker. This role focuses on the post-operative rehabilitation and safe and timely discharge of fracture patients.
- **Fractured neck of femur Working Groups** – in addition to the fractured neck of femur Patient Pathway Group (which meets monthly to oversee fractured neck of femur service improvements), a weekly Multi-Disciplinary Team (MDT) meeting has been set-up within the Division of Surgery to review the care pathway of patients with fractured neck of femur. This group includes both clinical and managerial staff, from different specialities, who contribute towards the care of fractured neck of femur patients. The main focus of the group is to recognise any possible delays that may occur in the pre or post-operative management of a fractured neck of femur patient and to put steps in place to actively manage each patient's pathway. This helps to minimise length of stay (LoS) and to promote a safe and timely discharge from hospital.

As a result of the changes highlighted above, the Trust's average time to theatre and LoS performance for fractured neck of femur patients has improved. In 2011, 44% of patients admitted to MRI with a fractured neck of femur received surgery within the national target of 36 hours - this has now increased to 73% (as of January 2014). In addition, the average LoS for fractured neck of femur patients has reduced from an average of 33 days to an average of 29 days. This means that patients are getting to theatre and being discharged home in a more timely way, which improves overall patient outcomes and experience.

Patient Experience

Improving Quality Programme IQP

What: The Trust aims to roll out sustainable quality improvements across all Clinical areas using our developed quality improvement methodology known as Improving Quality Programme (IQP)

How much:
- All wards to be able to demonstrate improvements in patient care as a result of using the IQP process
- To advance the spread and understanding of IQP process across the services

By when: March 2014

Outcomes
- All wards implemented or further developed the improvement methodology (IQP) during 2013/14 including Trafford hospitals
- Information is displayed at all ward entrances as a quality dashboards and evidence of local improvement is set out

Progress ✓

This year, a strong emphasis has been placed on using IQP in new areas of work. These include:

- Improving patient experience in Glaucoma Out-patient clinic
- Improving communications in ward rounds
- Adapting the 14 week IQP Programme for use in A&E
- Creative Thinking sessions for Paediatric Intensive Care
- Dementia Master Class
- Communication Master Class

Next steps

E-learning for Productive Community Services has started with a view to setting foundations for IQP.

IQP training will be incorporated in the Consultant Development Programme and is part of our Graduate Training Programme.

Real time patient experience: Friends and Family Test

The introduction of the Friends and Family Test (FFT) was announced by the Prime Minister in May 2012. It is a way for patients to give feedback on the care and treatment they receive, and the feedback we receive will help us improve our services.

The question that is asked at the point of discharge in in-patient and A&E/Assessment areas is:

"How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?"

A similar question is asked within maternity services, however the Friends and Family Test (FFT) question is asked of each woman at four separate touch points 1) at 36 weeks, 2) after delivery, 3) at discharge from post natal ward (if applicable) and 4) on discharge from community post-natal care.

What: We have been collecting real time patient feedback since 2009. This has always included the Friends and Family Test Question. This year, in line with national guidance, we ensured the NHS friends and family test was also asked at the point of discharge in all adult in-patient wards, adult A&E and assessment areas and at the four touch points within maternity services.

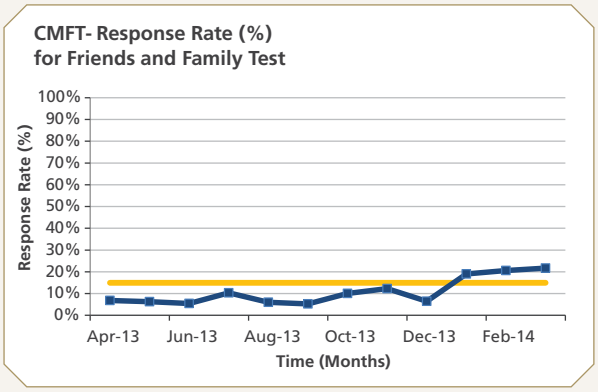
How Much:

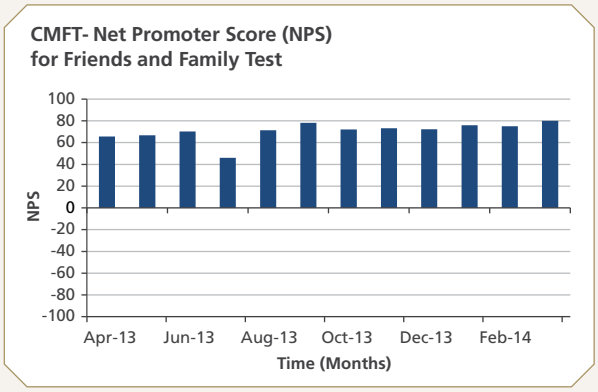
- All adult ward in-patients to offer the friends and family test at the point of discharge
- All adult A&E and Assessment areas to offer patients the FFT at the point of discharge
- To ensure a combined response rate of 20% for in-patients, A&E and Assessment areas
- To ensure the percentage of people likely to recommend our wards/departments is over 75%
- To ensure Friends and Family Test is rolled out to maternity services

By When: March 2014

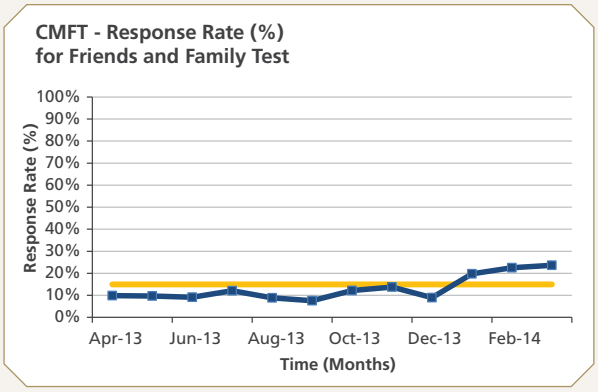
Outcomes: The graphs on the next page display the % response rates and NPS (Net Promoter Score) scores since April 2013.

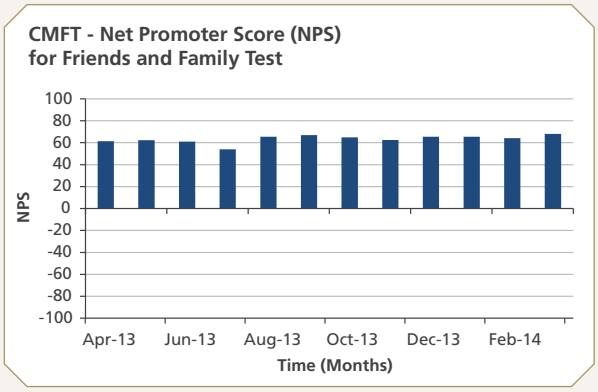
A&E and assessment areas



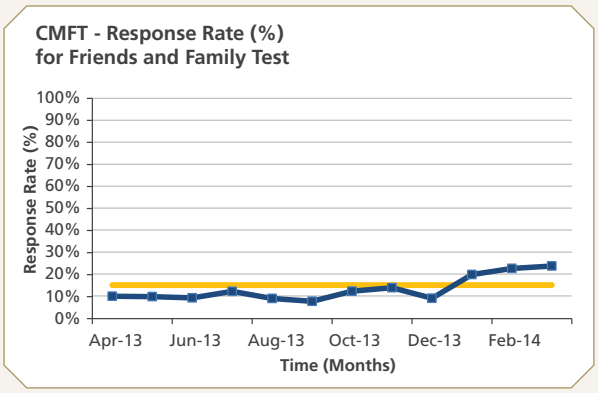


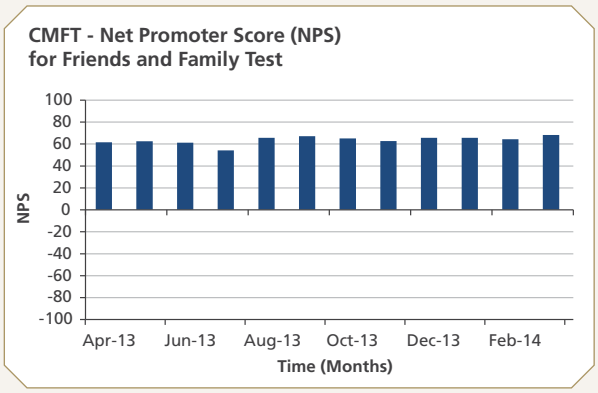
In-patient areas





Combined response rate scores (in-patient, A&E and Assessment Areas)





Progress

During April 2013, we launched a publicity campaign using internal media, printed materials, including postcards, bookmarks, flyers, posters, CMFTV (our internal TV system) and roller banners. Road shows were held in each of our hospitals to promote the FFT to staff, patients and public in order to raise awareness.

We use a combination of methods to collect the FFT data. These include:

- Electronic Patient Experience Tracker
- Electronic Patient Experience Kiosk
- Postcard shaped Bookmarks and ballot box

- Pre-paid postage post card
- Online survey (QR code, URL and web-link)
- SMS texting
- Bedside TV terminals

We have submitted response rate returns for both in-patient, A&E, and Assessment Areas on a monthly basis for the previous calendar month to the Department of Health. The results will be published on the NHS Choices website at www.nhs.uk.

In addition, FFT results are published locally at organisational, site and ward level, on our Central Intelligence database and are accessible to all wards and departments.

As part of a continuous improvement culture, ward teams are expected to collect and analyse ward level data, including patient experience feedback to identify areas for improvement.

Ward teams will continue to analyse the FFT results in detail on a monthly basis, alongside their monthly Quality Dashboard Metrics and will use the data to identify areas for improvement using IQP methodology to drive improvements and celebrate success.

Next steps

We are developing a system to provide individual wards with themed free text data from patients' comments and feedback related to specific wards.

The information from the FFT response feedback will be provided for each ward team to enable the ward managers to understand the themes coming from the FFT and help staff to use this information to drive improvements. Assurance that ward teams are using ward data to make improvements is tested as part of our Ward Accreditation Process.

On-going roll out of the Friends and Family Test will be in line with National Guidance which currently indicates that this will include out-patients, day case areas, dental services and some community settings.

Commissioning for Quality and Innovation (CQUINs)

The CQUIN framework is a national framework for quality improvement schemes. The framework was set up in 2009 to reward excellence in quality by linking a proportion of the Trust's income to achievement of quality improvement indicators. The framework has grown over the years, demonstrating the increasing emphasis being placed on quality. By embedding quality in discussions that we have with commissioners, a culture of continuous quality improvement is created. CQUINs are important to us and for patients as they are designed to improve patient experience, drive improved clinical outcomes and generally improve the quality of our services.

A proportion of Central Manchester University Hospitals NHS Foundation Trust income in 2013//14 was conditional on achieving quality improvement and innovation goals agreed between Central Manchester University Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2013/14 and for the following 12 month period are available electronically at http://www.cmft.nhs.uk/your-trust/cquins

Some CQUIN schemes are agreed nationally but others are agreed regionally or locally with Commissioners and Clinical Commissioning Groups. These CQUINs allow the Trust to focus on specific areas of work and improvements that offer benefits specific to our local and regional patients.

In 2013/14 we achieved 99% of our CQUIN targets.

At year end 2012/13, CMFT was successful in achieving a total of £14.5 million of CQUIN linked funding. In 2013/14 CMFT is projected to achieve £16.4 million of funding available, approximately 99% of the total amount available.

2013/14 CQUINs themes

There were over 50 individual CQUIN schemes for 2013/14, split into a number of goals examples of these are:

- Friends and Family Test, NHS Safety Thermometer, Dementia, and VTE Prevention, all of which are national priorities and are mentioned in other sections of this report

Some of the local and regional CQUINS focused on: Reducing avoidable short stay admissions of less than 24 hours, the quality of care patients receive at the end of their life, reducing alcohol abuse, improving communication at ward rounds and improving the continuity of care and communication at discharge. Other schemes looked at providing maternity care closer to home and improving the continuity of care for patients with both heart failure and diabetes.

Because we offer a high proportion of specialist services there was also concerted focus on a number of these areas with improvement schemes involving Bone Marrow Transplant, Cardiac Surgery, Renal Dialysis, Children's and Adolescent Mental Health Services (CAMHS) and Neo-natal Intensive Care Unit amongst others.

Some examples of 2013/14 CQUIN schemes are outlined below:

Dementia Care

Dementia care is a high priority for our organisation and we have continued to invest in this area of practice over the last year. We have a medical consultant as our clinical lead and our Director of Nursing as the nursing dementia champion and a Non-executive Board Champion. We not only have a dementia nursing specialist but have trained and supported two dementia champions on each of our identified wards. We have nine nurses that are key trainers and have developed a comprehensive programme of dementia training to raise awareness for staff, including specific study days and a new e-learning package. More than 400 members of staff of all disciplines have completed a full day study on dementia care. We also have worked closely with the Alzheimer's Society to raise awareness of dementia with staff, patients and visitors and have introduced innovative activities on the wards in partnership with external organisations such as museums, music colleges and theatre groups.

What

- To ensure that at least 90% of patients aged 75 or over are asked about memory problems, assessed further if indicated and referred for specialist input if evidence of cognitive impairment – this is known as the Find, Assess and Refer process
- To ensure that all patients identified as having known dementia, or display evidence of cognitive impairment, are identified with a forget-me-not flower symbol on the electronic nursing handover document
- To develop a shared care approach by developing and implementing a specific dementia shared care plan in 10 early adopter wards
- To continue to ensure support for staff through dementia training
- To work with carers to develop a support leaflet about their key issues
- To develop a dementia friendly environment

Outcome: Over 90% of our emergency in-patients aged 75 and over have had the Find, Assess and Refer process completed each month

Data from 1/04/13 to 31/12/13

Unify Submission	Length of Stay >= 72 hours		
	Find	Assessed and Investigate	Refer
Numerator	3386	166	86
Denominator	3532	176	91
% Performance	95.87%	94.32%	94.51%

The shared care plan was developed in partnership with nursing staff and carers. After initial testing in the pilot wards roll out to ten early adopter wards began in the autumn at a dementia care plan workshop. The workshop included the use of our improvement methodology to ensure that staff fully understood how and why the new approach was being introduced.

- The number of staff completing dementia training continues to increase. A dementia care study day is held each month and supports staff to understand the specific communication and care needs of people living with dementia. The percentage of nursing staff working within our in-patient wards, that have undertaken dementia training, continues to increase each quarter.

	End of Q1	End of Q2	End of Q3	Improvement Seen
Division of Acute Medicine and Community Services	33%	34%	35%	✓
Manchester Royal Eye Hospital	4%	8%	8%	–
Saint Mary's Hospital*	0%	0%	0%	–
Division of Specialist Medicine	13%	14%	17%	✓
Division of Surgery	15%	17%	18%	✓
Division of Trafford Hospitals	18%	21%	28%	✓

**Next year there will be a focus on dementia training in Saint Mary's Hospital*

In order to increase the pace at which staff can access training, we have developed a dementia awareness e-learning package. This was made available to staff in December 2013.

The increased awareness of the needs of people living with dementia has also had an impact on the number of carers being offered the opportunity to provide feedback about care. Initially it was noted that carers of patients living with dementia were rarely offered the opportunity to provide feedback in the same way as other patients. This year has seen a steady increase in the number of responses from carers across many of our wards.

- Partnership working with our carer champions through the forget-me-not focus group has resulted in the development of our 'sharing the caring' leaflet. This includes useful information to guide other carers through the services that are available to support them in their caring role.
- Using the Dementia Action Alliance audit tool all adult in-patient ward environments have been assessed against the dementia friendly standards. Areas of improvement have been identified and are being addressed by the healing environment design team. This has involved developing a design guide that incorporates best practice guidelines for dementia care to ensure that ward environments can be improved. Examples include the use of colour to highlight patient areas, the use of clocks for orientation and the availability of seating. Two wards have been selected to become the showcase areas for our dementia friendly designs.

In addition to improving the ward environment, a range of activities have been explored. These have been organised by the Healing Environment Activity Co-ordinator, in order to improve the patient experience. Examples include activities organised in partnership with charities such as Kissing it Better and Lime Arts. Choirs from local schools providing musical entertainment, beauticians, art therapy, 'Pets as Therapy' dog visits on wards, a magician and hospital volunteers trained in simple 'hand rubbing' techniques provide relaxation and distraction for patients.

Maternity

Women receiving their postnatal care from the Central Manchester Community Midwifery Team will receive a home visit a minimum of three times following their discharge in line with the NICE recommendation. These visits suffer a high number of 'no access visits', where women are unavailable/not at home. This is often due to the unpredictability of the appointment time and that new mothers often have to go out. This CQUIN focused on improving patient experience around the organisation of these home visits post discharge.

Goal: Improve patient experience of maternity services, engaging patients and staff in service redesign to move care closer to home.

Progress against goal: As part of the wider Maternity Transformation Programme within Obstetrics, the establishment of clinics to replace visits was explored. Pilot clinics in community settings were established with set appointment times, enabling new mothers the opportunity make an appointment to be seen whilst also giving them a chance to meet with other mums in their local community.

Clinics were established during the second half of 2013. Patient experience and satisfaction with the clinics has been high and has also freed up midwifery staff time by reducing travel time. New mothers have also reported benefits with meeting other women in the postnatal period and reduced isolation along with access to Sure Start services. Due to the success and high level of attendance rates at the pilot clinics this initiative is currently expanding to offer clinics in new areas and localities. The women attending the clinics have been surveyed regularly and have given the service fantastic reviews.

Reducing Alcohol Abuse

Excessive alcohol consumption is rising and is a significant contributor to public health problems and cause of hospital attendance and admission. Identifying excessive alcohol use and offering brief advice has been shown to be an effective intervention.

Building on a CQUIN from 2012/13 reported in last year's quality account, around improving screening of patients for problematic alcohol use and referring them for advice on how to reduce their alcohol intake. A 2013/14 CQUIN was agreed with the Clinical Commissioning Group that had a results focus for demonstrating the impact of Brief Intervention Advice (BIA).

Goal: Ensure frontline MRI emergency department and Community Primary Care Emergency staff are trained to employ BIA. Target of 90% of patients screened and BIA employed where appropriate.

Progress against goal: As of December 2013 approximately half of staff identified had been trained on BIA. This includes 100% of appropriate community primary care emergency staff. In addition in the emergency department 70% of the approximate 250-300 patients seen each day are screened with 90% of those patients screened and scoring positive receiving BIA.

We continue to work towards the target of screening 90% of all patients attending whilst also monitoring the number of referrals to the alcohol service to assess potential pressures.

Heart Failure and Diabetes

Heart failure affects nearly one million people in the UK and is associated with high morbidity and mortality rates. As many as 40% of people with Heart failure also have Diabetes, even though the prevalence in the general population is around 3-5%. Patients with both heart failure and diabetes are at increased risk of mortality and more frequent visits to hospital compared to heart failure patients who do not have diabetes. In addition, many of the complications of diabetes contribute to the development and aggressive progression of heart failure.

Despite these facts, the two conditions are often managed separately, with no unique pathway that manages both conditions and with no integration of services. Thus, the opportunity to optimise the management of diabetes during hospitalisation for heart failure is often missed.

Goal: Improve continuity of care for patients with heart failure and diabetes, in turn reducing the number of readmissions to hospital and improving patient experience for this cohort of patients.

Progress against goal: This CQUIN has involved us working collaboratively with Central Manchester Commissioning group and The University of Manchester to form a working group tasked with overseeing the project and developing an improvement plan. Clinical and management staff from the Trust, lecturers from the University and GP members of the CCG have all been involved.

A detailed audit of case notes for patients admitted with heart failure and diabetes has been conducted along with a number of semi-structured patient interviews to fully assess the issues these patients encounter. In addition, a representative of the University is presenting a poster of preliminary audit findings at the Euro Heart Care 2014 Conference in Stavanger Norway.

It is envisaged that this CQUIN will develop into a longer term piece of work with the recommendations made from work this year. This will be used as the basis of a CQUIN for 2014/15 which will focus on the implementation of changes to directly improve continuity of care and patient experience.

End of Life Care

We are committed to delivering the best care whilst supporting our patients and their families as they approach the end of life. Our aim is to provide the best standard of care and support patients and their families in a dignified and caring way at this difficult time.

Throughout 2013, our End of Life Care Facilitator nurses supported the care delivered on adult wards across MRI, Trafford Hospital and within our community services, providing education and expert advice to staff in the care of patients at the end of life and their families. We have audited the care delivered and will use the results to inform and improve practice.

In July 2013 a national report commissioned by NHS England, 'More Care, Less Pathway' recommended phasing out the Liverpool Care Pathway (LCP) by July 2014. This guidance changes the way we plan care with patients and families at the end of life. As a result we are currently reviewing end of life care. Teams from across the organisation are working together with a number of other external services on the development of a new care delivery model. The aim of this project is to help support our patients to die in the place of their choice, supported by excellent services. Included in the new model are several work streams across the acute Trust and community with the ultimate goal of improving care in the right place.

What: To improve the quality of care our patients and families experience at the end of life and following a death. To raise awareness and communication of the patients individual wishes.

How: To ensure our workforce is able to deliver the dignified, compassionate and safe end of life care.

By When: March 2014

Outcome: To develop a workforce across the organisation that is competent and confident in end of life care.

Progress

Improvements Achieved

- We submitted data to the 4th National Care of the Dying Audit
- The audit of spring 2013 was repeated this year and showed improvement in certain areas as well as highlighting areas which the Trust should focus on
- Submitted and approved a proposal for research in collaboration with The University of Manchester and Marie Curie Cancer Care to explore the needs of carers
- Palliative care in Trafford Division is now supported on a rotational basis via specialist nurse team based at central site
- We began a two year project with the Gold Standard Framework programme supporting the two Acute Medical Unit wards to help patients as they approach the last year of their life, identify their wishes and start Advance Care Planning
- Continued acute and community weekly multi-disciplinary meetings to plan and discuss palliative patients' care
- Progressed with Trust-wide delivery of the SAGE & THYME communication skills training helping staff deal with people in distress. This model is a two-step structure based on published evidence regarding how best to communicate with patients
- Delivery of Palliative care study days, aimed at staff who support patients and their carers facing the challenges of living with a long term complex conditions
- Work with the Manchester Eye Bank to increase awareness and opportunity for corneal donation across the organisation

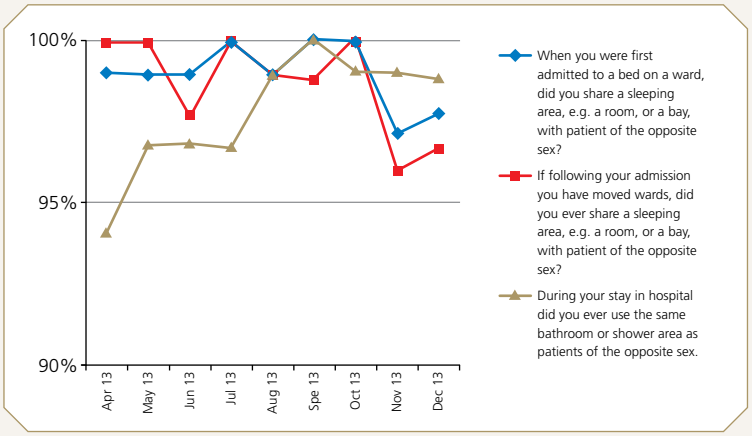
Single Sex Accommodation

We have continued with our commitment to ensure that all patients are provided with care in an environment which is compliant with the provision of same sex accommodation national guidance. Since March 2011 we have been able to declare annual compliance with the required national standards within our clinical areas.

We continue with our commitment to go beyond the requirements of the guidance and where clinically possible have moved to providing single sex wards. We currently have 51% of our clinical areas as single sex wards, with the remaining wards all providing single sex bays with identified single sex bathroom and toilet facilities.

We continue to monitor patient feedback in relation to provision of single sex accommodation in order to identify areas where patient perception indicates that they do not feel they have been cared for in single sex accommodation. Our monthly Quality Care Ward Rounds (QCR) require ward managers to ask patients the three predetermined Department of Health questions related to the provision of same sex accommodation.

These audits continue to demonstrate a high level of patient satisfaction in terms of perceptions of provision of same sex accommodation. Results for the year to date demonstrate 98% of patients surveyed believe they did not share a room or bay with patients of the opposite sex. Where sharing did take place this was within a critical care environment where the guidance acknowledges that a patient's clinical need takes priority over the provision of same sex accommodation.

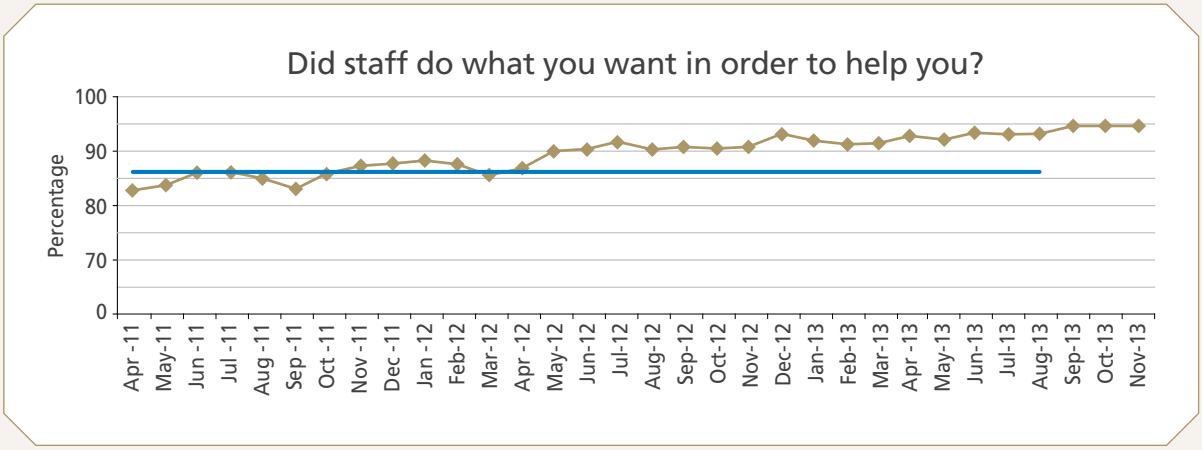


Other News

In addition to the key priorities we have been working to improve quality of care across a number of areas. Some of that work is detailed here.

Brilliant Basics

Brilliant Basics is an annual process where every three months nurses and midwives take a specific focus on practice to improve the 'fundamentals of care' that we provide to our patients. The four core areas are closely aligned to the Nursing and Midwifery Strategy and values.



The process during 2013/14 has further embedded the philosophy of inspiring staff to use improvement methodology to make changes to practice in order to improve patient and staff experience. Our areas of focus are:

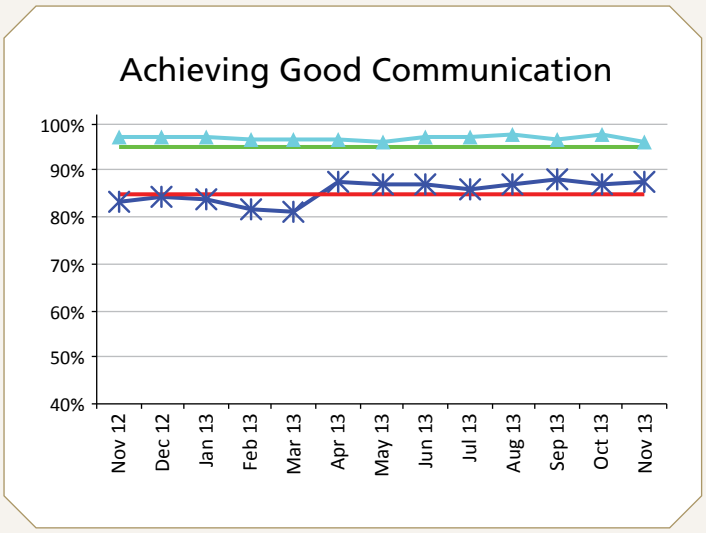
Communication, Harm Free Care, Leaving our Care and Care & Compassion.

The nurses in the Research and Innovation Division have taken the concept further starting a series of quarterly events – Brilliant Basics Research aimed specifically at research practitioners, including consent and patient involvement related to this area of practice.

Communication

As part of Brilliant Basics 2012 we introduced patient focused rounding which occurs every two hours within all our ward areas and this resulted in a number of improvements measured by feedback from our patients about communication which are seen in Table 1.

In April 2013 we used the first quarter of the year to celebrate our achievements and to implement an additional question to the patient focus rounding process 'Do you have any worries and fears?'. This was based on our review of feedback and patients



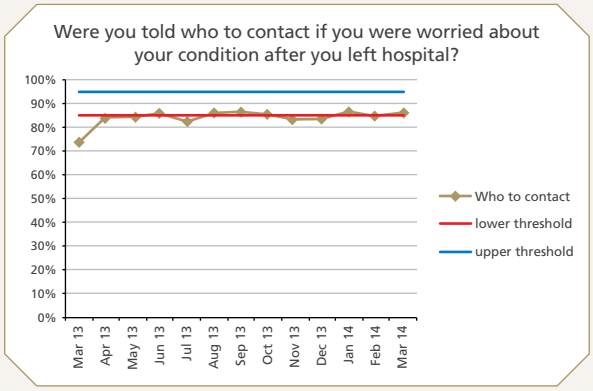
reporting that they had worries and fears. The graph below demonstrates the continued improvements we have seen this year as a result of this focus on communication.

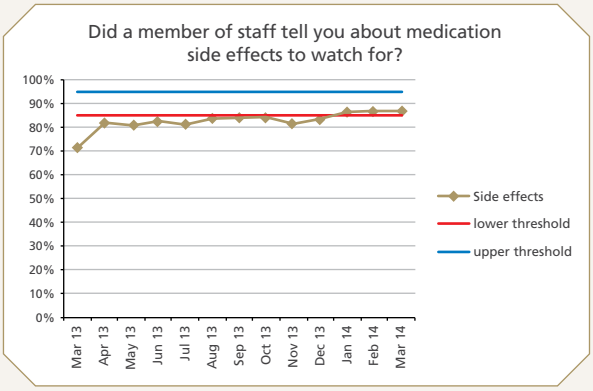
Brilliant Basics in quarter 2 of the year focused specifically on the care we provide to patients to reduce the risk of hospital acquired pressure ulcers and falls with harm. This focus included a comprehensive programme of training for staff, increased focus on accurately reporting incidents and ensuring changes in practice are made where incidents occurred in order to prevent these in the future.

The improvement is set out under the Harm Free Care report (page 109).

Leaving Our Care

Leaving our Care was our focus during quarter 3 Brilliant Basics. Nurses and midwives focused on ensuring that patients had information on discharge specifically in relation to who to contact after they left our care if they had any worries or concerns and patients understanding the side effects of any medication they were discharge with. This work has demonstrated some improvements but will continue to be an area of focus within the Brilliant Basics work during 2014/15.



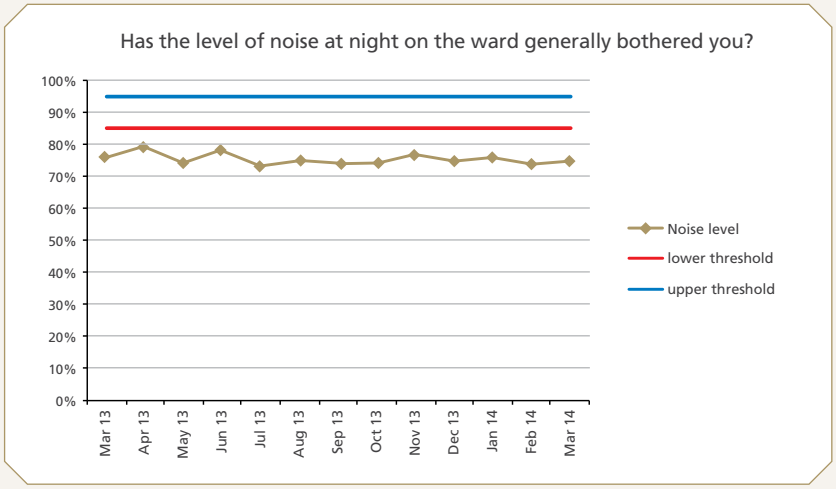


Compassion

Our final quarter of the year focused on the healing nature of rest and sleep. We have focused on understanding why patients tell us some wards are noisy at night and then put in place simple actions to make the environment conducive to sleep. The table below demonstrate patient feedback in terms of noise at night.

We believe that in providing the right environment and practice that is conducive to sleep, patients will be rested and recover faster.

Settle down
Lights dimmed
Everyone quiet
Extra Checks
Prioritise Care



Hospital at night team – Manchester Royal Infirmary

Core to the delivery of high quality care within the Trust is the ability to ensure that care delivered over the 24 hours of each day is consistent and of a high standard.

Our Trust comprises of a number of speciality hospitals, with specific needs who have individual arrangements in place to ensure that there is senior medical and nursing/midwifery support and leadership for staff at night. They include the Saint Mary's Hospital Night Co-ordinator and the Royal Manchester Children's Hospital night co-ordinators.

The Hospital at Night Team is responsible for the co-ordination and delivery of safe and effective clinical care at night within our Manchester Royal Infirmary ward areas. This is primarily our adult in-patient areas. The team was established in January 2009 as a multi-disciplinary team with a wide range of advanced technical clinical skills and knowledge to meet the patients' immediate needs during the night.

The Primary function of the team is to ensure the safety of patients during the night. The team provide various functions including:

- A site co-ordinator role
- The pathway co-ordination of the hospitals beds
- Respond to all clinical queries by providing both general advice and more specifically in emergency situations for patient's whose condition has deteriorated.

The team receives approximately 100 telephone calls per night. The diversity of requests from the ward and departments requires a high level of knowledge and experience from the night team in order to ensure each call is responded appropriately. Where necessary the hospital at night team will undertake a review of the patient or refer to the appropriate member of the medical team.

Trafford General Hospital is currently focusing on developing a new out of hours team with the right skills and knowledge to support patients and ward staff at nights and at weekends. The team will be able to report their successes during 2014/15.

The Health Foundation Supported Project – 'Safer Clinical Systems'

Within the organisation we have the opportunity to work with the Health Foundation in the Safer Clinical Systems project (SCS) utilising a new method for the identification of risk and assurance of safety in a patient's pathway. The project looked at the care of children with 'medical complexity' from admission to discharge at Royal Manchester Children's Hospital (RMCH). There had been concerns about the safety of children with medical complexity (i.e. those with long term conditions under the care of a number of different teams). This had been highlighted by a number of high level incidents, anecdotal evidence, parent feedback and complaints, all suggesting that at times care was disjointed with communication issues between teams.

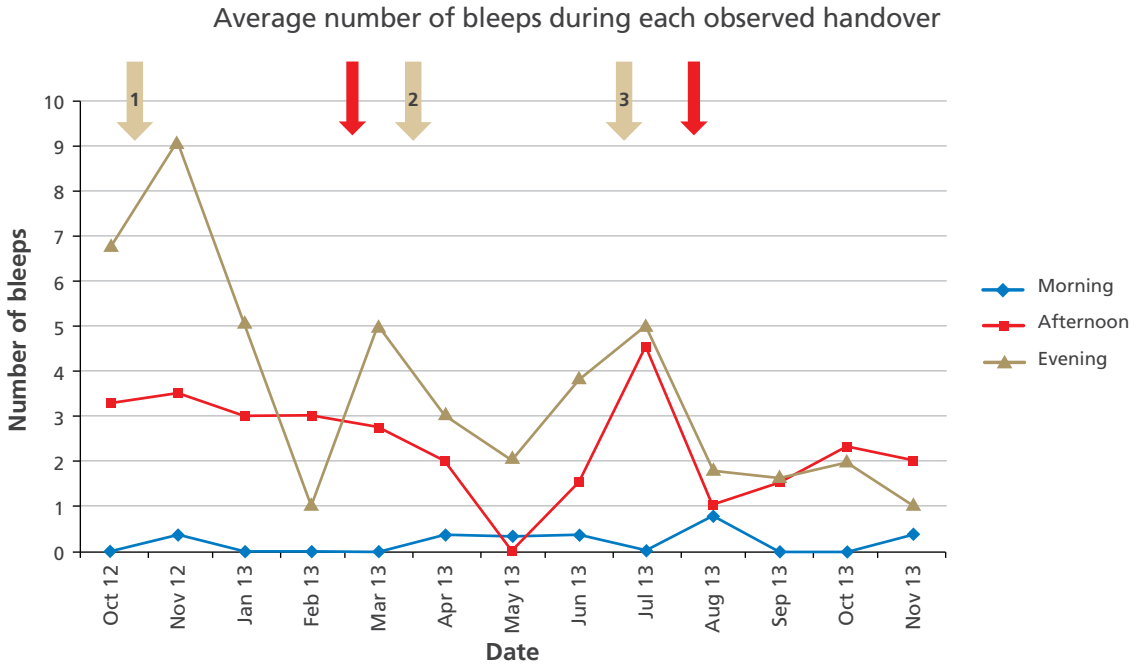
Following our successful application to the Health Foundation 'Safer Clinical Systems' Project, we were taught

these safety improvement techniques and processes, supported by Warwick University, to help with thorough examination and assessment of where the risks lay within this patient pathway. Supported by a project manager, lead clinician and multi-disciplinary team, five key areas were identified which were felt to impact on the patient experience and to be associated with potential risks and hazards.

These areas were: ward rounds (roles and responsibilities and lead consultant), handover (culture and process), Speech and Language Assessment (SALT) (delays with referral to assessment) and potential lack of experience and resources when caring for these patients.

The SCS tools enabled us to identify the root causes of these problems and design interventions.

Ward round: Following identification of a risk and discussions with the families, white boards were successfully trialled in one ward with the names of the lead consultant and nurse caring for the patient; this is now being rolled out division wide. Another risk was reduced with planning meetings pre and post ward round with the nurse in charge of the patient care (when nurses are unavailable to attend).

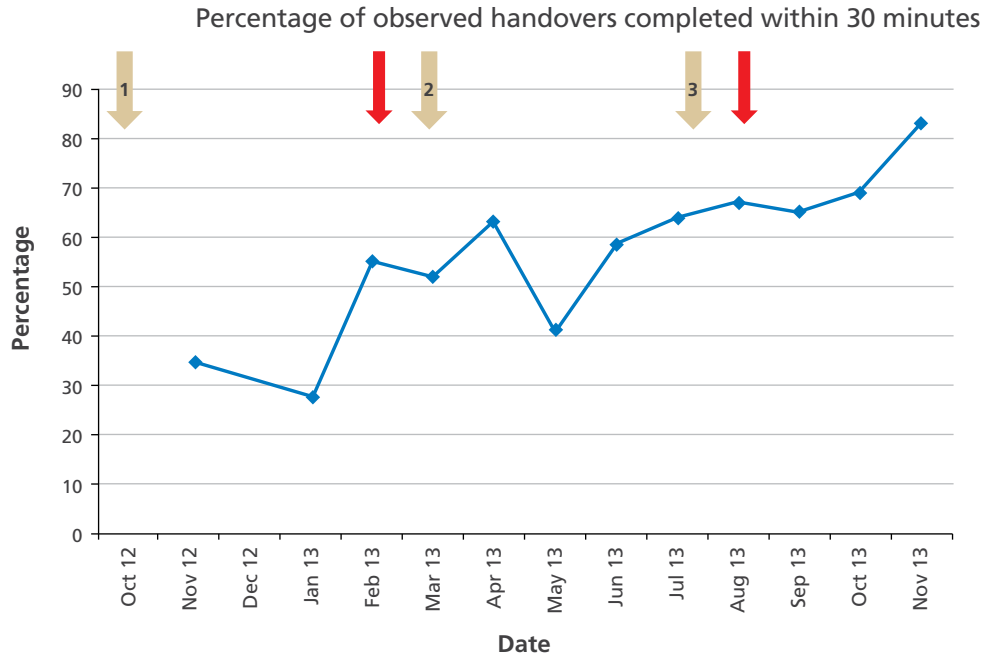


Key:

Red arrows: Junior Doctors Education on importance of leadership and human factors

Blue arrows: 1) Set room with equipment and layout– PED room (table/comp/chairs)
2) Standard for handover written and disseminated
3) Nursing Awareness of handover times with poster by telephones

Handover: Reduction of distractions utilising a poster campaign, use of a more suitable venue with appropriate equipment, cultural change by training and feedback for handover, a focus on leadership and timely attendance has made a clear impact on the process and improved safety.



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3) Nursing Awareness of handover times with poster by telephones

Speech and Language Therapy (SALT): We have introduced an electronic referral system, revised the prioritisation tool and revised the team structure. The interventions in this project ensure that children were seen within 48 hours from 40% or time to 100% of the time; time to being seen has been found to have a direct correlation with length of stay.

Patient carer: The introduction of a care co-ordinator and play specialist to support the complex children, their families and their pathway whist in hospital, by ensuring staff have the necessary knowledge and skills and reviewing care processes.

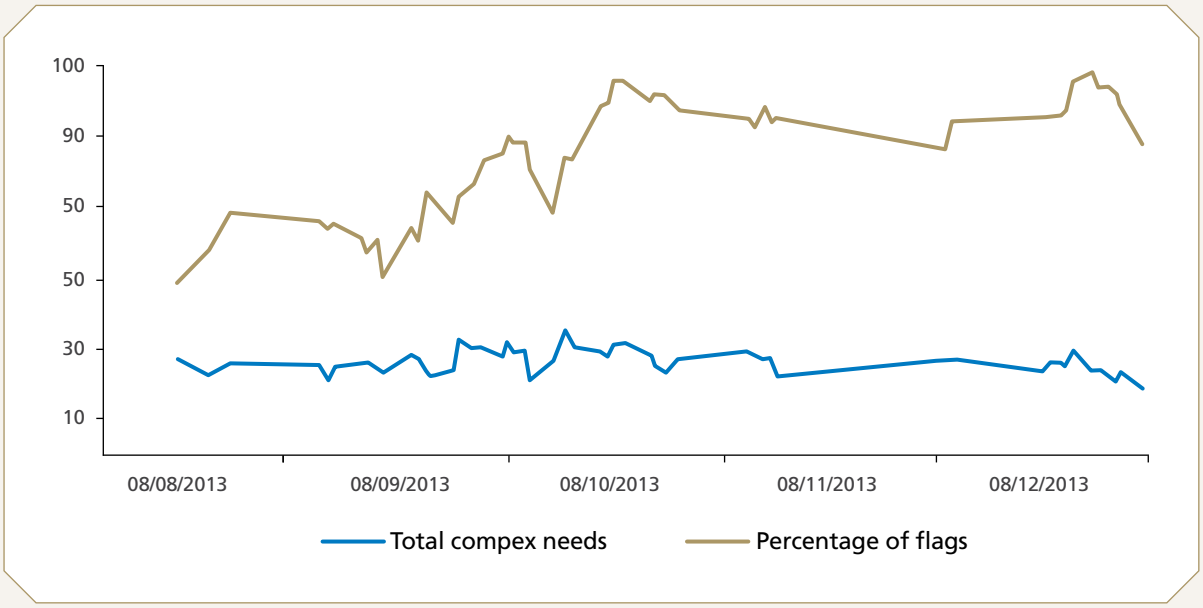
A theme through the whole project has been the problem of identifying and communicating with all the professionals involved in the care of complex children, thus a key intervention has been the introduction of an electronic flag which will appear on all handover notes and bed managing systems to identify these patients during their stay and on any readmissions.

Use of the flags

The support from the Health Foundation on this process enabled us to understand risk and to ensure that an accurate and true picture of the problem was uncovered. Working with this structured approach, appropriate interventions could be identified and implemented in a timely and measureable way.

The Safer Clinical Systems approach worked well for our project not least because it gave us the time and the impetus to gather the right people to analyse the problem and find solutions. Involvement of members of the

multi-disciplinary team with executive support has been invaluable in selecting appropriate interventions and ensuring that these are realistic and sustainable. The approach is now being rolled out into other areas of the organisation to review processes and ensure safety in the system.



Safeguarding (Vulnerable Adults)

'Vulnerable adults' are defined as those aged 18 years and over who are, or may be, in need of community services because of illness or a mental or physical disability, or individuals who are, or may be, unable to take care of themselves, or unable to protect themselves against significant harm or exploitation (No Secrets 2000). We, and other NHS organisations, have a duty to ensure that vulnerable adults are protected from harm and abuse. Both locally and nationally, safeguarding practice has developed considerably in recent years and a number of Government initiatives have been introduced to strengthen the options that agencies have when responding to concerns about abuse. With this comes a need to ensure that all staff working within the NHS have the skills to safeguard the needs of vulnerable adults, with access to appropriate training and specialist support. This ensures that the safeguarding principles of empowerment, protection, prevention, proportionality, partnerships and accountability are embedded in clinical practice and Trust structures.

Over the 2013/14 year the focus of Trust Safeguarding activities have included updating training packages to ensure they reflect the developing National Safeguarding Adults agenda and learning from Adult Serious Case Reviews. The Safeguarding Team have also established a safeguarding 'Champions' network of over 80 members of staff ensuring they have access to specialist support and training in order to provide additional safeguarding support to staff within their areas. This role is being supported by the Adult Safeguarding team via regular update teaching sessions and the offer of clinical supervision.

Developments within the realms of Mental Capacity and Deprivation of Liberty Safeguards (DoLS) have also been made, establishing a new 'Portal' for monitoring DoLS activities and CQC notifications and supportive guidance to staff as to the safeguards under the Act for vulnerable services users. This work has been supported by the completion of three audits into Mental Capacity and DoLS practice and the implementation of a mandatory e-learn package for staff.

With the support of the Safeguarding team, each Division within the organisation has been assisted to establish safeguarding operational groups to ensure information is disseminated appropriately locally. The team continues to support at these meetings and at groups such as the Learning Disability delivery group, dementia steering group and domestic abuse subgroup to ensure safeguarding remains at the heart of practice within the organisation. Considerable attention has also been paid to the safeguarding integration into processes involved with assessing pressure ulcers and this is planned to expand to other areas of clinical governance processes in the next financial year.

Safeguarding Children & Young People

We, and other NHS organisations, have a duty to ensure that children and young people are protected from harm and abuse. Both locally and nationally, safeguarding practice has developed considerably in recent years and the review of Child Protection carried out by Professor Munro has initiated a number of changes in how professionals work with children and families and how they respond to safeguarding concerns.

Over the 2013/14 year the focus of Safeguarding activities have included key subject areas such as neglect, child sexual exploitation and the Manchester Common Assessment Framework. The Safeguarding Team have updated training packages to ensure they reflect the recommendations from the Munro Review and the emerging national focus on the early help agenda. Work has been done across our acute and community services to improve recognition of need and sharing of information to support Manchester's early help offer. The development of a bespoke training package for neglect will support this work and the on-going training and supervision for staff will ensure that staff are supported to carry out their role within this process.

We have embarked on a large piece of work to identify level 3 training requirements across all areas in order to provide up to date compliance figures for safeguarding children training. Significant work has been undertaken across the different divisions to scope the types of patient contact with under 18 year olds and the requirements for this level of safeguarding training. This will enable us to develop our Safeguarding Training Strategy to ensure all staff have appropriate training commensurate to their role.

With the support of the Safeguarding team, each Division within the organisation has been assisted to establish safeguarding operational groups to ensure information is disseminated appropriately locally. The team continues to provide support at these meetings and at groups such as the Manchester Safeguarding Children Board, safeguarding children fora, Manchester Safeguarding Board Subgroups, our Domestic Abuse Subgroup and our Children & Young Person's Steering Group to ensure safeguarding remains at the heart of practice within the Trust and that we are contributing to multi-agency practice across Manchester.

Compliments, Concerns and Complaints

We take the views of our patients and visitors very seriously and the vast majority of people who use our services are happy with the quality of the treatment and services they receive. However, sometimes things do not go as well as expected. In these cases, we encourage our staff to deal with issues or concerns immediately, but when they cannot be resolved the Patient Advice and Liaison Service (PALS) can independently help staff and patients to navigate their way through simple issues of concern or help to deal with complex problems and help to resolve them.

There has been a steady increase in complaints in previous years but this increase appears to have levelled out during 2013/14. The main complaint themes over recent years have been around clinical assessment and access to diagnostic investigations such as scans, treatment and procedures together with concerns about consent,

communication and confidentiality. These themes have appeared consistently, but have changed position in prominence through each quarter.

Over the last year we received around 3,432 PALS enquiries (a 4% increase on the previous year) and 1,185 formal complaints (a 9% increase on the previous year). The Trust also received 21 new requests for information from the Parliamentary and Health Service Ombudsman (PHSO).

Of the total number of PHSO cases previously received, eight cases are currently under investigation. Two cases have been partially upheld which means that the Ombudsman believes an aspect of the concern, care or treatment fell below the standard expected. One of these cases related to delays in the complaints process and the remaining one related to a delay in providing medical records to the family. The Ombudsman's office has also informed the Trust that they propose to fully uphold two further complaints relating to the Divisions of Surgery and Saint Mary's Hospital. We will act on the Ombudsman's recommendations when we receive the report.

The Ombudsman's office did not uphold eight other remaining cases because they found that the Trust's response was either appropriate, or the Trust was not at fault, or the Trust recognised its failings and had made the necessary steps to address a service shortfall.

In total the Ombudsman investigated 1.7% of the formal complaints made or 0.45% of the total complaints or concerns raised.

We are confident that our complaints processes are designed to support our patients and service users and were delighted to be mentioned as an area of good practice in the Anne Clwyd MP and Professor Tricia Hart report 'Putting Patients back in the picture'.

The introduction of the role of Critical Friend - an independent Director or Deputy Director is provided to support families through a very complex complaint which may also involve a high level incident acting as a single point of contact for the family.

The Complaints Scrutiny Group - led by a Non-executive Director aimed at learning lessons from complaints and holding staff to account for their actions.

We recognise the need to continually improve and have started a comprehensive review of the complaints process. We aim to simplify the process for patients and carers and enable them to have faster access to resolve immediate concerns.

We are also looking at how we can improve our complaints handling and share complaints data with our divisions. We intend to introduce measures to improve response times to complaints. We propose to improve how we use the information we receive from complaints, learn from these and share good practice across all of our services.

The Quality Campaign

Ward Accreditation

Our Ward Accreditation process was established in 2011 and involves all in-patient wards and day-case areas being assessed annually. The ward accreditation aims to achieve a level of assurance for the Board of Directors that wards are consistently delivering high quality care across four key areas.

- Culture of continuous improvement, including leadership, team culture and use of evidence based practice.
- Environment of care including infection control and safety standards.
- Communication about and with patients, including team communication, documentation and patient feedback.
- Nursing processes specifically focused on medications and meals.

In previous years, wards have been given up to seven days' notice of a visit however in 20131/4 accreditations were unannounced. Consequently the results overall appear lower this year but are considered more representative of our patient's experience.

Wards are accredited as achieving Gold, Silver, Bronze or White based on the following definitions:

Gold	Achieving highest standards with evidence in the data
Silver	Achieving minimum standards or above with evidence in improvement data
Bronze	Achieving minimum standards, or below with active improvement work underway
White	Ward not achieving minimum standards in at least one category and no evidence of active improvement work

What: To develop and complete formal nursing accreditations across all clinical areas (including Trafford).

How much: 100% in-patient wards and day case areas on central site to complete third accreditation.
100% in-patient wards and day case areas at Trafford to complete first accreditation.

By when: End March 2014

Outcome

All in-patient and day case areas to be formally accredited as gold, silver or bronze

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

Progress

The ward accreditation process for 2013/14 was amended so that all visits are unannounced. The process of assessment remained the same; however the standards to be achieved were raised within each level of gold, silver and bronze.

Wards assessed as not meeting our agreed minimum standard were identified as white and a package of support was provided to ensure all relevant actions were completed in a sustainable way. White wards were then reassessed after six months giving a level of assurance that appropriate actions had been completed and the final results reported to the Board of Directors.

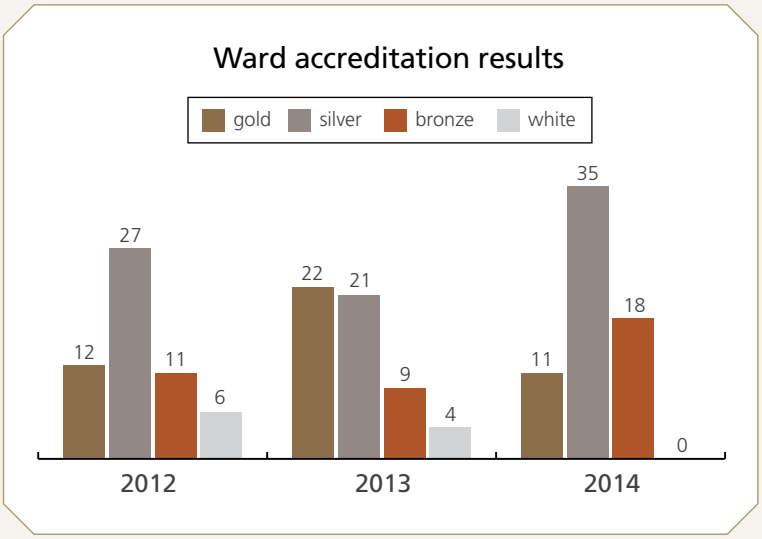
Wards that achieve gold continue to be celebrated through the 'We Are Proud of You' award scheme.

Improvements achieved

Based on the in-patient wards and day case areas including Trafford wards:

- Completed accreditation process, 64 wards (100%)
- Achieved bronze, silver or gold, 64 wards (100%)
- Achieved gold, 11 wards (17%)
- Achieved silver, 35 wards (28%)
- Achieved bronze, 18 wards (55%)

The table right highlights the accreditation results from the past three years.



Patient Focus Rounding

What: To ensure on-going sustainability of Patient Focus Rounding

To introduce the additional question for patients 'Do you have any worries or concerns?' as part of the well-established Patient Focus Rounding across wards.

How Much: To identify evidence in the patient feedback data that communication through Patient Focus Rounding continues to improve.

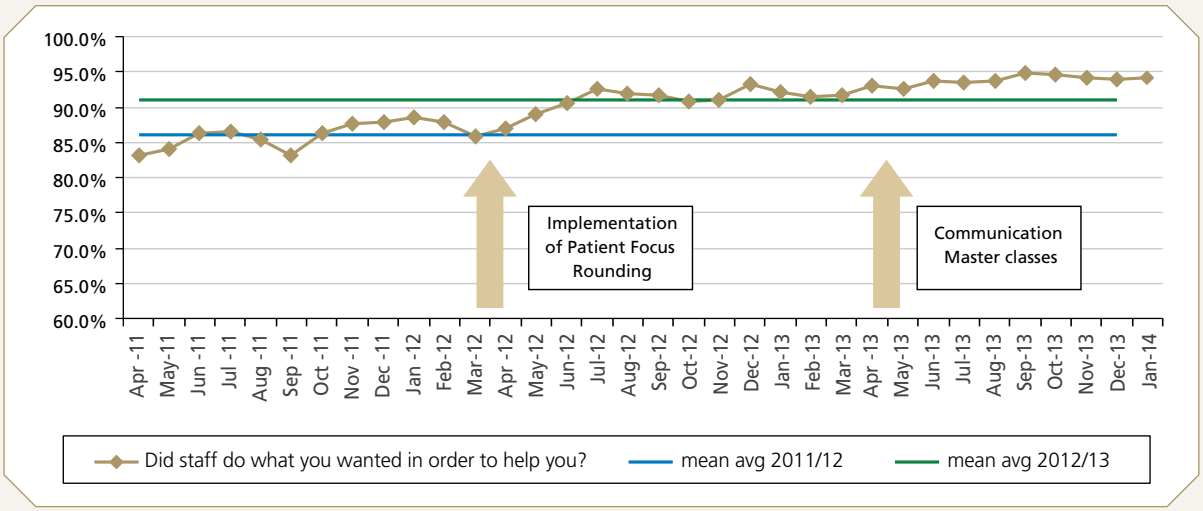
All wards to introduce additional question to Patient Focus Rounding with every patient being asked at least once daily 'Do you have any worries or concerns?'

By When: Monthly patient feedback data to be collected as evidence of sustainability and improvement.

All wards to start worries and concerns rounding by June 2014.

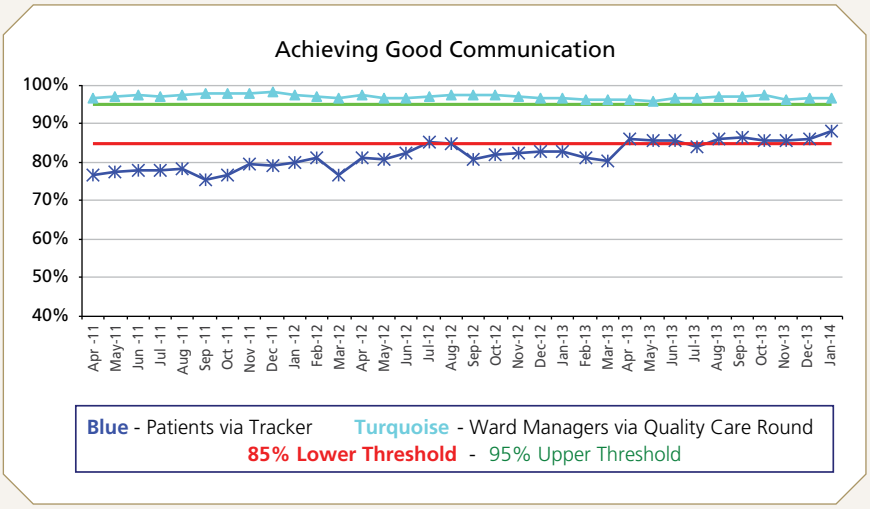
Outcome Demonstrated sustained improvement of patient feedback in relation to the question 'did staff do what you wanted to in order to help you?' and the results for overall communication.

85% of wards (57/64) attended the Improvement Quality Programme Communication workshop in May 2013.



Progress

Patient Focus Rounding was introduced in April 2012. Rounding takes place at least every two hours and involves one of the nursing team asking the patient a single open ended question "Is there anything I can do?" This is different from the widely used intentional 'rounding' which involves asking set questions of all patients each hour, which nursing staff felt did not allow them to address the individual patient needs.



After successful implementation of Patient Focus Rounding during 2012, staff were asked to add an additional round each day asking the question "Do you have any worries or concerns?'.

Improvement workshops, focused on communication, were held in May 2013 with a strong emphasis on putting the patient first in all things.

Next Steps

We will review the patient focused rounding approach during 2014/15 to see how we can improve its use in clinical practice.

Clinical Audit

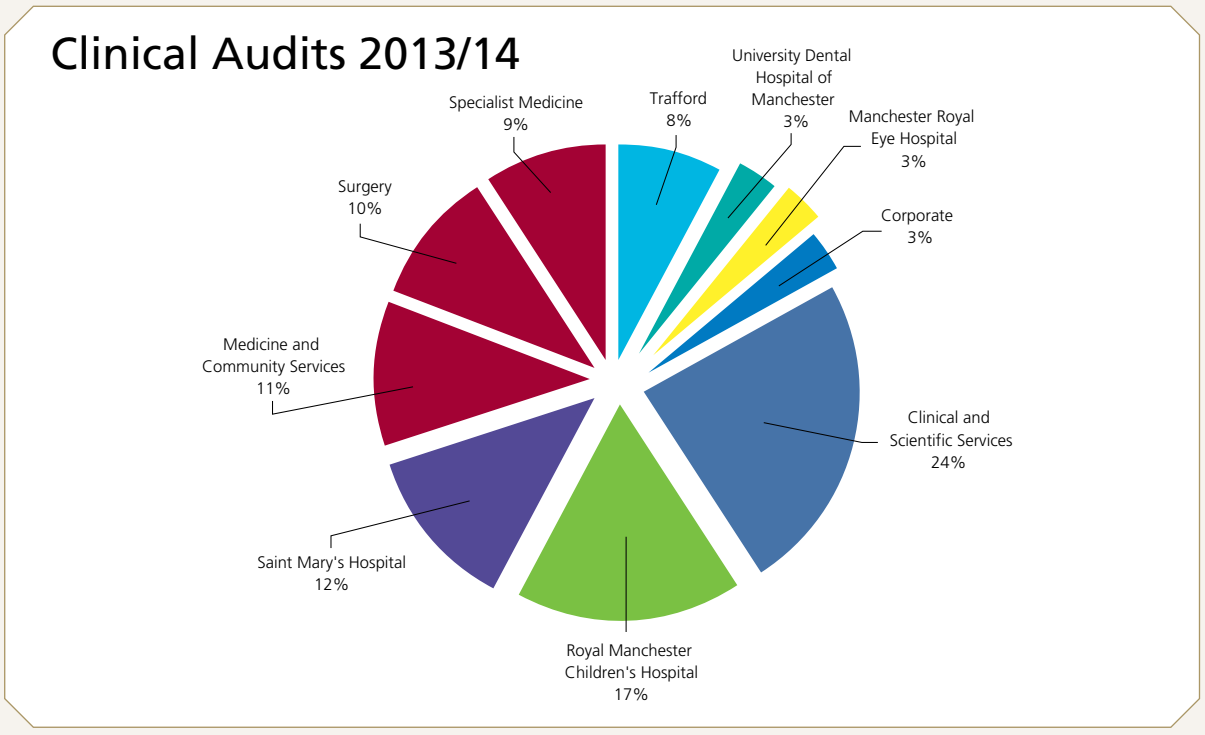
Local Clinical Audit

Clinical audits are carried out by doctors, nurses and other hospital staff. It's a way of ensuring that what should be done is being done, and if not, a plan is put in place to improve things.

Audits can be carried out by collecting information from a patient's health records or asking you for your feedback.

Audits can also be carried out by observing staff as they perform their duties. For example, a Hand Hygiene audit involves watching staff to see if they wash their hands before touching a patient. If the results are poor, changes are made to help improve patient care and ensure a better service. When the changes have been put into place there are further checks to confirm that any improvements have been made; this is called a re-audit.

We undertook 532 clinical audits in 2013/14.



The reports of 214 local clinical audits were reviewed by the provider in 2013/14 and Central Manchester University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

These are some examples of local clinical audit projects undertaken recently at the Trust which resulted in significant improvement:

- A clinical audit was undertaken looking at women of all ages attending continence clinics with bladder problems, making sure they were receiving all the correct assessments and treatment. The audit found that there were a couple of areas requiring improvement, a plan has been put in place to do this and staff are working to make sure that this happens. Once the improvements have been made a re-audit will be undertaken to make sure they are working.

- Hearing loss can be very distressing for people and having the correct hearing device fitted is very important. The Ear Nose and Throat Department (ENT) fit a vibrant sound-bridge which is a new form of hearing device, but an audit highlighted it is not suitable for all patients. Following the audit a new patient pathway was introduced where all patients who are thought suitable to have the new device are discussed at a meeting attended by doctors and other hospital staff before surgery can take place. When the re-audit took place the results showed that there had been an improvement with comments from patients such as, *"I had noticed an improvement hearing the television and in the supermarket I heard the check-out assistant".*

- The Manchester Royal Eye Hospital conducted an audit on the information about not eating or drinking given to patients who were having an eye operation before having their surgery. It found that the information patients received both in writing and verbally was not up-to-date and patients were often not having anything to drink for a longer time than is recommended. A plan has now been put in place to educate staff and also update the information patient's receive.

- Staff in the Manchester Dental Hospital wanted to ensure that they were following guidance issued by NICE, (the National Institute of Clinical Excellence), on the removal of wisdom teeth. To do this, they undertake an audit every year of their practice to see how well they are doing.

  The results of this year's audit showed that their practice is in line with the NICE guidance almost all of the time (96%) and that they had improved on last year, from 92% to 96%. By following these guidelines we can be sure that patient care is maintained at a high standard. Clinical staff involved in this project plan to continue to audit their practice in future.

- An audit was undertaken at Trafford Hospital to see how well staff are using the World Health Organisation's (WHO) Safer Surgery Checklist. The aim of the checklist is to improve patient safety by carrying out a series of additional checks before and after an operation.

  The results showed that there had been significant improvements made since a previous audit, for instance, it showed that the details of the patient who is due for surgery are checked and confirmed on the ward 100% of the time.

  The staff who took part in this audit will share the results with their colleagues to make sure everyone continues to be aware of the importance of completing the checklist correctly.

- The Royal Manchester Children's Hospital use a booking form for patients who need emergency surgery. Information on this form helps staff make sure that the sickest patient gets treated first. A previous audit showed that proper use of the form was poor and clinicians wanted to know if this had improved.

  The audit looked at 250 forms and measured 14 standards, for example, whether the time of booking was recorded. Five standards were met in every case and all other standards had improved to a point where they were met over 90% of the time.

Below are some examples of clinical audit projects where the results demonstrated a high standard of care or service:

- One of the things that patients often complain about is that they are not seen on time when they have an appointment. Staff in the Orthodontic Department at the Dental Hospital wanted to find out whether patients were being seen on time, and if not why that was the case.

  Looking at 146 appointments they found that only 23% (35 patients) arrived either early, or on time. On average patients were kept waiting for eight minutes after their booked appointment time. The main reason why people were seen late is that they arrived late for their appointment. In a very small number of cases, emergency patients had to be slotted in and appointments overran for about 16 patients.

Staff now tell patients how important it is to arrive on time for their appointment and there may be a short wait to be seen. They are also letting patients in the waiting room know if other patients are taking longer to treat that was first thought.

- We know that when patients are first discharged from hospital it is very important that they feel safe and know what help they can expect. Following a stroke, patients who require early supported discharge (ESD) services should expect to be visited at home by a team member within one working day of leaving hospital. The ESD team audited all those patients who required this service from the beginning of April to the end of June 2013 and found that all the patients (12) had been seen well within this timescale.
- Everyone is aware that resources in the NHS must be used in the best possible way. A specialist physiotherapist working with the on-call service carried out an audit to measure whether the service was being used for the right patients. She found that the information being recorded in the log book did not give enough information to decide whether all the patients really needed physiotherapy out of hours. Following discussions of the results with the healthcare team changes were made and when this was re-audited after two months the system was working well and staff were able to be sure that treatment was being given to the people who really needed it out of hours.
- It can be very frightening when our babies become unwell and we need to be sure that they get the right treatment quickly so that they have the best chance of living long healthy lives. Adrenal Insufficiency is not a common condition in babies but can be life-threatening if not recognised early. The specialist paediatric team looked at the treatment of babies up to six months old who were suspected of having this condition over a two year period to see if they had been referred to the Paediatric Endocrinology team. They found that all 44 babies had been referred and that the 22 babies who had abnormal test results were assessed by the team.

National Clinical Audit

During 2013/14 we participated 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 standard, 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 (patient data collected over a short, pre-determined period) for example the College of Emergency Medicine Paracetamol Overdose and those audits where data on every patient with a particular condition or undergoing specific treatment is included, for example patients who have had a stroke and patients who have treatment for certain types of cancer.

A total of 49 audits are listed on the HQIP database for inclusion in the Quality Report. There are a number in which we do not participate as the service is not provided by the Trust. Examples of these are adult mental health disorders

During the period 1st April 2013 – 31st March 2014, 45 national clinical audits and 5 national confidential enquiries covered relevant health services that Central Manchester University Hospitals NHS Foundation Trust provides.

During that period Central Manchester University Hospitals NHS Foundation Trust participated in 100% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The reports of six national clinical audits were reviewed by Central Manchester University Hospitals NHS Foundation Trust in 2013/14 and we intend to take the following actions to improve the quality of healthcare

provided. The majority of National Audits undertaken in 2013/14 will not report their finding until next year. However there are a number of national bodies who provide data on a more regular basis e.g. Sentinel Stroke National Audit Programme (SSNAP) for stroke patients and Trauma Audit and Research Network (TARN) for patients who have had major traumatic injuries and these results are discussed at multi-professional meetings when topics such as getting patient to CT scan in a timely fashion are discussed and actions put in place. These actions have demonstrated an improvement in patient care year on year although there is always the potential for further improvement.

The national clinical audits and national confidential enquiries that Central Manchester University Hospitals NHS Foundation Trust was eligible to participate in during 1st April 2013 – 31st March 2014 are listed below.

The national clinical audits and national confidential enquiries that we participated in, and for which data collection was completed during 2013/14 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Title	Partici-pated ✓/✘	Type of Audit	Target	Number Entered		Explanation of Audit
				CMFT	Trafford	
Acute						
Adult Critical Care Case Mix Programme – ICNARC CMP)	✓	All patients (12 months)	All applicable	1,856 (100%)	225 (100%)	The Case Mix Programme (CMP) is an audit of patient outcomes from adult and general critical care units. All admissions to intensive care and combined intensive care/ high dependency units are included. Data collection is continuous. MRI Critical Care Unit figures are from 01/01/2013 – 31/12/2013. Trafford figures 01/01/2013 – 31/10/2013. Trafford discontinued intensive care provision from 2/12/2013
BTS Emergency Use of Oxygen	CMFT ✓ Trafford ✘	Snapshot (3 months)	All applicable	35 (100%)	Didn't Partici-pate	Oxygen is a drug and must be prescribed in accordance with the hospital oxygen policy. The audit covers those patients on adult wards only over the age of 16 who are on oxygen therapy. Data collection period 15/08/2013 – 01/11/2013.
National Audit of Seizure Management (NASH)	✓	Snapshot	30 patients	30 (100%)	9 (100%)	NASH assessed the immediate care, onward care pathways and prior care of patients attending Emergency Departments with seizures. Sites provided anonymous data on 30 consecutive cases via a bespoke web-based database. Data collection period 01/01/2013 – 30/09/2013.
National Emergency Laparotomy Audit	✓	All patients	Data collection started 7/01/2014	✓	N/A	NELA stands for National Emergency Laparotomy Audit. A clinical audit like NELA is where an independent body assesses the quality of care in hospitals by looking at how it treats the patients and the outcomes of those patients. NELA is a national clinical audit, so that means it is being carried out in over 190 hospitals in England and Wales. NELA will look at the quality of care received by patients undergoing emergency laparotomy.

Title	Partici-pated ✓/✗	Type of Audit	Target	Number Entered		Explanation of Audit
				CMFT	Trafford	
National Joint Registry (NRJ)	✓	All patients (12 months)	All applicable	Hips 118 Knees 138 Shoulder 12 Elbows 3	Hips 86 Knees 140 Shoulder 7 Elbows 2	The National Joint Registry (NJR) was set up to collect information on all hip, knee, ankle, elbow and shoulder replacement operations and to monitor the performance of joint replacement implants. Data collection period 01/01/2013 – 31/12/2013
Paracetamol Overdose (care provided in Emergency Departments - College of Emergency Medicine)	✓	Snapshot (8 months)	Maximum up to 50 patients	47 (100%)	N/A	This audit has been conducted by the College of Emergency Medicine (CEM) before but it is the first audit conducted against the College's revised standards published in 2013, which were produced in cooperation with NPIS and MRHA. The audit reviewed the first 50 consecutive patients aged 18 years or older who present at the Emergency Department with a paracetamol overdose between 1st August 2013 and 31st March 2014.
Severe Sepsis and Septic Shock (College of Emergency Medicine)	✓	Snapshot (8 months)	Maximum up to 50 patients	35 (100%)	N/A	The purpose of the audit is to identify current performance in Emergency Department (EDs) against CEM clinical standards on the recognition and management of adults with severe sepsis or septic shock and show the results in comparison with other departments. The audit reviewed the first 50 consecutive adult patients 18 years of age or older who were diagnosed with either severe sepsis or septic shock (as defined on the CEM standards page) between 1st August 2013 and 31st March 2014.
Trauma Audit & Research Network (TARN)	✓	All patients (12 months)	All applicable	418 Adults 152 Children	N/A	TARN collects important information about the rates of survival for patients who have been injured and treated at different hospitals across England and Wales. It also provides information about the benefits of certain kinds of treatment. Data collection period 01/04/2012 – 31/03/2013
Blood Transfusion						
2012 Audit of the Use of Anti-D	✓ ✓	Snapshot (1 months)	No minimum sample size	44 (100%)	N/A	The Department of Health's latest Better Blood Transfusion initiative (HSC 2007/001) has emphasised the need for improving the safety around all aspects of administration of anti-D immunoglobulin. The audit includes all women booking for delivery. Data collection period 01/05/2013 – 31/05/2013.
2013 Audit of the Management of Patients in Neuro Critical Care Units	Not applicable			N/A	N/A	Central Manchester University Hospitals NHS Foundation Trust does not have Neuro Critical Care Unit

Title	Partici-pated ✓/✗	Type of Audit	Target	Number Entered		Explanation of Audit
				CMFT	Trafford	
2013 Audit of Patient Information and Consent	✓✓	Snapshot (3 months)	24 patients	Awaiting figures		Start date 13/01/2014 – 04/04/2014 across both sites Data submission 30/04/2014. The report is expected in summer 2014
Cancer						
Bowel Cancer (National Bowel Cancer Audit Programme)	✓	All patients (12 months)	All applicable	151 (100%)	53 (100%)	The National Bowel Cancer Audit is a high-profile, collaborative, national clinical audit for bowel cancer, including colon and rectal cancer. This includes patients with a diagnosis date of 01/04/2012 – 31/03/2013 submission date 01/10/2013
Head & Neck Cancer (DAHNO)	✓	All patients (12 months)	All applicable	151 (100%)	10 (100%)	The National Head and Neck Cancer Audit focuses on cancer sites within the head and neck (excluding tumours of the brain and thyroid cancers). This includes patients with a diagnosis date between 01/11/2012 – 31/10/2013.
Lung Cancer (National Lung Cancer Audit)	✓	All patients (12 months)	All applicable	143 (100%)	86 (100%)	The National Lung Cancer Audit looks at the care delivered during referral, diagnosis, treatment and outcomes for people diagnosed with lung cancer and mesothelioma. This includes patients with a diagnosis date between 01/01/2012 – 31/12/2012.
Oesophago-gastric Cancer (National)	✓	All patients (12 months)	All applicable	194 (100%)		The National Oesophago-Gastric Cancer Audit covers the quality of care given to patients with Oesophago-Gastric (OG) cancer. This includes patients with a diagnosis date between 01/04/2012 – 31/03/2013.
Heart						
Acute Myocardial Infarction (MINAP)	✓	All patient (12 months)	All applicable	718 (100%)	20/76 (26%)	MINAP is a clinical audit looking at performance of all ambulance and hospital services in England, Wales and Belfast that provide care for patients with a heart attack. Data is collected on all patients. The figures shown are from 01/01/2013 – 31/12/2013.
Adult Cardiac Surgery Audit (ACS)	✓	All patients (12 months)	All applicable	664 (100%)	N/A	The Adult Cardiac Surgery Audit aims to improve the quality of care for cardiac patients by comparing local hospital performance with national agreed standards, and to understand clinical trends within cardiac surgery in the UK. Data is collected on all patients. The figures shown are from 01/01/2013 – 31/12/2013.

Title	Partici-pated ✓/✘	Type of Audit	Target	Number Entered		Explanation of Audit
				CMFT	Trafford	
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	✓	All patients (12 months)	All applicable	200 (100%)	45 (100%)	The audit looks at implantable devices to assist in the management of heart failure. The figures shown are from the 01/01/2013 – 31/12/2013
Congenital Heart Disease (Paediatric Cardiac Surgery)	✓	All patients (12 months)	All applicable	11 (100%)	N/A	The majority of data is submitted from Alder Hey as only a few specialist procedures are performed at RMCH.
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	✓	All patients (12 months)	All applicable	1536 (100%)	N/A	This National Audit provides comparative data on the provision of PCI in the UK. The aim of the audit is to describe the quality and patterns of care, the process of care and outcomes for patients. The figures shown are from the 01/01/2013 – 31/12/2013
Heart Failure (HF)	CMFT ✓ Trafford ✘	All patients (12 months)	All applicable	257 (100%)	✘	The National Heart Failure Audit aims to provide national comparative data to help clinicians and managers improve the quality of heart failure services and outcomes for patients. The figures shown are from 01/01/2013 – 31/12/2013
National Cardiac Arrest Audit (ICNARC)	CMFT ✓ Trafford ✘	All patients (12 months)	All applicable (who meet audit criteria)	152 (100%)	✘	Audit Criteria for the 2011/12 Audit 1. Patient must be over 28 days old. 2. 2222 call must have been made. 3. Cardiac Arrest Team to attended 4. The patient received CPR and/or defibrillation Data collection period 01/04/2012 - 31/03/2013. Trafford began submitting to the audit in October 2013
National Vascular Registry (elements include CIA peripheral vascular surgery, VSGBI Vascular Surgery Database	✓	All patients	All applicable	272 (94%)	N/A	The National Vascular Registry (NVR) aims to improve the quality of care for patients undergoing different vascular procedures. Data entry commenced for Lower Limb Angioplasty/stenting, Lower Limb Bypass and Lower Limb Amputation on the 10th December 2013.
Pulmonary Hypertension Audit	Not applicable					The Pulmonary Hypertension Audit measures the quality of care, activity levels, access rates and patient outcomes of pulmonary hypertension services in centres designated by the National Commissioning Group.

Title	Partici-pated ✓/✘	Type of Audit	Target	Number Entered		Explanation of Audit
				CMFT	Trafford	
Long Term Conditions						
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	✓	All patients (3 months)	All applicable	Awaiting figures	Awaiting figures	The National COPD Audit Programme audit of acute exacerbation COPD starts 01/02/2014. This will be an audit of all admissions between 01/02/2014 – 30/04/2014, with data entry to be completed by 31/05/14.
National Adult Diabetes Audit	CMFT ✓ Trafford ✘	All patients (15 months)	All applicable	12866/ 13200 (98%)	✘	Trafford did not participate as they do not have the diamond database. The audit includes all patients of all ages with a diagnosis of diabetes mellitus recorded between 01/01/2012 – 31/03/2013.
National Pregnancy in Diabetes Audit	✓	All patients (18 months)	All applicable	28 (100%)	10 (100%)	The NPID audit will enable all diabetes pregnancy services to measure their performance against NICE clinical guidelines and quality standards and peer units. Submission January 2014.
National Diabetes In-patient Audit	✓	Snapshot (One week)	All applicable	172 (100%)	49 (100%)	The National Diabetes In-patient Audit (NaDIA) is a snapshot audit of diabetes in-patient care in England and Wales. The audit looks at the following areas: Harm resulting from the in-patient stay. Patient experience of the in-patient stay. The change in patient feedback on the quality of care since NaDIA 2011. In 2013 the audit took place during the week 16-20 September 2013
Inflammatory Bowel Disease (IBD)	✓	Snapshot (12 months)	50 Patients	13 (100%)	16 (100%)	Patients who have been admitted for treatment or surgery for ulcerative colitis Data collection for the in-patient care and in-patient experience elements of the audit will run between 1st January 2013 and 31st December 2013. Trusts are requested to collect data on up to 50 patients.
Inflammatory Bowel Disease (IBD Children)	✓ RMCH	Snapshot (12 months)	50 patients	2 (100%)	N/A	Children (up to age 15) who have been admitted for treatment or surgery for ulcerative colitis.
IBD Biologics Audit	✓	Snapshot	10 patients	11 (100%)	10 (100%)	The purpose of this audit is to measure the efficacy, safety and appropriate use of biologics therapies (Infliximab and Adalimumab) in patients with inflammatory bowel disease in the UK.
IBD Biologics Audit	✓ RMCH	Snapshot	10 patients	4 (100%)	N/A	Management of children on biological therapies and patient reported outcomes.
Renal Replacement Therapy (Registry)	✓	All patients (12 months)	All applicable	2082 (100%)	N/A	The UK Renal Registry monitors indicators of the quality as well as quantity of care, with the aim of improving the standard of care. Data collection period 01/04/2012-31/03/2013.

Title	Partici-pated ✓/✗	Type of Audit	Target	Number Entered		Explanation of Audit
				CMFT	Trafford	
Rheumatoid and Early Inflammatory Arthritis	✓ (CMFT/ Trafford)	All patients	All applicable			The national clinical audit is being led by the British Society for Rheumatology in partnership. The audit will use criteria derived from the NICE Clinical Guidelines for Rheumatoid Arthritis (CG79), NICE Quality Standards for Rheumatoid Arthritis (QS33) and the recently published Best Practice Tariff (BPT) for early inflammatory arthritis which will align with NICE Quality Standards. The audit will run over continuously over the three years. Data entry begins on the 01/02/2014.
Mental Health						
Mental Health Programme National Confidential Inquiry into Suicide and Homicide for People with Mental Illness	Not applicable					Not undertaken in this Trust
National Audit of Psychological Therapies (NAPT)	Not applicable					Not undertaken in this Trust
Prescribing Observatory for Mental Health (POMH)	Not applicable					Not undertaken in this Trust
Older People						
Sentinel Stroke National Audit Programme	✓ (CMFT/ Trafford)	All patients (12 months)	All applicable	309/313 (98%)	165 (100%)	The Sentinel Stroke National Audit Programme (SSNAP) collected information on a patient's first three days in hospital, this ended in December 2012 and from the 01/01/2012 data was entered onto the new Sentinel Stroke National Audit Programme (SSNAP)
Fall and Fragility Fractures Audit Programme (FFFAP) Includes National Hip Fracture Database.	✓ (CMFT/ Trafford)	All patients (12 months	All applicable	203 (100%)	87 (100%)	The National Hip Fracture Database is a joint venture of the British Geriatrics Society and the British Orthopaedic Association, and is designed to facilitate improvements in the quality and cost effectiveness of hip fracture care. Data collection from 01/01/2013 – 31/12/2013 (18/11/2013 Trafford) due to new service model.

Title	Partici-pated ✓/✗	Type of Audit	Target	Number Entered		Explanation of Audit
				CMFT	Trafford	
Women's & Children's Health						
Maternal, Infant and Newborn Programme	✓ St Mary's	All patients (12 months)	All applicable	61 (100%)	N/A	The aim of the programme is to provide robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services. Data collection period 01/01/2013 – 31/12/2013
Neonatal Intensive and Special Care (NNAP)	✓ St Mary's	All patients	All applicable	1019 (100%)	N/A	The audit addresses eleven questions and collects data on every baby admitted to a neonatal unit. Data collection period 01/01/2013 – 31/12/2013
Moderate to Severe Asthma in Children (College of Emergency Medicine)	✓ RMCH	Snapshot (8 months)	Maximum up 50 patients	50 (100%)	N/A	The purpose of the audit is to identify current performance in Emergency Department (EDs) against CEM clinical standards and show the results in comparison with other departments. The audit reviewed the first 50 consecutive cases of children aged between 5 years and under 16 years old who presented at the ED with moderate or severe asthma between 1st August 2013 and 31st March 2014.
Paediatric Intensive Care (PICANET)	✓ RMCH	All patients	All applicable	648 (100%)	N/A	PICANet aims to continually support the improvement of paediatric intensive care throughout the UK through clinical audit. The Paediatric Intensive Care Audit Network (PICANet) is a national audit co-ordinated by the Universities of Leeds and Leicester which collects data on all children admitted to paediatric intensive care units (PICUs) across the UK. The figures shown are from 01/01/2013 – 31/12/2013.
British Thoracic Paediatric Asthma (British Thoracic Society)	✓ RMCH	Snapshot (1 month)	All applicable	48 (100%)	N/A	The audit is of children over 1 year of age admitted with a final diagnostic coding label of pneumonia into a paediatric unit and under paediatric care. Data collection from 01/11/2013 – 30/11/2013. Data submission 28/02/2014
British Thoracic Paediatric Bronchiectasis (British Thoracic Society)	✓ RMCH	Snapshot (2 months)	All applicable	22 (100%)	N/A	The audit covers children who have an out-patient appointment for bronchiectasis (i.e. those under the care of a paediatrician) Data collection 01/10/2013 – 30/11/2013. This is a follow-up or review appointment (rather than the first clinic appointment for that patient). Data submission 07/02/2014
National Paediatric Diabetes Audit	✓ RMCH	All patients	All applicable	241 (100%)	69 (100%)	The audit is for all children (up to and including 24 years of age) that have been seen at paediatric diabetes clinics between 01/04/2012 – 31/03/2013 Data submission 31/01/2014.

Title	Partici-pated ✓/✗	Type of Audit	Target	Number Entered		Explanation of Audit
				CMFT	Trafford	
Child Health Programme (CHRUK)	✓ RMCH	All patients	All applicable	1 (100%)	N/A	The Child Health Reviews-UK case review project is a themed review of cases of mortality and morbidity in children and young people with epilepsy, at all stages of the care pathway including primary and emergency care.
Epilepsy 12	✓ RMCH	Snapshot (4 months)	All applicable	Awaiting figures	N/A	Epilepsy 12 is a national three-year audit to help improve patient outcomes and the quality of care and service provided. Inclusion Criteria. First EEG between 1st January and 31st October 2013. • The child has a 'first paediatric assessment' for the 'paroxysmal episode or episodes' between 1st January and 30th April 2013 • Child is older than 1 month and younger than 16 years at 'first paediatric assessment' Data submission 12/05/2014
Other						
Elective Surgery (National PROMS Programme)		Selected Patients	All appli-cable	733/ 1,088 (67.4%)	There were no eligible hospital episodes	Patients Reported Outcomes Measures (PROMS) are measures of a patient's health status or health-related quality of life. They collect information on the clinical quality of care delivered to NHS patients as perceived by the patients themselves. They are short, self-completed questionnaires, which measure the patients' health status or health-related quality of life at a single point in time. Data collection from 01/04/2012 – 31/03/2013.

The reports of six national clinical audits were reviewed by the provider in 2013/14 and Central Manchester University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. The majority of National Audit undertaken in 2013/14 will not report their finding until next year. However there are a number of national bodies who provide data on a more regular basis e.g. SSNAP for stroke patients and Trauma Audit and Research Network [TARN] for patients who have had major traumatic injuries and these results are discussed at multi-professional meetings when topics such as getting patient to CT scan in a timely fashion are discussed and actions put in place. These actions have demonstrated an improvement in patient care year on year although there is always the potential for further improvement.

National Confidential Enquiries (NCE)

Participation

In 2013/14 there were five National Confidential Enquiries (NCE) and we participated in all of the relevant studies.

During that period we participated in 100% national confidential enquiries which it was eligible to participate in. The national confidential enquiries that we were eligible to participate in during 2013/14 are as follows:

- Tracheostomy Care
- Lower Limb Amputation
- Subarachnoid Haemorrhage
- Alcohol Liver Disease

The national confidential enquiries that we participated in, and for which data collection was completed during 2013/14 are listed below alongside the number of cases submitted to each enquiry as a percentage of the number of registered cases required by the terms of the enquiry.

NCE Study	Eligible	Participated	% Submission	Status
Tracheostomy Care	Yes	Yes	86%	Complete
Lower Limb Amputation	Yes	Yes	50%	On-going
Subarachnoid Haemorrhage	Yes	Yes	On-going	On-going
Alcohol Liver Disease	Yes	Yes	83%	Complete

Outcomes

The report of two studies were received and are both currently being reviewed by the Trust; these were the reports of alcohol related liver disease and subarachnoid haemorrhage, published in June and November 2013 respectively.

NICE Guidance

NICE guidance sets the standards for high quality healthcare and encourages healthy living.

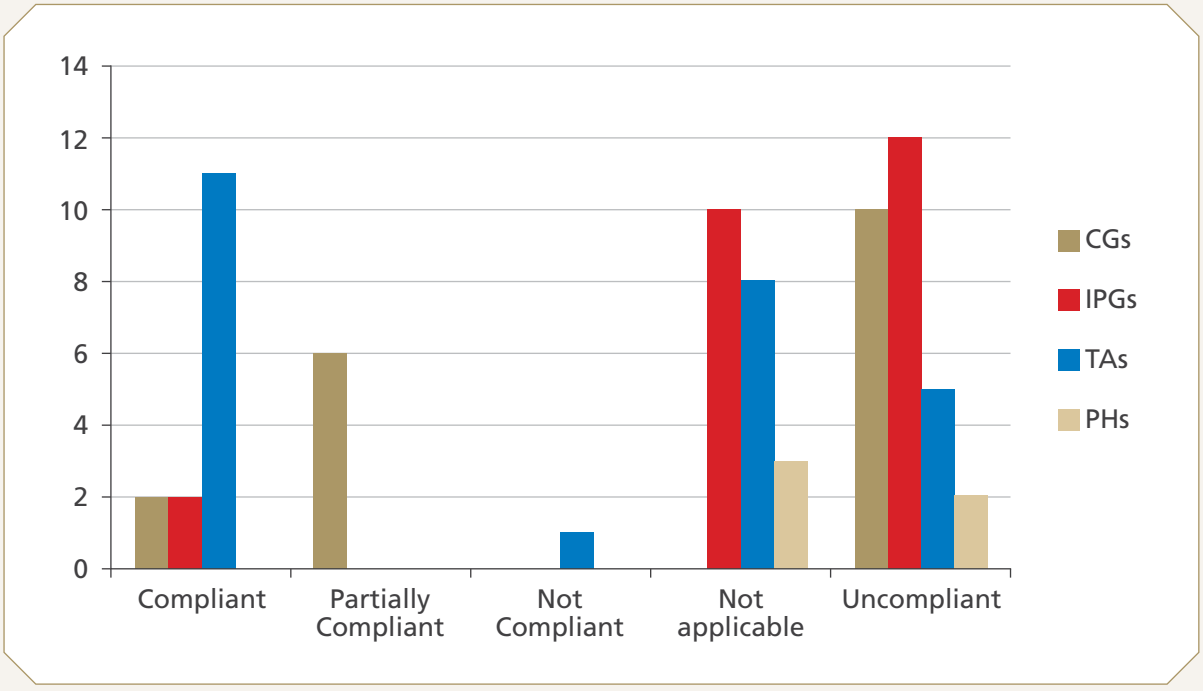
In 2013/14 NICE published guidance in the form of Clinical Guidelines (CGs), Interventional Procedures (IPGs), Technology Appraisals (TAs) and Public Health Guidance (PHs).

We undertake a communication and assessment process on each piece of NICE Guidance published. Newly issued clinical and interventional procedures guidance is sent to representatives in each Clinical Division. Technology Appraisals, (Medicines), are received by Pharmacy who identify an appropriate consultant to review, act and respond. These representatives discuss the applicability of the guidance within their divisions and respond to say whether it is applicable, where it is applicable and whether the Division complies with the recommendations. The Trust's position is that we aim to be fully compliant with all NICE guidance.

Responses to guidance citing compliance are recorded on a 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 our audit programme.

Pieces of guidance citing partial or non-compliance are referred to the Clinical Practice Committee which is a sub-committee of our Clinical Effectiveness Committee. Each Division is represented at the committee and the membership discuss the implementation of NICE guidance, any positions of partial compliance with recommendations and putting working groups, actions plans and timescales in place to lead to compliance. The committee also notes and approves on behalf of the Board any NICE guidance or parts of NICE guidance which the Trust will remain non or partially compliant with for the foreseeable future and the reasons for the decision.

Chart 1: Current Trust status of NICE guidance released in the year of 2013/14 to date.



Research and Innovation

Greater Manchester Research Landscape

Research and innovation at CMFT is a continuous cycle of discovering, translating and implementing new treatments and methods of care to improve the health of our patients. During 2013 we have developed and strengthened new and existing partnerships to improve the bench to bedside journey of research translation to improved healthcare for our patients.

Greater Manchester Academic Health Science Network (GM AHSN)

In May the GMAHSN was officially launched with the aim of improving the health of Greater Manchester through adopting effective methods of the NHS, implementing the most innovative and promising best practice in healthcare. The network aims to get the NHS working differently and think about a regional approach to yield a step change in healthcare and wealth.

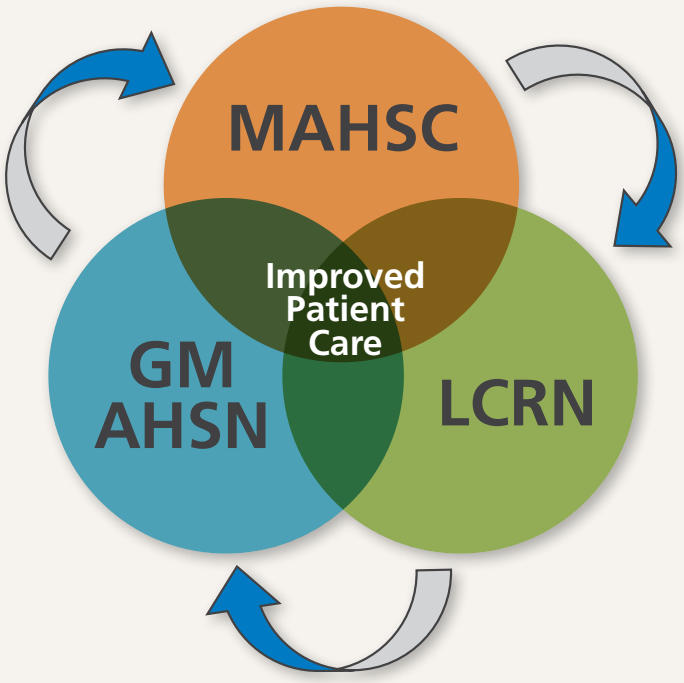
The footprint of the GMAHSN brings NHS commissioners and providers, including CMFT, together with the new matching footprint of NIHR Clinical Research Network: Greater Manchester, 13 local authorities and a number of other health organisations, to render strategic decision making for Greater Manchester less complex.

NIHR Clinical Research Network: Greater Manchester

In September the Department of Health announced we had been chosen as one of 15 Trusts nationally to host a NIHR Local Clinical Research Network (CRN). The CRN is the clinical research delivery arm of the NHS. It provides infrastructure funding to hospitals and surgeries for research nurses, scans and other costs associated with carrying out academic clinical research in the NHS and staff with appropriate expertise for recruiting to commercial clinical research.

The CRN: Greater Manchester will help to increase the opportunities for Greater Manchester patients to take part in clinical research, ensure that studies are carried out efficiently, and help companies to carry out vital clinical research into potential life-saving new treatments and diagnosis. As host, CMFT will help set the level of ambition for clinical research delivery across the network locally and ensure it occupies the place it deserves in the day-to-day work of the NHS.

The diagram right shows how all these networks work together to deliver improved patient care within the NHS.



Manchester Academic Health Science Centre (MAHSC)

In December Manchester was awarded the only Academic Health Science Centre (AHSC) outside of the South East. MAHSC is a partnership between The University of Manchester and six NHS organisations, including CMFT, with the aim of increasing strategic alignment of NHS providers and the university, specifically in world-class research, health education and patient care. MAHSC acts as a beacon within the health system, providing clinical and research leadership and helping health care organisations reap the benefits of research and innovation to drive improvements in care.

Excellence in research

In July 2013 it was announced that the Trust had achieved an all-time high in research activity during 2012/13. During this period over 20,000 of our patients were recruited to clinical studies, meaning we were the second highest recruiting Trust in the UK. We are committed to giving patients the choice to take part in clinical trials and have run several successful communications campaigns, including International Clinical Trials Day, to raise the awareness of research and its benefits, amongst staff and patients.

In 2013/14 15,583 patients were recruited to participate in research approved by a research ethics committee within the organisation.

Key achievements (April 2013–March 2014)

- CMFT researchers won a number of awards at the Greater Manchester 2013 Clinical Research Awards including Dr Rick Body, Principal Investigator of the Year and Sarah Thorpe, Research Nurse of the Year.
- Researchers from CMFT and The University of Manchester identified proteins in the blood that could be used to predict whether a woman in her first pregnancy is at increased risk of developing pre-eclampsia.
- The Chancellor, George Osborne, announced a Peking-Manchester Centre for Genomic Medicine in October. The new partnership between Peking University and the Manchester Centre for Genomic Medicine will deliver cutting-edge translational research that will help our clinicians develop innovative diagnostics and treatments to benefit patients both in the UK and worldwide.
- In December 2013 Dr Alex Heazell, Clinical Director of the Tommy's Maternal and Fetal Health Research Centre at Saint Mary's, was awarded a NIHR Clinician Scientist award for his research into the prevention of stillbirth.
- Researchers from CMFT and the Manchester Cancer Research Centre found pancreatic cancer cells may have their own specialised energy supply that maintains calcium levels and keeps cancer cells alive. Maintaining a low concentration of calcium within cells is vital to their survival and this is achieved by calcium pumps on the plasma membrane.
- In January 2014 the Manchester Royal Eye Hospital recruited the first three global recruits to the INJECT trial. This trial is a global observational study of the treatment JETREA (ocriplasmin) on the eye condition Vitreomacular Traction (VMT) to evaluate safety, clinical effectiveness and health-related quality of life outcomes in a large scale patient population.
- Researchers from The University of Manchester and CMFT found that newborn babies with transient congenital hyperinsulinism (CHI), the clinical opposite of diabetes, are at risk of developing long-term disability or brain damage due to low blood sugars. Previously it was thought only babies with the most severe form, known as persistent CHI, were at risk of brain damage.

- As part of an international study, researchers at the NIHR Musculoskeletal Biomedical Research Unit helped identify 42 genetic risk markers associated with rheumatoid arthritis.
- Researchers from Saint Mary's Hospital and The University of Manchester identified a new gene, which increases understanding of the rare inherited disorder Perrault syndrome.
- In November the MedTech Centre Incubator was officially opened by Miles Ayling, Director of Innovation, NHS England. The Incubator is a joint venture between Manchester Science Park, CMFT and TRUSTECH. The Incubator provides biomedical companies with accommodation and support, including access to clinical expertise within CMFT, to help them to grow and develop healthcare products.
- In December Alicia D'Souza, Honorary Lecturer at The University of Manchester, won 1st place in the CMFT Research Conference oral presentation competition. Her presentation *'Why do athletes have a slower heart rate?'* showed findings that heart rate response to exercise is not due to the effects of nerves on the heart as previously thought, but that there are training-induced changes to the heart's pacemaker function.

Improving our research figures (April 2013–March 2014)

1. 15,583 patients recruited to participate in research studies
2. 720 research studies open to recruitment or in the follow up phase
3. 278 new studies approved this year with set-up times and recruitment of first patient quicker than ever
4. 88 new external researchers enabled to conduct research in our organisation via research passports

Medical Education and Library Services

The Postgraduate Medical Education Team has continued to provide and host a wide variety of professional teaching programmes for our trainee and junior medical staff, local GPs and to support multi-professional internal events. A range of Trust organised events has attracted high profile delegates and speakers throughout the year. This included a well-received event for internationally qualified doctors in collaboration with the General Medical Council. Work around an enhanced induction and support programme for internationally qualified doctors recruited to the Trust has been recognised by a number of Royal Colleges and was nominated as a finalist and won an award in the LEAN Health Academy Awards in February 2014.

Support for our trainees and trainers have been strengthened with the appointment of a number of key Associate Directors for Postgraduate Medical Education and the implementation of a new internal Quality Improvement Framework. The Quality Improvement Framework has allowed the Postgraduate team to engage more closely with clinical and managerial teams within a structured process. This approach utilises the internal expertise of clinicians and managers to advise on the required change and improvement.

The Undergraduate Medical Education Team has continued to develop its support for medical students on their clinical placement years both here at the Trust and at its associated district hospitals. With the introduction of the new simulation requirements into the undergraduate curriculum, the team have been able to enhance the clinical skills environment and facilities by the acquisition of dedicated space for simulation provision for the medical students.

The Library Service has continued to deliver a very high quality service on both the central and Trafford sites, on an equitable basis, to all our staff, trainees and students. Highlights from 2013 include a growth in the number, range and quality of electronic learning resources, including the purchase of three very popular 'point of care' tools to enhance patient safety. We achieved a very high compliance score (98%) on the annual national Library Quality Assurance Framework (LQAF) return, making it the joint top score in the whole of the NHS North West. The service participated in a wide variety of activities and events, including contributions to enhancing equality and diversity. The service catered for an ever increasing demand for literature searches and training to support patient care, service development, research and educational needs.

Medical Revalidation

The law requires any doctor who treats patients to be registered with the General Medical Council (GMC). Medical Revalidation was introduced across the UK on 3rd December 2012 and will help the GMC improve the way they regulate doctors who practise medicine in the UK. The GMC is doing this by working with healthcare employers, such as ours to ensure we use our appraisal systems to regularly check that our doctors are up to date and fit to practise. A doctor's appraisal is an annual review of their performance against the various elements of their job role.

Medical Revalidation
right for patients, right for doctors

Revalidation ensures that doctors are constantly checked against the professional standards that the GMC sets and those that patients expect their doctor to meet. Over time, we believe Revalidation will improve the care that patients receive from doctors and will mean that they are safer when they receive treatment from them. Revalidation will help to do this because of the link that the GMC has made between their guidance for doctors and the appraisals they receive from CMFT. A better system of appraisals for doctors will also help the Trust to take action to deal with any concerns about a doctor's practice before patient safety and experience is affected.

We believe that patients have an important role to play in the appraisal and Revalidation of doctors. Patients will have an opportunity to be actively involved in the process by providing feedback to doctors about their practice. Some doctors have already asked their patients for feedback about their practice and now that Revalidation has begun, all doctors will do this regularly.

In order to support our doctors through the Revalidation process, we have provided them with a web based Revalidation system. This system records every doctor's appraisal electronically, making it easier for them to store documents that will help to show that they meet the required standards. It also means that we can track where doctors are in the appraisal and Revalidation process.

External Regulation

Central Manchester University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully registered with no conditions. Central Manchester University Hospitals NHS Foundation Trust has had no conditions on registration.

The Care Quality Commission has not taken enforcement action against Central Manchester University Hospitals NHS Foundation Trust during 2013/14.

Central Manchester University Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC in 2013/14.

We work closely with the CQC on maintaining high quality services. This year they visited a number of areas including the Manchester Royal Infirmary, the Royal Manchester Children's Hospital, Salford Child and Adolescent Mental Health Services and Trafford Hospital. Central Manchester University Trust is not subject to periodic reviews by the CQC.

Following the CQC unannounced inspection to the Manchester Royal infirmary and the Royal Manchester Children's Hospital of 16th-20th December 2013 the Trust was informed that the CQC had concerns in respect of Outcome 5 (Nutrition) and Outcome 21 (Records).

The concerns in respect of nutrition were related to the choice of food that patients have, this was a particular issue in the Royal Manchester Children's Hospital. The Trust has taken the comments of the CQC on board and will continue to strive to ensure that a choice of nutritious food is available to all patients regardless of age.

The concerns raised in relation to clinical record keeping are known to the Trust and are reviewed on a monthly basis at Board level. The Trust has invested a huge amount in the management of risks associated with the fact that the records are still, largely, paper based. The Trust is working hard to develop a bespoke electronic record which will meet the needs of patient care delivery for all specialties.

It is important to note that the CQC have judged the findings in respect of both Outcome 7 and Outcome 21 as having a "minor impact on people who use the service".

We welcome the unannounced CQC inspections as part of our own assurance mechanisms, it is important to us that people who are independent of the organisation provide feedback to make sure we are delivering the best possible care.

Our Commissioners have started a programme of quality review and we are working with them to ensure they have all the information they need to come to a view on care provided.

The first of these unannounced inspections by the Central Manchester Clinical Commissioning Group took place in February and March 2014. The CCG reported that the visits to the Trust were a positive experience on the whole, showing staff who were engaged and positive about the environment they worked in. There were no major concerns identified in relation to the quality or safety of services. As with any visit, recommendations were made and these will be addressed by the Trust. These concerns included issues such as effective discharge arrangements and multi-disciplinary team meetings.

Other external bodies such as the Human Tissue Authority visit our premises regularly and their findings are reported at Board level. This year they visited the Manchester Royal Eye Hospital Eye Bank and were very impressed with everything they saw. No compliance issues were identified.

We continue to work closely with all external regulators and inspection bodies and will use their findings to make improvements where needed and as an assurance of quality.

Our response to the Mid Staffordshire Hospital investigation recommendations

In January 2013 Sir Robert Francis published his report into standards of care at the Mid Staffordshire Hospitals. In his report he made 290 recommendations which were applied to both national bodies and local care providers such as ourselves. The publication of this report was followed by four other key reports, these are:

- **A promise to learn, a commitment to act:** Improving the safety of patients in England. National Advisory Group on the Safety of Patients in England. August 2013 (the Berwick Report).
- **Review into the quality of care and treatment provided by 14 hospital trusts in England:** Overview report. Professor Sir Bruce Keogh. July 2013
- **Patients first and foremost:** The initial government response into the Mid-Staffordshire NHS Foundation Trust Public Inquiry. March 2013
- **Hard Truths:** The journey to Putting Patients First. November 2013

Over the last year this organisation has completed an in-depth review and gap analysis of all of these reports, developing an action plan and, more importantly ensuring all of the areas were fully addressed in the organisational objectives and work plans.

The recommendations relevant to the organisation fall under 18 broad themes. These are:

- Implementing the recommendations
- Clarity of values and principles
- Identification of who is responsible for the patient
- Communication with and about patients
- Continuing responsibility for care
- Hygiene
- Provision of food and drink
- Medicines Administration
- Recording of routine observations
- Common information practices, shared data and electronic records
- Comparable Quality Report
- Accountability for Quality Report
- Regulatory oversight of Quality Report
- Access to data
- Access to Quality and Risk Profile (now called the CQC Intelligent Monitoring Report)
- Using patient feedback
- Follow up of patients
- Enhancing the use, analysis and dissemination of healthcare information

Progress

Within the last six months staff have worked extremely hard in implementing and embedding changes to support the recommendations and continue to do so. Although some of the recommendations are already in place, these have still been reviewed to ensure the systems remain effective.

The action plan was published on our website in December 2013 showing the organisation's position at the end of the calendar year 2013.

Some Achievements

- In September 2013, we implemented a Quality Review process across the entire organisation. The aim of the Quality Review is to examine the quality of care being delivered within each separate Division and to ensure any risks identified are appropriately managed and mitigated. The review involved around 200 staff of all grades, patients and governors. To avoid bias/conflict of interest and promote candour staff did not review their own Divisions. It is envisaged that this will develop into a standard process for reviewing quality of care across the organisation.
- We have developed a set of values and associated behaviours through widespread staff engagement and involvement. There is a strategic plan in place agreed at Board level that aims to clearly and explicitly communicate the values and behaviours across the Trust. This embedded in all organisational processes for example inclusion in employment contracts for all employees. The Nursing and Midwifery Strategy has been revised for 2013/14 to include refreshed commitments.
- As part of ensuring evidence based care is consistently given, Divisions were asked early this year to review their current clinical pathways ensuring these are up to date and where there are conditions with no pathways that these are developed. This is also reiterated in the Medical Director's work plan 2013/14.
- We continue to be committed to improving both nursing and medical education. In nursing, Practice Education Facilitators, ward managers and matrons continue to be involved in the recruitment and selection process to nurse training in all partner universities. Practice Educators sit on curriculum planning and development groups with staff currently sitting on pre-registration interview panels.
- There is a clear process agreed with partner Universities to support students in the escalation of any clinical or quality concerns when they are within practice placements. This process is monitored both internally and externally. In order to incentivise staff, we have implemented two types of awards; the GEM awards 2013 and Chief Nurse's award to recognise nursing and midwifery staff who go the extra mile.
- Various improvements have been made in relation to communicating with and about patients. For example in the Children's Division a project has been underway to review and improve the quality of ward rounds. This project has focused on communication between staff, patients and their families with a number of initiatives put in place to improve communication between teams and families.
- The Organisation is committed in supporting new staff in their various roles. For example we have a consultant leadership programme designed to support newly appointed consultants within the first 12 months of being in post.

- All staff new in post have a practical drug administration assessment which ensures compliance and knowledge of our drug policies and procedures. To further ensure the safe administration of drugs, the majority of wards have ward-based pharmacists who support the safe management and dispensing of medications.
- A number of policies have been reviewed to ensure they reflect the relevant recommendation for example, Being Open, Whistle blowing, Complaints policies.
- To improve the quality of patient records, the organisation has invested on an electronic patient record system which is currently being piloted in parts of the organisation. This is a bespoke system which has been developed in-house with the flexibility of being modified to meet the needs of the various specialities. It is anticipated that the whole organisation will be using this system in 2018.

Further work to be done

Although progress has been made in implementing and embedding some of the recommendations as highlighted above, not all have been implemented therefore work continues. Examples of what we are doing include:

- Consideration of the 'being open' concept being embedded in all policies in the organisation and not just those relating to complaints and incidents.
- We are working with Sodexo, our facilities provider, to ensure that the provision of food and drink meets the requirements of all our patient groups. The organisation is currently working towards implementing an electronic menu ordering system which incorporates pictures of food to support choice for patients at the point of ordering.
- Although clinical audit continues to be a process used by the organisation to monitor and improve the quality of care delivered to patients, the Clinical Audit Team is working with Divisions to ensure not only are audits being done but that all actions arising from clinical audits are being addressed.

The provision of safe, high quality care is central to what we want to do here and we remain committed to learning the lessons from Mid Staffordshire. We will continue to work hard to implement all of the recommendations and share those improvements with patients and partners going forward.

Prevent Strategy

The UK faces a range of terrorist threats. All the terrorist groups who pose a threat to us seek to radicalise and recruit people to their cause. Prevent is part of the Government's counter-terrorism strategy, which is led by the Home Office. The Prevent strategy focuses on stopping vulnerable people before they become terrorists or support terrorism.

Prevent addresses all forms of terrorism, including some aspects of non-violent extremism. The NHS has been identified as a key player in supporting the Prevent strategy, as healthcare staff are considered to be well placed to help to identify concerns and protect people from radicalisation, ensuring that vulnerable people are given appropriate advice and support.

As part of the Prevent strategy, a programme known as 'Channel' is available across England and Wales. This is a multi-agency, safeguarding programme that provides support to people at risk of being drawn into terrorist related activity.

We are currently undertaking a programme to raise awareness and help staff to identify signs of vulnerability in those people they come across. At the heart of this work has been the Workshop to Raise Awareness of Prevent (WRAP), an interactive and facilitated workshop developed by the Home Office. It covers issues such as the history of terrorism, radicalisation as a social process, connections to other forms of extremism and factors which may contribute to vulnerability. The workshop is intended to provide NHS staff with:

- An awareness and understanding of Prevent and their role within it;
- The knowledge and confidence to discuss related issues; and
- The ability to use existing expertise and professional judgement to recognise and refer potentially vulnerable individuals who may be susceptible to radicalisation.

In order to deliver this training to approximately 12,500 staff throughout the organisation, we have trained 57 members of staff to be WRAP facilitators. Training started in September 2013 and, at time of publication 3,551 members of staff have received the WRAP.

Changes at Trafford Hospitals

In November 2013 a number of the services provided by Trafford Hospitals Division (THD) changed significantly as the new clinical model for Trafford was introduced. The new model was designed to enable the continued provision of high-quality, safe and sustainable hospital services at Trafford General Hospital and was the subject of a public consultation process led by Trafford Clinical Commissioning Group (CCG).

Urgent Care - A new Urgent Care Centre replaced the Accident & Emergency Department at Trafford General Hospital (TGH). It is open from 8.00 am to midnight and is staffed by a highly skilled team of Accident and Emergency doctors and nurses. It provides treatment for adults and children who have a need for care that is not life-threatening but where prompt help, care or advice is required. Those who attend with more serious conditions that prove to be life-threatening are stabilised and safely transferred to the most appropriate nearby hospital.

Acute Medicine - The Acute Medical Unit (AMU) receives patients from the Urgent Care Centre and also directly from GPs. The AMU provides an ambulatory care service and has beds for patients requiring admission to hospital. In-patient acute medical care is also provided by two medical wards.

Manchester Elective Orthopaedic Centre - The Manchester Elective Orthopaedic Centre is expected to become a centre of excellence for Orthopaedic patient care and research. Most of the planned day case and in-patient Orthopaedic surgery for Trafford and Manchester patients, including joint replacements for hips, knees, shoulders and elbows, now take place in purpose-built facilities on the Trafford Hospital site.

Surgery - Day case surgery continues to take place at Trafford Hospital and the volume is expected to grow in the future. However, emergency and major planned surgery, which may require an overnight stay, is no longer carried out at Trafford Hospital. This surgery is now carried out at Manchester Royal Infirmary or Saint Mary's Hospital.

Critical Care - Patients needing more intensive observation, treatment and nursing care than is possible on a general medical or surgical ward are cared for in Trafford's Critical Care Unit. Patients requiring a full intensive care facility are stabilised at Trafford Hospital and transferred elsewhere.

Services Unchanged Under the New Model - Trafford Hospital continues to provide a number of other services, including in-patient care for Stroke, Rehabilitation and Intermediate Neuro-Rehabilitation patients, Children's day surgery, pre-op clinics, diagnostic facilities and a comprehensive range of out-patient clinics.

Moving Forward – Trafford Division is looking forward to the opening of the new Altrincham Hospital in early 2015, allowing the services currently provided from the old Altrincham Hospital to move into brand new purpose-built facilities and also facilitating the development of new services in Altrincham. The overall vision for Trafford General Hospital is that it becomes a centre of excellence for Orthopaedics, Day Surgery, Elderly Care, Rehabilitation and Out-Patients.

Data Assurance Processes and Information Governance

Central Manchester University Hospitals NHS Foundation Trust submitted records during 2013/14 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 include the patient's valid NHS number

Admitted patient care	97.2%
Accident & Emergency	97.8%
Out-patients	85.3%

- which include the patient's valid General Practitioner Registration code

Admitted patient care	100%
Accident & Emergency	100%
Out-patients	100%

Central Manchester Information Governance Assessment report for 2013/14 scored 75%, achieving level 2 for all indicators, resulting in a rating of 'Green' from the Information Governance Toolkit grading scheme.

The Trust's Information Governance Assessment achieved compliance at level 2 for all indicators. The Trust continues to work on mitigating data protection risks and has implemented a number of awareness raising programmes.

Central Manchester University Hospitals NHS Foundation Trust is taking the following actions to improve data quality:

- Restructure of the Data Quality Department to better align to the hospital services and administrative functions.
- Develop Data Quality performance dashboards.
- Implementing a new system training package for our core systems and relating back directly to the information reporting work programme.

The Trust was subject to a Payment by Results (PbR) 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 treatments coding (clinical code) were as follows:

Primary procedure	90.5%
Secondary procedure	76.2%
Primary diagnosis	86.0%
Secondary diagnosis	90.2%

Central Manchester University Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding were:

	All errors	Coder errors only
Primary diagnosis correct	90.23%	94.85%
Secondary diagnosis correct	84.91%	87.88%
Primary procedure correct	94.02%	96.71%
Secondary procedure correct	89.21%	91.01%

The PbR assurance audit is a review of 200 case notes and was focused on the Accident & Emergency specialty and a random sample across the specialties in the Royal Manchester Children's Hospital. These results should not be extrapolated further than the actual statement audited. The audit breaks the results into coder/non coder error. The results from the audit are a useful snapshot and combine with the other internal and external audits as a means of providing assurance and ensuring we actively manage and improve quality on an on-going basis. These results are a small sample of 200 patients taken from 170,000 in-patient spells and are also focused on a specific area within the overall case mix.

A second external audit is also underway and is the Payment by Results clinical coding audit during undertaken by the Audit Commission. The results will be available in the next financial year.

There is a detailed programme of work aimed at improving the quality of clinical coding through improved clinician engagement, improved audit and review processes and also our Health Records Improvement programme of work.

Our People

A New Tailor-Made General Management Graduate Trainee Scheme

In October 2013, eight graduates embarked on an 18 month journey that will give them wide experience across our divisions as part of an innovative in-house graduate management trainee scheme.

The intensive development programme provides each General Management Officer (GMO) with on-the-job training and knowledge so that they can acquire the skills required to be competent managers, able to operate confidently in our ever changing environment. During the scheme, each GMO undertakes four placements, two operational, one project-based placement, and another in facilities management.

The graduate trainee scheme is among the first of its kind to be launched by an NHS organisation. As a large and diverse organisation, we realised that there was enormous potential to develop our own tailor-made scheme that could rival the national graduate management trainee scheme and could provide us with future managers.

The candidates have beaten off fierce competition – more than 200 applicants - and a thorough assessment process to end up as the chosen few.

The programme includes competency completion through experiential learning on placements, a series of master classes, individual and team based development sessions facilitated by the Organisational Development & Training team, access to the national graduate scheme master classes as well as completing an Institute of Learning Management (ILM) accredited leadership development programme and a Post Graduate Diploma in Management.

They also have an online learning portal to create their own supportive learning community.

Staff Recognition – We're Proud of You and Divisional Star Awards

The annual 'We're Proud of You' Awards recognise the fantastic achievements of our staff who every day go that extra mile to deliver excellent services. These awards allow us to acknowledge their outstanding contributions. All employees and volunteers are eligible for the awards and many nominations represent quality improvements, innovative ways of working and development.

A new award scheme was opened for 2013 following the plans to extend the scheme to include more localised recognition. The Divisional Star Awards allow staff to nominate any colleague or team for demonstrating any of the Trust values of respect, dignity, compassion, consideration, empathy or pride.

Achievements for both the 'We're Proud of You' and 'Divisional Star' Awards are celebrated through workplace presentations within departments, before being recognised on a larger scale at the annual gala dinner.

Wards who had achieved 'Gold' status as part of the Improving Quality Programme over the last 12 months were also presented with certificates by the Executive team in their ward areas and have been invited to take part in the celebrations at the Gala dinner. Gold Wards are presented with wall plaques to display at the entrance to their wards by the Chairman.

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

Staff Engagement Update

Throughout 2013/14, there have been increased efforts to improve staff engagement following the results of the National Staff Survey. The initial focus areas determined by staff feedback were identified as leadership, employee voice, improved working environment and staff recognition.

Programmes of work around leadership have included staff engagement sessions held by the executive team. Two master classes on Leadership have been held by Julia Bridgewater, Chief Operating Officer, and feedback for both of these sessions have been very positive.

Focus groups were held throughout July and August 2013 in each Division in order to allow staff to share ideas and be involved in decisions and changes that affect their working lives. Lists of prioritised changes and solutions were created from each of these Divisional focus groups, and have since been actioned.

Examples of changes which have been suggested and implemented include the installation of cash machines on

site; management structures have been made clear through video clips and updated organisational charts online and the creation of leadership master classes.

In terms of staff recognition, the 'We're Proud of You' Awards mentioned previously have been widely promoted over the last 12 months, resulting in over 100 nominations. The new 'Divisional Stars' ensure recognition is wide reaching and momentum is maintained throughout the year.

A brand new Staff Engagement approach was presented and discussed by the HR Committee in February 2014. The approach focuses on five key aims; to engage with staff by treating them as individuals, acknowledging how hard staff work and their personal contribution to both patients and the service, ensuring staff are kept up-to-date with issues which may be of interest or affect them, affording staff space and time to complete their duties, and by encouraging a healthy work/life balance. This strategy involves close partnership work with Staff-side colleagues, the Communications team and Occupational Health. Changes proposed will begin to be implemented from March 2014, and will include a re-evaluation of the current reward and recognition schemes, the launch of open space events to collect qualitative staff feedback, the creation of a Valuing your Voice staff group, and clearer dissemination of the results of the NHS Staff Survey.

Employee Health and Wellbeing

We are fully committed to the health and wellbeing of our employees, for we believe that the way to provide the best experience for our patients is to provide the best experience for our staff. We know that **Healthy Staff = Better Care for Patients**. As a health service, health and wellbeing applies as much to our employees as it does to our patients, their carers and the local population and we want to do as much as we can to support our employees to enable them to be at their best, be energised, be motivated and committed to their work and to reach their full potential.

Our 'Employee Wellbeing Strategy' brings together multiple strands of on-going work that are addressing and improving the health and wellbeing of employees. These strands include initiatives aimed at:

- Improving the physical wellbeing of our staff
- Improving the mental wellbeing of our staff
- Improving the wellbeing through people management practices
- Supporting the economic and social wellbeing of our staff

We have demonstrated our commitment to supporting our staff through a range of methods such as the availability of dedicated staff counselling support services, Occupational Health & Safety services, and access to staff physiotherapy, plus a number of other initiatives including:

- Programme of health and wellbeing campaigns
- Spiritual and pastoral care
- Preventive interventions e.g. stress risk assessments and facilitated team working
- Coaching and guidance for managers concerning psychological support
- Mediation for teams undertaking complex work or dealing with distressing incidents
- Training and communication about workplace stress and handling conflict
- Staff Benefits and Incentives
- Staff Recognition schemes

We have an Occupational Health Service, designed to maximise the physical, psychological and social health of all employees, and supporting managers by undertaking health interventions and providing advice on medical issues. In addition to the core services of new employee health assessments, management referrals

and immunisation/vaccination programmes, other services offered to staff include physiotherapy, podiatry, osteopathy, counselling, and lifestyle health advice.

Our campaign to vaccinate as many staff as possible against winter seasonal flu saw the highest uptake rate the Trust has ever achieved with 75.4% of frontline healthcare workers coming forward to be vaccinated. This resulted in us being selected in the most improved category of the NHS Employers Flu Fighter Awards 2013/14.

2013 National Staff Survey

	2012/2013		2013/2014		
	Trust	National Average	Trust	National Average	Trust Improvement or Deterioration
Response Rate	46%	49%	47%	49%	Improvement +1%

Again staff were offered the chance to complete their survey online or via the traditional paper form and a slight improvement was seen in the overall response rate with an increase to 47%.

Summary of performance

The response rate for the census results in 2013 has improved slightly from last year.

The vast majority of results are also shown to be positive, with large improvements in the percentage of staff working extra hours and high scores for staff feeling they received a well-structured appraisal. When considering all 28 Key Findings, 14 Key Findings are above average, 3 are below average and the remaining 11 are average for acute Trusts. Of the 14 above average Key Findings, 8 are in the top 20% of acute Trusts.

The table below details our best and worst scores when compared to other acute Trusts.

	2012/13		2013/14		Trust Improvement or Deterioration
Top 5 Ranking Scores 2013	Trust	National	Trust	National	
KF5. Percentage of staff working extra hours (the lower the score the better)	68%	70%	62%	70%	Improved by 6%
KF18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (the lower the score the better)	22%	30%	24%	29%	Deteriorated by 2%
KF10. Percentage of staff receiving health and safety training in the past 12 months. (the higher the score the better)	80%	74%	83%	76%	Improved by 3%
KF4. Effective team working. (the higher the score the better)	3.75	3.72	3.83	3.74	Improved by 0.08
KF14: Percentage of staff reporting errors, near misses or incidents witnessed in the last month (the higher the score the better)	93%	90%	93%	90%	No Change

	2012/13		2013/14		Trust Improvement or Deterioration
Bottom 5 Ranking Scores 2013	Trust	National	Trust	National	
KF17. Percentage of staff experiencing physical violence from staff in last 12 months (the lower the score the better)	1%	3%	4%	3%	Deteriorated by 3%
KF11: Percentage of staff suffering work-related stress in the last 12 months (the lower the score the better)	35%	36%	43%	36%	Deteriorated by 8%

Bottom 5 Ranking Scores 2013	2012/13		2013/14		Trust Improvement or Deterioration
	Trust	National	Trust	National	
KF12. Percentage of staff saying hand washing materials are always available (the higher the score the better)	49%	59%	47%	61%	Deteriorated by 2%
KF22: Percentage of staff able to contribute towards improvements at work (the higher the score the better)	69%	68%	67%	68%	Deteriorated by 2%
KF28. Percentage of staff experiencing discrimination at work in last 12 months (the lower the score the better)	11%	11%	11%	10%	No Change

NB- This is still in line with the national average for Acute Trusts, but we did not improve our performance in 2013/14.

Staff Engagement Score

Over the last 12 months, several initiatives have been rolled out in an attempt to address key staff concerns such as confidentiality as well as providing additional ways throughout the year for staff to feedback their opinions through the Voices programme. Many actions have been taken as a direct result of staff suggestions and the programme has shown very positive results in terms of the staff engagement score, placing us above average for all acute Trusts.

2012/13		2013/14		Trust Improvement or Deterioration
Trust	National Average	Trust	National Average	
3.72	3.70	3.76	3.74	No change

Work on Staff Engagement and communication of survey results and subsequent actions will continue across the next 12 months to hopefully lead to a further improved score for 2014/15.

Friends and Family Test for Patients

A question in the survey asks: 'If a friend of relative needed treatment I would be happy with the standard of care provided by this organisation'. All Acute trusts were ranked on this question and we ranked above average with a score of 66.851.

Leadership

Through our leaders, we aim to support the implementation of the HR Strategy with the ultimate aim of enabling managers to operate in a complex demanding service, which meets the demands of ever increasing customer expectations, and 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 Strategy is being developed in order to focus 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 programmes:

Institute of Leadership and Management

In 2012/13 over 30 employees enrolled onto the Institute of Leadership and Management (ILM) Level 5 Award in Leadership & Management 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. The Leadership Framework 360 degree review is incorporated as standard and facilitation of feedback reports is conducted internally giving leader's valuable self-awareness and feedback in order to continually drive for improvement. 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.

In addition OD&T (Organisational Development & Training) also offer a Level 3 ILM Award in Leadership and Management aimed at first line managers new to the role of management. Over 60 managers have completed, or are near to completing, the qualification in the last year. The programme equips first line managers with the theoretical knowledge on various leadership theories and models, providing an insight into team workings, effectiveness and managing through service changes.

Newly Appointed Consultant Development Programme

The programme is now in its third successful year and since its introduction back in 2011, a further 50 participants have enrolled onto the newly appointed consultant leadership and management development programme. Participants on a recent programme showcased their work at a luncheon poster presentation event. It really was a tremendous occasion with representation attending from colleagues across each of the Divisions. Mr Mike Deegan, Chief Executive, and other members of the Executive Board team were also in attendance to show their appreciation of the work that has been done and gave extremely positive feedback to each of the consultants involved. Some of the quotes received from attendees on the day were:

"Very impressive – good development for new consultants"

"Impressive projects, enthusiasm of participants almost palpable – a great resource for us all"

"The future is bright with you all in the organisation"

The programme was commissioned by Professor Pearson, Medical Director, back in 2011 and has continued to develop so that now all newly appointed consultants within their first 12 months of appointment are automatically offered a place on the programme. The programme consists of a series of action learning sets and workshops, over a 12 month period, designed to enhance the leadership and management skills and expertise of the consultants. They are also asked to develop a specific service improvement project in relation to their own area of work which will enhance and improve the quality and delivery of care to patients. We are already beginning to see positive outcomes from the projects undertaken, demonstrating improvements to the quality of patient care, cost efficiency savings and in some instances financial return on investment for the organisation.

Apprenticeships

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 sufficiently and adequately trained with the necessary qualifications, skills and competencies to perform effectively within their roles. In the preceding 12 months, we have enrolled over 160 learners onto the Health Care Support Apprenticeship programme for clinical support workers helping to ensure staff working within support roles are fit for purpose.

The Organisational Development and Training Department is a recognised training provider offering accredited 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 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.

The benefits of the Apprenticeship Framework are that employees are provided with the necessary and relevant training required in order to meet the needs of the job role. Training is tailored to meet the demands of the role and the employer, and the learner is supported throughout the life of the programme both on and off the job. New employees are given the opportunity to earn while they learn and, specific to Nursing and Midwifery only at present, all new appointees to Trainee Clinical Support Worker roles with no previous, relevant, Level 2 qualification must undertake the Apprenticeship programme. The programmes are offered to existing employees and there are no age restrictions, although we are keen to engage with the local school leavers who perhaps leave school with little or no qualifications and who are seeking alternative employment options.

Other benefits for the individual include increased knowledge and understanding of the expectations of the role, the acquisition of practical skills and a recognised qualification. Organisational benefits include improved retention and productivity, a more highly committed, skilled and competent workforce with a greater opportunity for career development.

Recruiting and retaining our people

We will always be about people and recognise that staff are fundamental to our success. Therefore there is a need to be able to attract and retain staff of the highest calibre and a professional approach to recruitment is necessary to do this.

We will need to ensure that our values and behaviours are inherent in our workforce, and that we continue to recruit the very best staff who demonstrate, as always, high levels of skills and competence.

Employing over 12,000 people in extremely diverse roles, we ensure that the opportunity for career development exists across each and every part of the business. This is important in retaining the important skills that our staff bring to us, and this is reflected in the fact that in the last year our turnover rate across all departments has fallen.

Part 3. Other Information

Performance of Trust against Selected Metrics

The following information sets out the Trust's performance against 10 important indicators which have been selected in conjunction with the Governors, other key stakeholders and the Board of Directors. You will see that the information is presented to show results over three years and where possible we have provided results from other Trusts so that a comparison against performance is possible. Overall the results demonstrate year on year improvement and we will continue to focus our efforts to ensure even better results. We value the feedback from our patients which we continuously use to improve care and treatment. The results featured below in the areas of nutrition and hydration has seen a slight deterioration this year and therefore will be a feature of targeted improvement efforts.

	Data Source	2011/12	2012/13	2013/14	Latest Available Benchmark	Indicator Comments
Patient Safety Measures						
Improvement in VTE risk assessments carried out	Trust Data	90%	90%	96%	Feb 2014 – Highest 100% Lowest 77%	Includes all of 2013/14. Based on final quarter position
Reduction in hospital acquired grade 3 or 4 pressure	Trust Data	25	*103	63	Not Available	2013/14 figures are based on a full year effect
Reduction in a serious patient safety incidents resulting in actual harm (those graded at Level 4 or 5)	National Patient Safety Authority Data	21	**56	42	Not Available	Includes all of 2013/14 data as of 19/05/14.
Clinical Outcome Measures						
Reduce hospital standardised mortality ratio (HSMR)	Dr Foster	97.3	104.6	91.6	Av 100	2013/14 figures are based on a full year effect
Reduce Summary Hospital Mortality Indicator (SHMI)	Dr Foster	N/A	110.5	103.9	Highest - 106.19 Lowest - 73.51 Average - 89.89	2013/14 figures are based on a full year effect
Reduce the number of potentially avoidable cardiac arrests outside of critical care area (Trust Data)	Trust Data via Resuscitation Summary Report	146	191 (1st year of data which includes Trafford Hospitals)	174	Not Available	2013/14 figures are based on a full year effect
Improve stroke care audit composite score	National Audit Data	40.35 (SINAP)	53.05 (SINAP)	Q4 43.7 (Grade D)	National 69.9	. The grading for this indicator has changed to give an overall rating. We continue to see improvements in year

Patient Experience Measures						
Increase overall satisfaction expressed with pain management	Locally collected data via electronic tracker devices	74.06%	84.07%	89.18%	Not Available	These data are sourced from patient/carer feedback devices situated across all of our wards/ departments. For 2013/14 this represent more than 31,000 views
Increase overall satisfaction expressed with fluids and nutrition provided		72.66%	78.47%	78.11%	Not Available	
Increase overall satisfaction with the cleanliness of the ward or department		75.96%	87.89%	90.51%	Not Available	

* *This number differs from that reported in the account 2012/13 because it now represents a full year's figure.*

** *This number differs from that reported in the account 2012/13 because the criteria used for this has been amended in this year's report to include, fracture neck of femur (broken hip), incidents from Trafford hospital and those incidents identified after year end.*

Achievements against key national priorities and National Core Standards

	Data Source	2011/12	2012/13	2013/14	Latest Available Benchmark	Indicator Comments
Infection Control						
Reduction of the number of Clostridium Difficile cases (Intelligent Board)	Intelligent Board	82	74	54	51	Includes all of 2013/14
Clostridium Difficile Infection per 100,000 bed days in patients aged 2 or over		26.7	18.8	12.7	17.3 (national rate 2012/2013)	Includes all of 2013/14
Reduction of the number of MRSA cases (Intelligent Board)	Intelligent Board	4	9	8	6	Includes all of 2013/14
Cancer Waiting Times						
Maximum waiting time of two weeks from urgent GP referral to first out-patient appointment for all urgent suspected cancer referrals	Open Exeter Cancer Waiting Times system	94%	95%	96%	Target - 93%	Includes all of 2013/14
Maximum 31 days from decision to treat to start of treatment extended to cover all cancer treatments	Open Exeter Cancer Waiting Times system	99%	99%	98%	Target - 96%	Includes all of 2013/14

Maximum 31 days from decision to treat to start of subsequent treatment	Open Exeter Cancer Waiting Times system	99%	100%	98%	Target: Surgery (94%) Radiotherapy (94%) Chemotherapy (98%)	Includes all of 2013/14
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	Open Exeter Cancer Waiting Times system	87%	88%	87%	Target - 85%	Includes all of 2013/14 (prior to passback)
Maximum waiting time of 62 days from cancer screening programme	Open Exeter Cancer Waiting Times system	93%	94%	85.1%	Target - 90%	Includes all of 2013/14 (prior to passback)
Referral to Treatment						
18 weeks maximum wait from point of referral to treatment (non admitted patients)	Intelligent Board	96%	97%	96%	Target - 95%	Includes all of 2013/14
18 weeks maximum wait from point of referral to treatment (admitted patients)	Intelligent Board	90%	92%	92%	Target - 90%	Includes all of 2013/14
18 weeks maximum wait from patients not yet treated (new indicator 2012/13)	Intelligent Board	N/A	94%	93%	Target - 92%	Includes all of 2013/14
Urgent Care						
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	Sitrep	95%	96%	95%	Target - 95%	YTD as at w/e 30th March 2014

Feedback from the Governors

The Patient Experience Group has a primary function to support the Quality Strategy and therefore ensuring a strong focus on delivering the highest standards of care for patients and families.

Over the past 12 months the Governors have been involved in a number of initiatives that form part of this year's Quality Report, we have received a number of presentations which has kept us informed on new initiatives and developments as well as areas that have been identified as needing further work. There has been a strong focus this year on the internal quality reviews which were developed by the Trust in response to the reports from Francis, Keogh and Berwick. This is an area of work that will continue to provide a good level of assurance and learning in the future.

There has been regular robust monitoring of pressure ulcers, and it is pleasing to see progress in the management of these as well as the reduction of incidences from the 2013 position.

Complaints monitoring continues to be a priority with particular emphasis this year on the review of the complaints process as well as oversight of the annual report. The correlation of this work and the work of the legal team in terms of claims management has also been part of our work programme. Governors have agreed to focus on high level incidents (harm free care) for this coming year and as such this has been included within the work programme for the Patient Experience Group.

The new clinical model at Trafford was reviewed from a patient perspective as this came into force in November 2013.

We are pleased that the new Director of Transformation will take forward the work required to improve the patient experience of our Out-Patients Services which is something we have been championing for.

A review of the feedback from a range of surveys including patient, staff, cancer and the friends and family test continue to provide the Trust with areas to improve which is being progressed as part of its work programme.

We have worked closely with many members from the Trust but would especially like to thank Deborah Carter, Deputy Director of Nursing up until September 2013; Dawn Pike, Acting Deputy Director of Nursing and Brenda Smith, Non-Executive Director who all support our work in this area.

Peter Dodd
Chair of the Patient Experience Group

Commissioners' Statement

The CMFT Quality Report is an accurate and positive account of a provider with a well developed patient safety culture and ambitious and innovative aims for improving quality.

As a Clinical Commissioning Group we have responsibility for ensuring that the services we commission are safe, effective and provide a positive patient experience. To this end we have worked closely with the Trust to ensure we have the right level of assurance in relation to the commissioned services. We have undertaken commissioner walk rounds in the Trust, attended internal governance committees and as a CCG we visit the Trust regularly sometimes on a daily basis. We feel this puts us in a strong position to comment on this Quality Report.

This year has continued to see quality improving within CMFT and its associated hospital sites and services. The trust has met 29/30 of its acute trust quality indicators with one indicator gaining a partial achievement. It has also met all of the 13 quality indicators assigned to Community Services. In particular there has been a substantial amount of innovative work around children's asthma treatments. We are particularly pleased with the work in relation to Harm Free Care and the reduction in patient falls and pressure ulcers.

Mortality and Standardised Hospital Mortality rates have continued to improve and we are pleased with the current figures and outcomes. To the credit of the Trust they have not only looked at how these cases are reported but have undertaken a clinical review of each death to identify good practice and any areas where care could have been improved.

CMFT have considered and acted on the published inquiries of the failings of care at Mid Staffordshire led by Robert Francis QC. The Trust put a robust action plan in place and also undertook a Quality Review process across the entire organisation, this initiative complements the ward accreditation programme that has been in place for several years and we are pleased that the quality reviews will continue.

CMFT is one of the highest reporters of patient safety incidents in the country. Over 90% of incidents that they report are incidents that have caused no harm to patients. This approach to promoting the reporting of patient safety incidents and being able to identify potential problems before they cause actual harm to patients is a positive approach. It is pleasing to see that this area remains a priority for the Trust. CMFT have reported 3 Never Events this year, this is a reduction from the previous year. There has been a considerable piece of work undertaken by the Trust in respect of this area and as a CCG we will continue to monitor this area moving forward.

This is a very positive Quality Report from CMFT. There are still areas for improvements to be made and as commissioners we will continue to monitor these areas and work with our CMFT colleagues to ensure that patients in Manchester receive the best quality care available.

Dr Ivan Benett
Dr Ivan Benett (GMC 2489690)
FRCP FRCGP M.Med.Sci. Dip. Cardiol.
Clinical Quality Lead, Central Manchester Clinical Commissioning Group

Health and Wellbeing Overview and Scrutiny Committee

As Chair of the Health Scrutiny Committee I would like to thank you for the opportunity to comment on the Central Manchester Foundation Trust Draft Quality Report for 2013/14. Copies of the draft quality report were circulated to members of the Committee for consideration and comments received have been included below. We would like to submit the following commentary to be included within your final published version.

Manchester City Council's Health Scrutiny Committee welcomes the opportunity to comment on the Central Manchester Foundation Trust Report for 2013/14. Members of the Committee have been given the opportunity to comment and this statement included is a summary of their responses.

In our commentary last year, we highlighted that more progress was needed on improving hospital mortality rates, and on reducing 'never events', medication safety incidents, pressure ulcers with harm and MRSA infections.

The Committee note the figures which show significant progress has been made in relation to the SHMI (Summary Hospital – level Mortality Indicator) and HSMR (Hospital Standardised Mortality Indicator Ratio) indicators. The Committee further welcome the reduction in 'Never events' of Patient Harm that have reduced from 8 in 2012/2013 to 3 in 2013/2014. However the target is rightly zero and the Committee is disappointed that the progress is limited.

The Committee welcome the significant reduction in pressure ulcers, particularly in more severe ulcers and the improvements that have been achieved for Acutely Unwell Patients, Medication Safety and Harm Free Care of Catheter Acquired Urinary Infections and Venous Thromboembolism.

The Committee further welcome the reduction to zero in 2013/2014 from 4 'severe' incidents of Medication Safety Incidents in 2012/2013. They also acknowledge the substantial reduction of near miss / no harm incidents and recognise this as a significant progress. However the increase in slight and moderate incidents needs to be reversed. We also note that the provisional figure of 7 MRSA infections, of which 4 were regarded as avoidable indicates that further progress is required.

We further welcome the table as produced at page 19 of your report. This provides a very useful summary of performance against the key priorities identified under the three headings of Patient Safety, Clinical Effectiveness and Patient Experience.

In relation to Clinical Effectiveness we recognise that improvements have been achieved or are on-going for cases of Fractured Neck of Femur and for most of the areas covered by the North West Advancing Quality Initiative i.e. Acute Myocardial Infraction (Heart Attack), Heart Failure, Hip and Knee replacement, Pneumonia and Strokes. However improvements for cases of Coronary Artery Bypass Graft (CABG) have not been achieved, so further work is required.

The Committee welcomes that the report indicates that much progress has been made in regard to the Patient Experience, but note that up to date figures have not yet been provided for most areas.

The Committee note that the Board of Directors have set out 4 Key Priorities for 2014/2015 that have been chosen to reflect both National and local issues of importance. These are in the areas of Mortality, Harm Free Care (including reduction of pressure sores), Dementia Care and Sepsis. The Committee agree that these appear to be sensible, alongside the other clinical priorities that were set out for 2013/14 including CAGT.

We acknowledge the progress made by CMFT following publication of the Francis report in January 2013. Whilst we recognise this is an ongoing process the Committee welcome the achievements made to date, namely the Quality Review that was undertaken across the organisation, and the development of a set of values and behaviours for the Trust and its staff. The Committee welcome the commitment given to improving both nursing and medical education; the establishment of an agreed process for students to raise clinical or quality concerns during practice placements; the implementation of Whistle blowing and Complaints policies; improved patient communications; staff support; the undertaking given that all staff new in post will have practical drug administration assessments and the improvement in the quality of patient records.

The Committee further acknowledge that work continues to be undertaken to implement the recommendations resulting from the Francis Report and note that 'being open' is to be embedded in all policies in the organisation. We further acknowledge the steps being taken to ensure that the food and drink provision meets the requirements of all patient groups and the development of the system whereby the Clinical Audit Team are ensuring that all actions arising form a clinical audit are being addressed. The Committee welcome these and the commitment given of continuing with this work.

Our commentary does not deal with Accident and Emergency targets, nor with the issues arising from the "New Health Deal for Trafford"; they are under ongoing scrutiny by our Committee, by Trafford's Health Scrutiny Committee and by the Manchester and Trafford Joint Health Scrutiny Committee.

Our comments on this Quality Report are not as thorough as would ideally be the case. Our Committee does not have access to the resources to give a full analysis. In future, our Committee will seek to rectify this.

It has been important to highlight areas of some concern where we expect CMFT to improve over the next year. Overall the Quality Report is positive and reflect successful operation of a large and complex organisation serving many thousands of patients in an efficient and compassionate manner. This will be increasingly difficult in the national context of financial pressures.

Councillor Eddy Newman
Chair of the Health and Scrutiny Committee

Quality Report Comment from Healthwatch Trafford

Healthwatch Trafford welcomes the opportunity to comment on the Quality Report report by Central Manchester Foundation Trust. It gives a clear picture of the current status and of the areas that it wishes to improve in 2014/15. To the best of our knowledge they are an accurate account.

We welcome in particular:

- The rollout of the Improving Quality Programme and Ward Accreditation across the Trafford Division and the improvements in care these have brought.
- The Trust's investment in Dementia Care seeing it as a high priority.
- The Acutely Unwell Patient programme.

We were pleased to see the Harm Free Care campaign resulted in a reduction in the incidence of pressure ulcers and falls and hope to see this continue in 2014/15.

We would like to see in 2014/15 continued effort to reduce the number of hospital acquired infections particularly MRSA bacteraemia.

Ann Day
Chair Healthwatch Trafford

Quality Report Comments from Healthwatch Manchester

As Chief Officer of Healthwatch Manchester I'd like to thank you for the opportunity to comment on the Central Manchester Foundation Trust Draft Quality Report for 2013 – 14. I would like to submit the following to be included in your published version.

Last year due to Healthwatch Manchester only having been recently established and myself being appointed, the deadline for comment on your Draft Quality Report was missed and so I have no basis for comparison with this year's commentary.

Healthwatch Manchester is pleased to hear there is an 'easy-read' version of the report to be published. The narrative in this version of the report reads quite well although the different styles are evident.

There is a reported improvement in all patient safety and experience indicators with the only deterioration in CABG which Healthwatch Manchester would hope to see progress towards addressing in the next year. Robust systems appear to be in place to ensure accurate reporting of patient safety issues and to improve patient safety.

There were 3 never events reported as a reduction from last year as were the incidence of pressure ulcers which indicate good progress against targets.

In March 2014 Healthwatch Manchester visited the A & E Department at Manchester Royal Infirmary to carry out an Enter & View exercise. A full report is yet to be published however it is useful to note that our identified improvements are aligned with the ones in this section of the Quality Report including 'improved signage across all our hospitals' mentioned elsewhere. Healthwatch Manchester would welcome collaboration with the Trust in realising these improvements.

Healthwatch Manchester also welcomes the work around Dementia care as a thorough and timely initiative especially through the involvement of carers, would hope to see this work developed and again would welcome collaboration with the Trust around this.

The emphasis on care and compassion with for example the introduction of patient focused rounding and the night teams is welcome.

The Compliments Concerns and Complaints section of the report could be more comprehensive and the systems and pathway for complaints made more explicit.

Yours sincerely,

Neil Walbran
Chief Officer, Healthwatch Manchester

Statement of Directors' Responsibilities in Respect of the Quality Report 2013/14

Introduction

Monitor has published guidance for the external audit on Quality Reports for 2013/14. 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 them 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 2013/14.

The Trust is also required to obtain external assurance from its external auditor over at least two mandated indicators and incidents of severe harm 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 2013/14 Performance Indicators

The Auditors have undertaken testing of the systems to support the preparation of the mandated indicators included in the 2013/14 Quality Reports as follows:

i) C Difficile

ii) 62 day waiting time

iii) Emergency readmissions within 28 days of discharge

Delegated Authority and Recommendation

The Board of Directors at its meeting in May 2014 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 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 NHS foundation trust boards should put in place to support 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 2013/14;

- 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 2013 to June 2014
  - papers relating to Quality reported to the Board over the period April 2013 to June 2014
  - feedback from commissioners
  - feedback from governors
  - feedback from local Healthwatch organisations
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - [latest] national patient survey
  - [latest] national staff survey
  - the head of internal audit's annual opinion over the trust's control environment
  - CQC quality and risk profiles.
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information 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 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) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

Peter W Mount CBE, Chairman 27th May 2014

Mike Deegan, Chief Executive 27th May 2014

Independent auditor's report to the Council of Governors of Central Manchester University Hospitals NHS Foundation Trust on the quality report

We 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 31st March 2014 (the "quality report") and certain performance indicators contained therein.

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. We permit the disclosure of this report within the Annual Report for the year ended 31st March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Central Manchester University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31st March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Patient treated within 62 days of GP urgent suspected cancer referral; and
- Emergency re-admissions within 28 days of discharge from hospital.

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

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

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

- the quality report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the quality report is not consistent in all material respects with the sources specified in the Detailed Requirements for Quality Reports 2013/14; 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 2013/14.

We read the quality report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with those documents listed below:

- board minutes for the period April 2013 to March 2014;
- papers relating to quality reported to the board over the period April 2013 to March 2014;
- feedback from the Commissioners dated May 2014;
- feedback from local Healthwatch organisations dated May 2014;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2013;
- the latest national patient survey dated 2013;
- the latest national staff survey dated 2013;
- Care Quality Commission quality and risk profiles dated 13th March 2014; and
- the Head of Internal Audit's annual opinion over the trust's control environment dated March 2014.

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

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

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries 'of management'.
- 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.
- Reading the documents.

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

Limitations

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

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

The scope of our 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 our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31st March 2014:

- 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 Detailed Requirements for Quality Reports 2013/14; 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.

Deloitte LLP
Chartered Accountants
Manchester
29 May 2014

Glossary of definitions

Brilliant Basics	A process used by the Trust to improve the fundamental principles of care across nursing and midwifery
Bacteraemia	The presence of bacteria in the blood
Care provider	An organisation that cares for patients. Some examples of which are hospital, doctors, surgery or care home
Catheter Associated Urinary Tract Infection (CaUTI)	An infection believed to have been caused by a urinary catheter
Clinical	Relating to the care environment
Clostridium difficile	A type of infection. Symptoms of C. difficile infection range from mild to severe diarrhoea
Condition	An illness or disease which a patient suffers from
COPD	Chronic obstructive pulmonary disease. The name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease
Core Values	A group of ideals which the Trust believes all staff should exhibit
CQUIN	Commissioning for Quality and Innovation. This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specialised areas of care
Dementia	Is a syndrome (a group of related symptoms) that is associated with an on-going decline of the brain and its abilities
Emergency readmissions	Unplanned readmissions to hospital that occur within 28 days after discharge from hospital. They may not be linked to the original reason for admission
Falls	Unintentionally coming to rest on the ground floor/lower level, includes fainting, epileptic fits and collapse or slip
Harm	An unwanted outcome of care intended to treat a patient
Improving quality programme (IQP)	An approach taken to bring about quality improvement in our clinical areas using specific improvement tools
HSMR	Hospital Standardised Mortality Ratio. A system which compares expected mortality of patients to actual numbers
Monitor	Monitor was established in 2004 and authorises and regulates NHS Foundation Trusts. Monitor works to ensure that Foundation Trusts comply with the conditions they have signed up to and that they are well led and financially robust
Mortality	Mortality relates to death and in health care mortality rates means death rate
MRSA	Methicillin-resistant Staphylococcus Aureus is a bacterium that is found on the skin and in the nostrils of many healthy people without causing problems. However, for some people it can cause **infection that is resistant to a number of widely used antibiotics**
Never Events	These are largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented

NICE	National Institute of Clinical Excellence. An independent organisation that provides national guidance and standards on the promotion of good health and the prevention and treatment of ill health
Patient safety incidents	Is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care
Pressure ulcer	Sometimes known as bedsores or pressure sores, are a type of injury that affect areas of the skin and underlying tissue, caused when the affected area of skin is placed under too much pressure. They can range in severity: Grade One – Discolouration of intact skin not affected by light finger pressure Grade Two – Partial thickness skin loss or damage Grade Three – Full thickness skin loss involving damage of subcutaneous (underlying) tissue Grade Four – Full thickness skin loss with extensive destruction and necrosis (dead tissue)
Patient reported outcome measures (PROMs)	Tools which help us measure and understand the quality of the service we provide for specific surgical procedures. They involve patients completing two questionnaires at two different time points, to see if the procedure has made a difference to their health
Root Cause Analysis (RCA)	A systematic method of doing an investigation that looks beyond the people concerned to try and understand the underlying causes and environmental context in which the incident happened
Safety thermometer	A point of care survey which is used to record the occurrence of four types of harm - pressure ulcers, falls, catheter associated urinary tract infection and venous thromboembolism
SHMI	Standardised hospital mortality index. A system which compares expected mortality of patients to actual mortality (similar to HSMR)
The Trust	Central Manchester University Hospitals NHS Foundation Trust. A Foundation Trust is part of the National Health Service in England and has to meet national targets and standards. NHS Foundation Trust status also gives greater freedom from central Government control and new financial flexibility
Urinary Catheter	A device which is placed into a patient's bladder for the purpose of draining urine
Venous thromboembolism (VTE)	A blood clot forming within a vein
Vein	A blood vessel that carries blood towards the heart

Monitor's Regulatory Ratings

The Trust submits quarterly reports to Monitor, the independent regulator of foundation Trusts. Performance is assessed by Monitor to identify where actual or potential problems may arise. In doing this Monitor publishes quarterly and annual risk ratings. The ratings are designed to indicate whether compliance is being maintained with the terms of authorisation.

Risk ratings are published for the following areas:

- Finance (Rated 1-5, where 1 represents the highest risk and 5 the lowest)
- Governance (Rated Green, Amber/Green, Amber/Red, Red)

During 2013/14 minor revised the technical mechanics of the assessment so that from Quarter 3 (Q3) the finance rating became a continuity of service rating. The governance rating descriptor remained the same but there were changes within such as the removal of the MRSA clinical quality indicator.

Table of analysis

	Annual Plan 2013/14	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14
Under the Compliance Framework					
Financial risk rating	3	3	3	n/a	n/a
Governance risk rating	Amber-Red	Green	Green	n/a	n/a
Under the Risk assessment framework					
Continuity of service rating	n/a	3	3	3	3
Governance rating	n/a	n/a	n/a	Green	TBC

During the annual plan setting the Trust declared a governance risk concern with meeting the stringent infection control reduction objectives. This was based upon clinical evidence of higher infection risk associated with the patient's acuity level's seen within teaching trusts, and the setting of reduction levels for the Trust higher than the national rate. This declaration was discussed in detail with Monitor who agreed there was a risk and therefore an Amber-Red rating was determined.

Analysis of Actual Governance Rating compared with the Annual Plan.

The Trust has received a Green rating for governance consistently throughout the year. There have been individual periods where a key indicator has not been met, but after discussion with, and consideration by Monitor, the basis was understood and the risk rating given was green.

The main points in year Governance risk discussions is as follows:

- C-Difficile incidence of 54 for the year compared with 51 objective – The figure of 54 is in line with the national objective, but at odds with the Trust objective. The Trust was able to demonstrate high levels of embedded infection control procedures which were independently reviewed by University College London Hospital Trust
- A&E 4 hour standard not met in Q3 – The Trust demonstrated increased demand in acuity of A&E presentations during that period and subsequently took action resulting in delivery of Q4 and the year overall.

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. The Board of Directors is committed to understanding the views of Governors and Members via its Council of Governors and via holding and attending regular Governor and Members' Meetings.

The Council of Governors discharges its duties at its meeting of the Council of Governors which has met three times during the course of 2013/14. Governors are encouraged to act in the best interests of the Trust and are bound to adhere to its values and code of conduct.

Governor Role and Statutory Requirements

We have developed a Governors' Strategy which outlines the role and responsibilities of Governors and incorporates the statutory mandatory duties defined in the Health and Social Care Act (2012) namely:

- To hold the Non-executive Directors individually and collectively to account for the performance of the Board of Directors, and
- To represent the interests of the members of the Foundation Trust as a whole and the interests of the public.

Governors hold our Non-executive Directors (individually and collectively) to account for the performance of our Board of Directors by ensuring that they act so that we do not breach the terms of our authorisation. Governors receive details of meetings, agendas and approved minutes of each Board of Directors' Meeting of the Trust also by attending Governors' Trust Board Update Meetings in order to facilitate further review of the performance of the Board of Directors. Governors also monitor performance via quarterly Performance Review Meetings to ensure high standards are maintained. The Council of Governors are encouraged to ensure its interaction and relationship with the Board of Directors is appropriate and effective, with the Trust's Constitution outlining the process to resolve any disagreements between the Council of Governors and Board of Directors.

Governors are responsible for feeding back information i.e. our vision, forward plan (including our objectives, priorities and strategy) and our performance to members and the public. In the case of Nominated Governors, this information is fed back to the stakeholder organisations that nominated them. Governors are, in return, also responsible for communicating back to the Board of Directors the opinions canvassed.

In order to facilitate this process we hold a Governors' Annual Planning Workshop with Governor views and opinions being invited and considered in relation to our forward plans. The public version of our forward plan is available to members and the public on our website www.cmft.nhs.uk in addition to the membership webpage www.cmft.nhs.uk/foundation-trust. Future plan priorities are also communicated to Members via the Membership Newsletter (Foundation Focus Newsflash) with Members' views being invited.

The canvassing of members and public views in relation to the Trust's forward plan is a key priority outlined in the Governor Strategy. Further details as to how Governors facilitate this process is outlined on page 201.

Each year at a Council of Governors' Meeting and Annual Members' Meeting we fulfil our statutory requirement of providing the Council of Governors with the following documents:

- Annual Accounts
- Any report of the auditors on them and
- Annual Report.

The above reports were also presented by Directors to Members at the Annual Members' Meeting which was open to the public and held on 1st October 2013.

Governor Elections

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

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 staff class that they represent (Staff Governors) or are no longer supported in office by the organisation that they represent (Nominated Governors).

Governor elections were held during the Summer 2013 in order to fill the seats of those Governors whose term of office ended during 2013 in addition to filling vacant seats. As part of the Governor election process, the names and biographies of Governor candidates (contested seats) were forwarded to relevant member constituencies in order to enable members to make informed election decisions and, where applicable, included the prior performance of those Governors standing for

The table below outlines the composition of our Council of Governors:

Governor Constituency/Class/Partner Organisation			Number of Governor Posts
Public	Manchester		9
	Trafford		3
	Greater Manchester		4
	Rest of England & Wales		2
		Total:	**18**
Staff	Nursing & Midwifery		2
	Other Clinical		2
	Non-Clinical & Support		2
	Medical & Dental		1
		Total:	**7**
Nominated	Manchester University		2
	Central Manchester Clinical Commissioning Group		1
	Trafford Clinical Commissioning Group		1
	Specialised Commissioning		1
	Manchester City Council		2
	Trafford Borough Council		1
	Youth Forum		1
	Volunteer Services		1
		Total:	**10**

Governor Election Turnout Data - 2013					
Date of Election	Constituencies Involved	Number of Members in Constituencies	Number of Seats Contested	Number of Contestants	Election Turnout
September 2013	Public – Manchester	6,032	4	11	14.7%
	Public – Greater Manchester	N/A (election unopposed)	2	2	N/A
	Public – Rest of England & Wales	1,289	2	3	10.7%
	Staff – Other Clinical	N/A (election unopposed)	1	1	N/A
	Staff – Non-Clinical & Support	N/A (election unopposed)	1	1	N/A

re-election by outlining their attendance at Council of Governor Meetings. All successfully elected Governors' biographies (including candidates that were elected unopposed) are available via the 'Meet the Governors' webpage: www.cmft.nhs.uk/foundation-trust/council-of-governors/meet-the-governors.

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.

Successful candidates (both new and re-elected) and new Nominated Governors formally commenced in post at our Annual Members' Meeting held on 1st October 2013.

Members of the Council of Governors – Constituency/ Organisation, Election/ Nomination and Term of Office Information

Lead Governor & Public Governors

Keith Paver – Manchester Constituency
Elected 2009 and re-elected 2012
Term of Office - 3 years ending 2015

Lead Governor elections were held following closure of our Annual Members' Meeting (1st October 2013) with Dr Keith Paver being elected unopposed for a one year term of office (ending October 2014).

Public Governors

Jayne Bessant - *Manchester Constituency*
Elected 2008 (shadow Council of Governors) and re-elected 2011
Term of Office - 3 years ending 2014

Peter Dodd – *Manchester Constituency*
Elected 2008 (shadow Council of Governors) and re-elected 2010 and 2013
Term of Office - 3 years ending 2016

Margaret Parkes – *Manchester Constituency*
Elected 2008 (shadow Council of Governors) and re-elected 2011
Term of Office - 3 years ending 2014

Andrew Peel – *Manchester Constituency*
Elected 2013
Term of Office – 3 years ending 2016

Susan Rowlands – *Manchester Constituency*
Elected 2010 and re-elected 2013
Term of Office - 3 years ending 2016

Stephen Webster – *Manchester Constituency*
Elected 2013
Term of Office – 3 years ending 2016

Sue Webster – *Manchester Constituency*
Elected 2008 (shadow Council of Governors) and re-elected 2011
Term of Office - 3 years ending 2014

Malcolm Chiswick – *Trafford Constituency*
Elected 2012
Term of Office - 3 years ending 2015
Greater Manchester Constituency – Elected 2008 (shadow Council of Governors) and re-elected 2010

- resigned July 2012 and was successfully re-elected as a Public Governor for the Trafford Constituency (Governor Elections September 2012).

George Devlin – *Trafford Constituency*
Elected 2012
Term of Office - 3 years ending 2015

Matthew Finnegan – *Trafford Constituency*
Elected 2012
Term of Office - 3 years ending 2015

Ivy Ashworth-Crees - *Greater Manchester Constituency*
Elected 2008 (shadow Council of Governors), re-elected 2009 and 2012
Term of Office - 3 years ending 2015

David Edwards – *Greater Manchester Constituency*
Elected 2013
Term of Office – 3 years ending 2016

Lynne Richmond – *Greater Manchester Constituency*
Elected 2011
Term of Office - 3 years ending 2014
Manchester Constituency – Elected 2009 – resigned February 2011 and was successfully re-elected as a Public Governor for the Greater Manchester Constituency (Governor Elections February 2011)

Barrie Warren – *Greater Manchester Constituency*
Elected 2013
Term of Office – 3 years ending 2016

Alan Jackson – *Rest of England & Wales Constituency*
Elected 2013
Term of Office – 3 years ending 2016

Richard Jenkins – *Rest of England & Wales Constituency*
Elected 2010 and re-elected 2013
Term of Office - 3 years ending 2016

Public Governor Term of Office Ended during 2013/14:

Dave Brown – *Manchester Constituency* – Resigned (May 2013)

Abu Chowdhury - *Manchester Constituency* - Term of Office Ended (October 2013)

Alexena Morrison - *Manchester Constituency* – Term of Office Ended (October 2013)

Bernice Reid – *Manchester Constituency* – Term of Office Ended (October 2013)

Helen Scott – *Manchester Constituency* – Resigned (December 2013)

Dr Syed Nayyer Abidi – *Greater Manchester Constituency* – Resigned (July 2013)

Professor Lawrence Cotter – *Rest of England & Wales Constituency* – Resigned (April 2013).

Staff Governors

Isobel Bridges – *Non-Clinical & Support Constituency*
Elected 2012
Term of Office - 3 years ending 2015

Peter Gomm – *Non-Clinical & Support Constituency*
Elected 2013
Term of Office – 3 years ending 2016

Sharon Green – *Nursing & Midwifery Constituency*
Elected 2012
Term of Office - 3 years ending 2015

Beverley Hopcutt – *Other Clinical Constituency*
Elected 2008 (shadow Council of Governors) and re-elected 2010 and 2013
Term of Office - 3 years ending 2016

Erica McInnis – *Other Clinical Constituency*
Elected 2011
Term of Office - 3 years ending 2014

Mary Marsden – *Nursing & Midwifery Constituency*
Elected 2009 and re-elected 2012
Term of Office - 3 years ending 2015

Mr John Vincent Smyth – *Medical & Dental Constituency*
Elected 2012
Term of Office - 3 years ending 2015

Nominated Governors

Cllr Rabnawaz Akbar – *Manchester City Council*
Nominated 2011
Term of Office - 3 years ending 2014

Julie Cheetham – *Central Manchester Clinical* Commissioning Group
Nominated 2012
Term of Office - 3 years ending 2015

Professor Peter Clayton – *The University of Manchester*
Nominated 2011
Term of Office - 3 years ending 2014

Mariam Gaddah – *Volunteer Services*
Nominated 2011
Term of Office - 3 years ending 2014

Dr Michael Gregory – *Trafford Clinical Commissioning Group*
Nominated 2013
Term of Office – 3 years ending 2016

Linda Harper – *Trafford Borough Council*
Nominated 2013
Term of Office – 3 years ending 2016

Angela Harrington – *Manchester City Council*
Nominated 2008 (shadow Council of Governors) and re-nominated 2011
Term of Office - 3 years ending 2014

Arif Islam – *Youth Forum*
Nominated – 2013
Term of Office – 3 years ending 2016

Jenny Scott - *Specialised Commissioning Group*
Nominated 2008 (shadow Council of Governors) and re-nominated 2011
Term of Office - 3 years ending 2014

Nominated Governor Term of Office Ended during 2013/14:

Cllr Dr Karen Barclay – *Trafford Borough Council* – Resigned (May 2013)

Dr George Kissen – *Trafford Clinical Commissioning Group* – Resigned (April 2013)

Farhana Naseem – *Youth Forum* – Resigned (May 2013)

Professor Gillian Wallis - *The University of Manchester* – Resigned (January 2014).

Governor Contact Details

Governors welcome the views and opinions of Members and the Public - Governor contact details and biographies are available via our website – 'Meet the Governors' webpage www.cmft.nhs.uk/foundation-trust/council-of-governors/meet-the-governors. Alternatively Members and the Public can contact Governors via the Foundation Trust Membership Office (0161 276 8661 or ft.enquiries@cmft.nhs.uk).

In addition, views and opinions are welcomed by Governors during their attendance at key Membership and Trust Events (including Annual Members' Meeting and Young People's Event) with event information being available on the Trust's Membership Events webpage www.cmft.nhs.uk/foundation-trust/events

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).

Governor Development

We provide many opportunities for Governors to be actively involved, which we feel help to make a real difference to our patients and the wider community. Each year the Chairman receives a Governor Effectiveness Report which is produced to highlight the Governor-driven actions that have progressed and resultant outcomes to demonstrate the effectiveness of Governors.

Over the course of the past year Governors have attended a wide variety of meetings/events from which over 200 Governor-driven actions have been taken forward. These have included actions to improve both our patient and staff experiences in addition to raising issues on behalf of our members and the public. An overview of the Governor Effectiveness Report is communicated to Members in our Membership Newsletter (Foundation Focus Newsflash).

The main Governor involvement areas include:

- Having a key role in holding the Board of Directors to account and attending regular Performance Meetings in order to review our performance across patient quality, clinical effectiveness, patient experience, finance and productivity.
- Regularly attending 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.
- Working closely with the Board of Directors, Governors are involved in the Annual Plan priority decision-making process. Governors are formally presented with the final Annual Report/Accounts and Annual Plan and are consulted on the development of forward plans and any significant changes to the delivery of our Business Plan. Governors are presented with the Trust's progress in attaining its Annual Plan objectives at Governor Development Sessions.
- Being involved in recruiting new members, ensuring that our membership communication is effective and regularly review the progress of our Membership Strategy.
- Casting a critical eye over the experience that our patients have, in areas such as accessibility, cleanliness and the environment, and overall 'customer care'.
- Ensuring that we meet our responsibilities to the wider community and plays a key role in monitoring employment, education, procurement and environmental initiatives.
- The Council of Governors' Remuneration and Nominations Committee (panel of Governors rotated each year and chaired by the Lead Governor) reviews and makes recommendations to the Council of Governors as a result of actively participating:
    - in the selection of the appointment of the Chairman and Non-executive Directors in addition to their remuneration.
    - in an annual appraisal programme which facilitates the 360° appraisal process for the Chairman and receives feedback on the appraisals of the Non-executive Directors in addition to re-appointment recommendations (including terms of office) of the Chairman and Non-executive Directors.
- Being involved in the selection of and approving our External Auditors.
- Casting a critical eye over the health and wellbeing of our staff in areas such as staff survey findings, training programmes, sickness absence and appraisals etc. with Governors actively progressing staff engagement initiatives.
- Actively participating in the Ward Accreditation Process and Quality Mark Assessments for 'Elder-friendly Hospital Wards'.
- Governors have actively participated in our Children's Disability Network, Complaints Review Panel and the Equality & Diversity Implementation Group.
- Governors have continued to contribute towards the development of our IT Strategy and been included on the selection panel for the Staff Recognition Programme – 'We're Proud of You Awards'.
- Governors have taken part in the Workplace Shadowing Programme and been involved in several 'Voices' initiatives (established as a result of previous staff survey findings to look at ways of improving staff engagement).
- Governors have actively participated in the Internal Quality Reviews which is an evolutionary process developed in order to give the Trust a better understanding of its delivery of care.

The Health and Social Care Act (2012) states that a Foundation Trust must take steps to ensure that the Governors are equipped with the skills and knowledge in order to fulfil their role with the Trust being committed to providing high quality information including regular updates, presentations, and training to Governors in order to facilitate this in addition to aiding the Governor decision making process. We encourage Governor Development in a number of key areas namely:

- Equality and Diversity Training – including patient case-studies with a Governors' Equality & Diversity Work Programme being produced which incorporates regular updates and detailed training being provided via each Governor Working Group (focused upon the key themes of each Groups' work programme).
- Detailed Induction Training for all new Governors including the establishment of a Governors' Resource Pack.
- Governor mentor/buddy assigned to our Nominated Youth Governor – support provided in preparation for Council of Governors' Meetings.
- Chairman led Governor Development Sessions (Summer and Winter Development Events) – topical health matters (impact on Trust/Governor role) in addition to the progress made in achieving our Annual Plan objectives are discussed.
- Governor attendance at External Governor Development Events – Foundation Trust Governors' Association and Northwest Governors' Forum.
- Annual Governor Development Programme informed via Governor questionnaire findings, Governor Working Group assessments and Governor skill mix matrix findings.
- Annual Lead Governor elections/succession planning.
- Dedicated Lead Governor/Governor meetings – promotes free discussion/debate.

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

- The continual development and implementation of a detailed Governor Development Programme informed via a Governor-led Development Group, Governor Questionnaire Findings, Governor Working Group Reviews and Governor Skill Mix Assessment – 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 and scrutiny of Intelligent Board Reports and workforce data enabling Governors to effectively hold the Board of Directors to account.
- Governor Skill Mix Matrix which enables Governor competencies/expertise to be captured ensuring that Governors' expertise is utilised to their full potential when assigning/progressing Governor-led involvement projects.
- The implementation of a Governor Strategy which sets out Governor aims and objectives and key Governor priorities to further facilitate programmes of work and membership/public engagement plans for the forthcoming year.
- The establishment of dedicated Governor and Non-executive Director Networking Meetings in order to identify and capture additional development needs.
- The establishment of a specialised Governor Engagement Training Session including a Governor Briefing Pack in order to further enhance Governor/Membership Engagement practices.

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.
- An annual Governor Effectiveness Report is produced outlining the actions driven by Governors with corresponding benefits and outcomes.

Governor 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 Staff Health and Wellbeing Strategy by being involved in work initiatives identified/generated as a result of the annual staff survey findings and staff engagement initiatives.

Over the course of the past year presentations/ information has been received in relation to Staff Health & Wellbeing Strategy, Equality & Diversity, Staff Survey findings, Staff Recognition Programme (We're Proud of You Awards), staff psychological support, Occupational Health and workforce data.

Recent work projects include Governor involvement in the development of the Staff Health & Wellbeing Strategy delivery plans in addition to the continuing involvement in the Staff Recognition Programme.

Corporate Citizenship – advises and engages with the Corporate Citizenship programme with work projects being generated around five main themes namely Employment, Carbon Reduction (Energy and Sustainability), Sustainable Travel & Transport, Sustainable Procurement 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, Cross City Bus Scheme, Equality and Diversity and an update in relation to the Whitworth Park Plans.

Recent work projects include Governor involvement in developing cultural partnerships and supporting our employment, apprenticeships and work placement programmes (Supported Traineeships, Clinical Pre-Employment and Manchester Health Academy) with Governors continuing to monitor the Employment Key Performance Indicator to measure progress made to recruit young, local employees. Support is also given to the development of carbon reduction and sustainable procurement initiatives.

Patient Experience - supports the implementation of our Quality Strategy by advising on accessibility, customer focus, front of house/reception areas, 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 the Francis and Care Quality Commission Reports, Quality Report, Cancer Survey findings, pressure ulcer data, complaints, family and friends data, ward rounds/ visits, Patient and Staff Survey findings, hospital signage, food, Trafford, A&E and Out-patient development plans.

Recent work projects include Governor involvement in Annual Quality Report/Accounts review, Children's Learning Disabilities, Patient and Staff Environment Group, Patient Led Assessments of the Care Environment and the internal Quality Reviews.

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 the Equality and Diversity, Healthy Schools Programme, Youth Forum, Young People's Event (June 2013) and Annual Members' Meeting (October 2013), Northwest South Asian Community – Organ Donation Campaign, Website User Reports and Annual Patient Profile Report (2012/13).

Recent work projects include Governors support of our Public Member recruitment campaign (campaign held to enlist young members and address short fallings in the membership profile to more accurate reflect the new 2011 census data). Governors are actively involved in the planning of membership engagement events (Young People's Event and Annual Members' Meeting) which included a dedicated Governor Question and Answer Session at the recent Annual Members' Meeting. Governors continue to support the Annual Membership Engagement Communication Plan. Governors support initiatives targeted at reaching Seldom

Heard Groups which included raising awareness of the organ donation campaign in south Asian communities and supported the campaign feature in Membership Newsletter (Foundation Focus Newsletter).

All Governors were invited to attend a Membership Working Group (29th January 2014) with Governor driven actions being generated to further enhance Governor/Membership Engagement initiatives over the coming year.

Monitoring Arrangements:

The Chairman meets with the Lead Governor and the four Governor Working Group Chairs and 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. Each Governor Working Group Chair/ Supporting Director completes an end of year report with the Terms of Reference and Membership of each Group being reviewed. In addition, the minutes of each Group is incorporated into each Council of Governors' Meeting with the Governor Chair of each group providing a verbal update at each meeting.

Governor and Director Attendance at Council of Governor Meetings – 2013/14

Governor Attendance at Council of Governor Meetings – 2013/14

Governor Name	3rd July 2013	16th October 2013	5th March 2014
Syed Abidi	✘		
Rabnawaz Akbar	✓	✘	✘
Ivy Ashworth-Crees	✓	✘	✓
Jayne Bessant	✓	✘	✓
Isobel Bridges	✘	✘	✓
Julie Cheetham	✘	✘	✘
Malcolm Chiswick	✓	✓	✓
Abu Chowdhury	✓		
Peter Clayton	✓	✓	✘
George Devlin	✓	✓	✓
Peter Dodd	✓	✓	✓
David Edwards		✓	✓
Matthew Finnegan	✓	✓	✘
Mariam Gaddah	✘	✓	✘
Peter Gomm		✓	✓
Sharon Green	✓	✘	✓
Michael Gregory		✘	✘
Linda Harper		✘	✘
Angela Harrington	✓	✓	✓
Beverley Hopcutt	✓	✓	✓
Arif Islam		✘	✓
Alan Jackson		✓	✘
Richard Jenkins	✓	✓	✘

Governor Name	3rd July 2013	16th October 2013	5th March 2014
Mary Marsden	✓	✓	✓
Erica McInnis	✘	✓	✓
Alexena Morrison	✓		
Farhana Naseem	✓		
Margaret Parkes	✓	✘	✘
William Keith Paver	✓	✓	✓
Andrew Peel		✓	✓
Bernice Reid	✓		
Lynne Richmond	✓	✘	✓
Sue Rowlands	✓	✓	✓
Helen Scott	✓	✘	
Jenny Scott	✘	✓	✘
John Vincent Smyth	✓	✘	✓
Gillian Wallis	✓	✘	
Barrie Warren		✘	✘
Stephen Webster		✓	✓
Sue Webster	✓	✓	✓

Director Attendance at Council of Governor Meetings – 2013/14

Director Name	3rd July 2013	16th October 2013	5th March 2014
Lady Rhona Bradley Non-Executive Director	✓	✓	✓
Julia Bridgewater Chief Operating Officer		✓	✓
Rod Coombs Non-Executive Director	✘	✓	✘
Kathy Cowell Non-Executive Director	✓	✓	✓
Mike Deegan Chief Executive	✓	✓	✓
Gill Heaton Executive Director of Patient Services/Chief Nurse	✓	✘	✓
Margot Johnson Executive Director of Human & Corporate Resources	✓	✓	✓
Anthony Leon Deputy Chairman/Non-Executive Director	✘	✓	✓
Peter Mount Chairman	✘	✓	✓
Steve Mycio Non-Executive Director	✓	✓	✓
Robert Pearson Medical Director	✓	✓	✓
Adrian Roberts Executive Director of Finance	✓	✓	✓
Brenda Smith Senior Independent Director/Non-Executive Director	✓	✓	✘

Membership

Membership Aim & Key Priorities

Membership Aim:

For the Trust to have a representative membership which truly reflects the communities that it serves with Governors actively representing the interests of members as a whole and the interests of the public.

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 by equiping Governors with the skills and knowledge in order to fulfil their role (see page 198 for further 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. Our Public Member constituency is subdivided into four areas:

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

The maps opposite illustrate the Manchester, Trafford 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 four classes:

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

Membership & Engagement Strategy

A Membership & Engagement Strategy has been produced with its purpose being to outline how patients, carers, members of the public and the local communities that we serve can become more involved by becoming members of the Trust with the Strategy outlining how we recruit, engage, support, consult and involve our 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 is available to members and the public via the Membership webpage http://www.cmft.nhs.uk/foundation-trust. Alternatively, a copy can be obtained from the Membership Office (contact: 0161 276 8661 or ft.enquiries@cmft.nhs.uk)

Greater Manchester

Manchester

Trafford

Membership Community

In 2013/14 the Trust held a public membership recruitment campaign to address the short fall in its membership profile as facilitated via the Governors' Membership Working Group, specifically being focused upon young people (aged 11 - 16 years) in addition to recruiting members across a range of ethnic groups in order to more accurately reflect the 2011 census findings. This was achieved via a recruitment event held across our Hospitals' sites.

The Trust's total public membership is now around 14,000 (public members) in addition to housing a staff membership of around 13,000 (staff members) giving an overall membership community of around 27,000 members at year end. During the forthcoming year, we aim to uphold our membership community by addressing natural attrition and membership profile short-fallings.

Membership promotion was further facilitated via our website homepage (electronic banner), Facebook and Twitter pages which include a statement from our Lead Governor outlining the benefits of becoming a member. A Trust/Membership promotional video is also available via 'You Tube'. In addition, Membership is promoted via a Membership Display Stand which is rotated throughout the various hospital entrances.

Membership welcome packs are sent to all new members' including an invitation to their family/ friends to become a member. Regular membership newsletters (Foundation Focus Newsflash) and an Annual Members' Meeting invitation is circulated to members (electronically and via post) in addition to

being circulated to key community groups (seldom heard groups) and displayed on the website. Membership promotion is a regular feature in our GP newsletters circulated to GPs across Manchester, Trafford and Greater Manchester areas. Membership promotional materials are also available at key patient/public areas throughout our hospitals.

The dedicated Foundation Trust section of the website is regularly updated promoting membership, the role of Governor, Elections and forthcoming membership events and includes the facility for individuals to apply for membership via the completion of an online application form.

A key priority area for the forthcoming year is to again target membership recruitment in the young people's age group to sustain an 11 – 16 year old membership population of around 5%. 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 organisation 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 with the Trust monitoring and submitting an annual Membership Profile Report to Monitor (Independent Regular of Foundation Trusts).

Membership Analysis Data

Public Membership				
	Membership 2012/13	%	Membership 2013/14	%
Age				
0 – 16	764	5.6	731	5.2
17 – 21	1,292	9.4	1,238	8.7
22+	10,758	78.5	11,325	79.9
Not Stated	894	6.5	878	6.2
Ethnicity				
White	10,357	75.6	10,579	74.7
Mixed	272	2.0	285	2.0
Asian or Asian British	1,416	10.3	1,737	12.3
Black or Black British	883	6.4	914	6.4
Other	215	1.6	86	0.6
Not Stated	565	4.1	571	4.0
Gender				
Male	6,609	48.2	6,651	46.9
Female	7,032	51.3	7,449	52.6
Not Stated	67	0.5	72	0.5
Recorded Disability	2,094	15.3	2,027	14.3

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

Total Public Membership (31st March 2014) = 14,172 (878 members with no stated age, 571 members with no stated ethnicity and 72 members with no stated gender). Staff membership at 31st March 2014 = 13,070 this includes facilities management contract staff and clinical academic (The University of Manchester) staff (see page 34 for workforce analysis data).

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 2013/14 membership engagement initiatives have included:

- A Young People's Health Event which included health information and interactive demonstrations from varying health professionals stands promoting key health service areas (including support services), within the Trust in addition to advice on NHS careers/voluntary services. The latest event also included attendance by our Youth Governor and provided an opportunity for young people to forward their views and opinions.
- An Interactive Annual Members' Meeting which included an overview of our past performance and plans for the future. The theme of the meeting was 'Proud to Care for You' and our staff ran health information stands showcasing the innovative and high quality care provided by all our hospitals and community services with health professionals providing advice and interactive demonstrations/health checks. The latest event also included a dedicated Governor Question and Answer Session in order to provide a platform for members and the public to forwards their views and opinions.
- Invitations sent to members to attend key Health Events including:
  - 'It's OK to Ask' your Doctor about Research Event as part of the International Clinical Trials Day
  - Movember Men's Health Awareness Event
  - Living Longer Living Better (integrated health and social care programme) Event.
- Invitations sent to members to become involved in the Trust's Patient Led Assessment of the Care Environment (PLACE) Assessments.
- A series of Chairman/Staff Governor Engagement Sessions with Staff Members were held at which staff members were encouraged to forward their views and suggestions from which detailed action plans were produced to ultimately improve service provision for our patients.
- A quarterly Governor bulletin is produced and circulated to all staff members which highlights membership and Governor information and feedback from previous Chairman/Staff Governor Engagement Sessions. In addition, an overview of the key Governor meetings/events that have taken place is provided including associated Governor involvement project/work streams. Electronic copies of past Governor bulletins are available on the website.
- 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 including the circulation of membership promotional materials to Seldom Heard Groups.
- A Membership Engagement Communication Plan has been developed with initiatives being implemented over the course of the forthcoming year.
- Public and Members are also encouraged to contact our Governors with their views and suggestions via our 'Meet the Governors' webpage in addition to contact information being promoted in our Membership Newsletter (Foundation Focus Newsflash). In addition, views and opinions are welcomed by Governors during their attendance at key Membership and events (including Annual Members' Meeting and Young People's Event).
- Members in Action and Governors in Action features included in our Membership Newsletters (Foundation Focus Newsflash).

- Members and Public views to be canvassed by Governors (including Annual Plan objectives, priorities and strategy) via direct face-to-face meetings and attendance at local Public/Patient events. In addition members and public views are encouraged via the Membership and Governors' webpages with responses received via Governor interactions and via e-mails (including dedicated Foundation Trust Enquiries e-mail account) being forwarded to the Board of Directors.

Membership engagement will continue to be our key priority over the forthcoming year with Governor driven actions being implemented to further enhance Governor/Membership Engagement initiatives over the coming year.

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

Monitoring Arrangements:

We are committed to supporting Governors in canvassing the views and opinions of our Members and the public with membership and public engagement initiatives being developed and monitored via the Governors' Membership Working Group in conjunction with the Council of Governors with questionnaire findings utilised to gage levels of engagement.

Board of Directors Engagement with Governors

The Board of Directors engages with the Governors on a regular basis in order to obtain their views and respond to any concerns.

All Executive and Non-executive Directors attend the Council of Governors' Meetings at which Governors have the opportunity to challenge the Directors and seek assurances to concerns they may raise.

At the quarterly performance review meetings, Executive and Non-executive Directors hold discussions with the Governors in order to understand their views on our performance and provide details of actions in place to improve performance where required. Governors have been involved this year to provide feedback on the Board Performance reporting with a view to ensuring that the right level of detail is available to inform accurate decision making.

A Non-executive Director is a member of each Governor Working Group and is a sounding board for the views of the Governors which are conveyed to the Board.

The Chairman also hosts a number of Governor Development Sessions attended by both Executive and Non-executive Directors. A range of topics are discussed for example performance against the Trust's key priorities, patient and staff survey results and patient experience. Governors are able to raise their concerns and offer their views and suggestions to take forward.

Governors play a key role in the Annual Planning Workshop led by the Executive Director of Finance. Non-executive Directors also attend and strong engagement with Governors is demonstrated as Governors' views are discussed.


ALKRINGTON
TRUCK & CO

Board of Directors

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 Year's 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 CBE, 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

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

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

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

- Responsible Officer for CMFT
- Appointed Consultant Surgeon MRI 1990.
- 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
- Previously Chair of the NHS National Technology Adoption Hub Stakeholder Board
- Member of Executive Management Team, Manchester Academic Health Science Centre (MAHSC)
- MAHSC representative on Greater Manchester AHSN (Academic Health Science Network) Strategic Board

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 securing Stockport's authorisation as one of the first 10 Foundation Trusts in April 2004

Margot Johnson, Executive Director of Human and Corporate Resources (Appointed May 2013)

Worked in the NHS for over 30 years, mostly within Human Resources.

Is a fellow of the CIPD and is a firm advocate of CPD ensuring she has clear annual learning objectives. Holds a Masters in Strategic HRM and is a qualified coach.

- First started work in Finance but after 3 years took the opportunity to transfer into Human Resources. Has worked across all sectors of the NHS but mostly in the Acute hospital environment.
- During career she worked in generalist HR roles and has also specialised in Workforce Planning, Organisational Development and Medical Staffing and as part of a team responsible for developing a privately financed NHS hospital, from business case through to opening.
- Has also spent a short period working in general management and took a secondment to work as part of a multiagency inquiry team, working alongside the police, Social Services and Education.
- Has been an HR Director in a teaching hospital for 10 years, having recently moved to Central Manchester to take up the position of Director of Human and Corporate Services, which in addition to HR covers legal services, communications and corporate governance.

Julia Bridgewater, Chief Operating Officer (Appointed September 2013)

- Julia joined the NHS Graduate Training Scheme in 1984 after completing a degree in Theology at The University of Manchester. She has spent the majority of her career in the acute sector in the West Midlands, in various roles, including managing Surgery, Orthopaedics, Business Planning and Service Development.
- Julia was appointed as Chief Executive at the University Hospital of North Staffordshire NHS Trust (UHNS) in 2007 where she guided the hospital through a period of Turnaround. UHNS was successful in having approved a £400 million PFI Scheme in May 2007 and services were transferred to the single site development in 2012.
- Julia moved to lead Shropshire Community Trust for a period of six months before joining Central Manchester University Hospitals NHS Foundation Trust in September 2013.

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

A Chartered Accountant who was Managing Partner of the Manchester practice of Binder Hamlyn for 15 years.

- Director of Bright Futures Educational Trust
- Previously Chairman of the Mancunian Community Health NHS Trust, from 1995 to 2001
- 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)

Deputy President and Deputy Vice Chancellor University of Manchester.

- Rod Coombs has a BSc in Physics, and MSc and PhD degrees in the economics of innovation and technical change. After a short period at the beginning of his career working in laboratory research, he switched to social science. Thereafter he worked for over 25 years on analysing the role of technical change in the economy; the management of R&D and innovation processes in large companies; and the role of government policy in promoting innovation in the economy. During much of this time he was in the School of Management at UMIST, becoming its first Professor of Technology Management in 1993. During that period he initiated and ran several large collaborative research programmes, and also worked as a consultant to a number of large research-intensive companies, as well as advising national and European government agencies.
- In 2002 he became a Pro-Vice-Chancellor of UMIST, and thereafter was heavily involved in the project to merge UMIST with the former Victoria University of Manchester in order to create a new University of Manchester (which legally came into existence in October 2004).
- In 2004 he was appointed as one of the Vice-Presidents of Manchester University and had responsibility for various aspects of Knowledge Transfer, Research and External Relationships.
- In August 2010 he became Deputy President and Deputy Vice Chancellor of Manchester University.

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
- Previously worked for what is now the Care Quality Commission (CQC) as a Service Inspector, conducting statutory inspections of Youth Offending Teams and Local Authority Children's Services
- 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.

- Interim Chief Executive, Office of the Police Commissioner, Greater Manchester
- Director, Manchester United Foundation Trading Limited
- Deputy Chair of Governors at Manchester Health Academy

- Board member of Manchester Credit Union
- Previously Deputy Chief Executive, Manchester City Council (1998 - retired September 2011)
- Background in Housing Management and Regeneration culminating in the role of Director of Housing 1992-1998

Kathy Cowell OBE, Non-Executive Director (Appointed March 2013)

A banker by profession, having worked for Cheshire Building Society for 24 years until taking early retirement in 2006. With a keen interest in local communities, past roles include: chair of the Queens Award for Voluntary Service, chair of Cheshire Building Society Foundation, Chairman of the Cheshire & Merseyside Courts Board since its inception in April 2004, a member of the Lord Chancellors Advisory Committee on the appointment of Justices of the Peace, and a member of the Manchester United Foundation. Kathy has held several Non-executive roles in Health, in both the provider and commissioner roles.

Current roles include:

- Chair of Your Housing Group (a social housing provider)
- Deputy Chair of Cheshire Young Carers
- Founder member of Cheshire Community Foundation
- Deputy Lieutenant of Cheshire
- Member of the Strategic growth Community East Cheshire Hospice

Attendance at Board Meetings

	May 13	Jul 13	Sept 13	Nov 13	Jan 14	Mar 14
Peter Mount Chairman	✓	✓	✓	✓	✓	✘
Mike Deegan Chief Executive	✓	✓	✓	✓	✓	✓
Robert Pearson Medical Director	✓	✓	✓	✓	✓	✓
Gill Heaton Executive Director of Patient Services/Chief Nurse	✓	✓	✓	✓	✓	✓
Margot Johnson 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	✓	✓	✓	✓	✓	✓
Kathy Cowell 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); Director Manchester Academic Health Sciences Centre (MAHSC).

Mike Deegan, Chief Executive: Trustee, Nuffield Trust.

Professor Rod Coombs, Non-executive Director: Deputy President, The University of Manchester; 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; Director of Bright Futures Educational Trust.

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.

Lady Rhona Bradley, Non-executive Director: Chief Executive, ADS (Addictions Dependency Solutions); Deputy Lieutenant in Greater Manchester; Member of the Labour Party.

Kathy Cowell, Non-executive Director: Chair of Your Housing Group; Deputy Chair Cheshire Young Carers; Board member of Cheshire Community Foundation; Member of Strategic Advisory Group, East Cheshire Hospice; Deputy Lieutenant for Cheshire.

Steve Mycio, Non-executive Director: Directorships: Manchester Health Academy; Manchester United Foundation Trust; Manchester Credit Union; Interim Chief Executive of the Office of Police and Crime Commissioner for Greater Manchester.

Julia Bridgewater, Chief Operating Officer: Foundation Director of Multi Academy, All Saints Catholic Collegiate.

Robert Pearson, Medical Director: Strategic Board, Greater Manchester Academic Health Sciences Network.

Margot Johnson, Executive Director of Human and Corporate Resources: Governor, Manchester Health Academy.

No interests to declare: Gill Heaton, Director of Patient Services/Chief Nurse; Adrian Roberts, Executive Director of Finance.

Remuneration (Audited)

2012-13	Salary	Taxable Benefits in Kind	Annual Performance-Related Bonuses	Long-Term Performance-Related Bonuses	All Pension-Related Benefits	Total
	(Bands of £5,000) £000	(Rounded to Nearest £100) £	(Bands of £5,000) £000	(Bands of £5,000) £000	(Bands of £2,500) £000	(Bands of £5,000) £000
P Mount, Chairman	60-65					60-65
R Bradley, Non-Executive Director	15-20					15-20
R Coombs, Non-Executive Director	15-20					15-20
K Cowell, Non-Executive Director	0-5					0-5
A Leon, Non-Executive Director	15-20					15-20
S Mycio, Non-Executive Director	15-20					15-20
B Smith, Non-Executive Director	15-20					15-20
A Wiseman, Non-Executive Director (to 31st January 2013)	10-15					10-15
M Deegan, Chief Executive	210-215				67.5-70	280-285
R Pearson, Medical Director	195-200					195-200
G Heaton, Executive Director of Patient Services/Chief Nurse	160-165				80-82.5	240-245
J Bridgewater, Chief Operating Officer (from 23rd September 2013)	N/A				N/A	N/A
A Roberts, Executive Director of Finance	155-160				25-27.5	180-185
M Johnson, Executive Director of Human & Corporate Resources (from 3rd July 2013)	N/A				N/A	N/A
D Welsh, Executive Director of Human & Corporate Resources (to 2nd July 2013)	125-130					125-130

2013-14	Salary	Taxable Benefits in Kind	Annual Performance-Related Bonuses	Long-Term Performance-Related Bonuses	All Pension-Related Benefits	Total
	(Bands of £5,000) £000	(Rounded to Nearest £100) £	(Bands of £5,000) £000	(Bands of £5,000) £000	(Bands of £2,500) £000	(Bands of £5,000) £000
P Mount, Chairman	60-65					60-65
R Bradley, Non-Executive Director	15-20					15-20
R Coombs, Non-Executive Director	15-20					15-20
K Cowell, Non-Executive Director	15-20					15-20
A Leon, Non-Executive Director	15-20					15-20
S Mycio, Non-Executive Director	15-20					15-20
B Smith, Non-Executive Director	15-20					15-20
A Wiseman, Non-Executive Director (to 31st January 2013)	N/A					N/A
M Deegan, Chief Executive	215-220				50-52.5	265-270
R Pearson, Medical Director	210-215					210-215
G Heaton, Executive Director of Patient Services/Chief Nurse	160-165				52.5-55	215-220
J Bridgewater, Chief Operating Officer (from 23rd September 2013)	90-95				65-67.5	155-160
A Roberts, Executive Director of Finance	155-160				42.5-45	195-200
M Johnson, Executive Director of Human & Corporate Resources (from 3rd July 2013)	120-125				Not Known*	Not Known*
D Welsh, Executive Director of Human & Corporate Resources (to 2nd July 2013)	50-55					50-55

	2013/14	2012/13
Band of Highest Paid Director's Total	215,000	213,000
Median Total Remuneration	27,901	28,005
Remuneration Ratio	7.8	7.6

* The Trust has not been able to obtain information as to M Johnson's Pension Benefits as they stood at 31st March 2013

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 salaried remuneration of the highest paid director in Central Manchester University Hospitals NHS Foundation Trust in the financial year 2013/14 was £215,000 (2012/13 £213,000). This was 7.8 times (2012/13 7.6 times) the median remuneration of the workforce, which was £27,901 (2012/13 £28,005).

In 2013/14 six (2012/13 nil) employees received remuneration in excess of the highest paid Director. Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, and any severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

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 Age 60 (Bands of £2,500)	Total Accrued Pension at Age 60 at 31st March 2014 (Bands of £5,000)	Lump Sum at Age 60 Related to Accrued Pension at 31st March 2014 (Bands of £5,000)	Cash Equivalent Transfer Value at 31st March 2014	Cash Equivalent Transfer Value at 31st March 2013	Real Increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
M Deegan, Chief Executive	0 to 2.5	5 to 7.5	45 to 50	135 to 140	836	752	58
G Heaton, Executive Director of Patient Services/ Chief Nurse	0 to 2.5	5 to 7.5	55 to 60	165 to 170	1,184	1,074	73
J Bridgewater, Chief Operating Officer (from 23rd September 2013)	0 to 2.5	2.5 to 5	60 to 65	180 to 185	1,120	1,028	56
A Roberts, Executive Director of Finance	0 to 2.5	2.5 to 5	50 to 55	155 to 160	960	885	43
M Johnson, Executive Director of Human & Corporate Resources (from 3rd July 2013)	Not Known*	Not Known*	50 to 55	150 to 155	921	Not Known*	Not Known*

* The Trust has not been able to obtain information as to M Johnson's Pension Benefits as they stood at 31st March 2013.

The above table gives Pension Benefits accruing from the NHS Pension Scheme up to 31st March 2014 - note that as Non-Executive Directors do not receive pensionable remuneration, there are no entries in respect of Pensions for these Directors. Additionally, as in 2012/13 there are no longer any details given above regarding two Executive Directors, D Welsh (now retired) and R Pearson, as both ceased to be members of the NHS Pension Scheme in the 2011/12 Financial Year.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the Pension Scheme benefits accrued by a Scheme 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 which the individual has accrued as a consequence of their total membership of the Pension Scheme, not just their service in a senior capacity within this Trust and this Group, to which the disclosure applies.

The CETV figures and 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.

Expenses

Directors

The total number of Directors in office during 2013/14 was 14 (2012/13 - 13 Directors)

The number of Directors receiving expenses in 2013/14 was 7 (2012/13 - 8).

The total expenses paid to Directors in 2013/14 was £7,600 (2012/13 - £5,200).

Governors

The total number of Governors in office during 2013/14 was 44 (2012/13 - 38 Governors).

The number of Governors receiving expenses in 2013/14 was 4 (2012/13 - 5).

The total expenses paid to Governors in 2013/14 was £500 (2012/13 - £600).

Off-payroll engagements

Table 1

For all off-payroll engagements as of 31st March 2014, for more than £220 per day and that last for longer than six months

No. of existing engagements as of 31st March 2014	7
Of which	
No. that have existed for less than one year at a time of reporting	1
No. that have existed for between one and two years at time of reporting	2
No. that have existed for between two and three years at time of reporting	2
No. that have existed for between three and four years at time of reporting	0
No. that have existed for four or more years at time of reporting	2

Table 2

For all new off-payroll engagements or those that reach six months in duration between 1st April 2013 and 31st March 2014 for more than £220 per day and that last for longer than six months

No. of new engagements or those that reached six months in duration between 1st April 2013 and 31st March 2014	13
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	12
No. of who assurance has been requested	12
Of which…	
No. for who assurance has been received	9
No. for whom assurance has not been received	3
No. that have been terminated as a result of assurance not being received	0

Table 3

For any off payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1st April 2013 and 31st March 2014

No. of off-payroll engagements of board members and/or senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed "board members and/or senior officials within significant financial responsibility during the financial year. This figure should include both off-payroll and on-payroll engagements.	0

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 compliance with the principles and provisions of the NHS Foundation Trust Code of Governance.

The Board of Directors meets formally on a bi-monthly 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, independence, balance and completeness that is appropriate to the requirements of the Trust.

Non-executive Directors are appointed for a term of 3 years by the Council of Governors. The Council of Governors at a general meeting shall appoint or remove the Chairman or the Non-executive Directors. Removal of the Chairman or another Non-executive Director shall require the approval of three-quarters of the members of the Council of Governors.

The Chairman has ensured that the Board of Directors and the Council of Governors work together effectively and that Directors and Governors receive 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.

Annual Audit Committee Report

Purpose of the Report

This annual report 2013/14 has been prepared for the attention of the Board of Directors and reviews the work and performance of the Audit Committee during 2013/14 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 Risk Assessment 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 2013/14 comprised:

Mr Anthony Leon	Deputy Chairman of the Board and Chair of the Audit Committee
Professor Rod Coombs	Non-executive Director
Lady Rhona Bradley	Non-executive Director
Mrs Brenda Smith	Non-executive Director
Mr Steve Mycio	Non-executive Director
Mrs Kathy Cowell	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 2013/14.

All meetings have been quorate.

Audit Committee minutes are submitted to the next available Board of Directors' meeting.

Audit Committee members met in private with the Internal and External Auditors prior to the Audit Committee meeting in February 2014.

The Executive Director of Finance, Director of Operational Finance, Chief Accountant, Director of Corporate Services, 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 November 2013.

Attendance

Date	Anthony Leon	Rod Coombs	Rhona Bradley	Brenda Smith	Steve Mycio	Kathy Cowell
03/04/13	✓	✓	✓	✓	✓	✓
28/05/13	✓	✘	✓	✓	✓	✓
04/09/13	✓	✓	✓	✓	✓	✓
06/11/13	✓	✓	✓	✓	✓	✓
05/02/14	✓	✘	✘	✓	✓	✓

Audit Provision

Internal Audit has been provided by Mersey Internal Audit Agency.

External Audit has been provided by Deloitte LLP. The Council of Governors at its meeting in October 2013 approved the Audit Committee's recommendation for the appointment of Deloitte LLP.

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 covered the following:

- Monitoring of the Audit Committee's Work Programme 2013/14
- 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 2013/14

Work Programme 2013/14

The Audit Committee has adhered to the Work Programme agreed in April 2013. All reports scheduled for each Committee meeting have been received on time.

Reports from Board Committees

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 Trading Gap challenge in the Children's and Medicine and Community Divisions.

External Audit

The 2012/13 accounts were audited by Deloitte LLP and the findings presented to the Audit Committee in May 2013. An unqualified opinion on the accounts was given.

The Chairman of the Audit Committee and Non-executive Directors had met earlier with the Executive Director of Finance and the Director of Operational Finance to discuss and interrogate the 2012/13 accounts. External Audit commented on the additional assurance this had given the process.

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 2012 to 31st March 2013.

The Council of Governors subsequently received the report on the accounts from the Independent Auditor in July 2013.

Deloitte LLP carried out an audit on the Quality Account 2012/13 and provided recommendations to the Audit Committee in September 2013.

Deloitte LLP provided regular progress reports to the Audit Committee throughout the year. In addition regular updates were provided on:

- New Accounting Pronouncements
- Mid-Staffordshire NHS Foundation Trust Published enquiry – the 'Francis Report'
- Monitor Risk Assessment Framework (RAF)
- 2012/13 Foundation Trust Performance – Year to 31st March 2013
- Quality Governance: how does a Board know that its organisation is working effectively to improve patient care?
- The 2013/14 Compliance Framework
- Monitor's Enforcement Guidance
- National Audit Office Report on Confidentiality Clauses and Special Severance Payments
- Monitor consultation on the 2013/14 Annual Reporting Manual
- Health Tourism
- Information on NHS Developments
- The NHS Foundation Trust Code of Corporate Governance changes
- 2013/14 Annual Reporting Manual changes
- Quality Governance Framework compliance

The Committee reflected upon the lessons learned from the Audit last year but in view of the changes to the Audit team and the different approach adopted this year, the Committee would like to use Deloittes' framework for assessing the effectiveness of the external audit process once the audit for 2013/14 has been completed to ensure maximum learning.

Internal Audit

The Audit Committee received the draft Internal Audit plan for 2013/14 in April 2013. 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 Annual Governance Statement.

- The Head of Internal Audit Opinion 2012/13 was presented to the Audit Committee in May 2013 and a significant assurance was given on the adequacy of the system of internal control.

The following Internal Audit Reports have been received by the Audit Committee throughout the year.

Report	Issued	Assurance Rating
ESR Payroll Review	April 2013	Significant
Information Governance Toolkit	April 2013	Limited
Waiting Time targets –		
Activity Waiting	April 2013	Significant
Accident & Emergency	May 2013	Significant
Assurance Framework	April 2013	Met
Risk Management	May 2013	Significant
Recruitment	May 2013	Significant
Data Integrity - Duplicate PAS records	May 2013	Significant
Technical Continuity Review	May 2013	Significant

Report	Issued	Assurance Rating
Bereavement Centre	September 2013	Significant
Incidents Management	September 2013	Significant
Network Infrastructure	November 2013	Significant
Trafford Divisional Review	November 2013	Significant
Procurement/Tenders/Waivers	January 2014	Limited
General Ledger	January 2014	Significant

The Audit Committee received the status on implementing Internal Audit Recommendations at each meeting. This year the audit committee focused again on the timescales for the implementation of action plans and monitored the breaches.

Performance against key indicators in the Internal Audit Plan was reviewed at each meeting by the Committee.

Limited Assurances and Significant Issues Considered

The Committee focused on audit reports which had received a limited assurance and where the risk profile represented significant issues for the Trust and where appropriate requested the presence of key individuals to present their action plans to fulfil the recommendations. In particular presentations and reports were received on:

- Community Services
- Private Patients/Chargeable Patients/Reciprocal Patients
- Quality Report
- IT Infrastructure at Trafford

The Committee undertook a review of the work of Internal Audit in year based on the findings of the feedback questionnaires completed by Senior Managers when undertaking audit.

The Committee will consider the review undertaken of the work of Internal Audit next year based on the findings of the feedback questionnaires completed by Senior Managers.

Counter Fraud

The Counter fraud service to the Trust was provided by Mersey Internal Audit Agency who had been appointed from April 2013 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 May 2013. Areas which continued to be covered during 2013/14 included:

- Creating an anti-fraud culture
- Deterrence
- Prevention
- Detection
- Investigation
- Sanction
- Redress

A Counter fraud annual report was presented to the Audit Committee in April 2013 and provided a summary of the counter fraud work undertaken based upon the annual work plan.

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.

Throughout the year bad debts and claims abandoned accounted for the biggest proportion of losses reported to the Committee.

Tenders Waived

A summary of all tenders waived above a £50k value was presented at each Audit Committee meeting.

Other Reports

The Audit Committee received further information on the following:-

The Audit Committee received the Annual Report and the Quality Report for the Trust in May 2013.

The Audit Committee received the Annual Governance Statement 1st April 2012 to March 2013, in May 2013.

The Annual Governance Statement described the system of internal control that supports the achievement of the organisation's policies, aims and key priorities.

The Annual Governance Statement was supported by independent assurances and reflected that there were no control issues that required disclosure.

The Audit Committee received the revision to the Standing Orders in February 2014, prior to approval by the Board of Directors.

The Audit Committee received regular reports on the review of the Trust's financial processes.

Priorities for 2014/15 (ensure backward look at these areas)

The Audit Committee will review the arrangements to be put in place/developed in relation to:

- Oversight of Whistle-blowing arrangements including appropriate safeguards to protect whistle-blowers
- Compliance with Foundation Trust authorisation/ licence
- Care Quality Commission and compliance
- Approval of internal regulatory documents
- Board Assurance Framework
- Clinical Audit Strategy and Plan with a particular focus on links with complaints and incidents
- Monitoring audit recommendations and reviewing all audits with a limited assurance
- Outcomes of the Complaints Review
- Learning from the due diligence exercise - Trafford

Developing the Role and Skills of the Audit Committee

A session on Audit Committee effectiveness facilitated by Mersey Internal Audit Agency was undertaken in September 2013 this has led to a revision of the terms of reference of the Committee and a full review of the Board Assurance Framework.

Audit Committee members are encouraged to attend workshops arranged by Internal and External Auditors.

Conclusion

The Audit Committee has continued to consider a much wider spectrum of risk during the year. This will continue during 2014/15. Also in co-operation 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 2014/15 on following up Internal and External Audit reports where limited assurances have been given and will continue to monitor the clinical audit process.

The Audit Committee has met its terms of reference as detailed throughout this report.

Anthony Leon
Chairman
Audit Committee

April 2014

The Remuneration and Nominations Committee Report

The Remuneration and Nominations Committee of the Council of Governors met twice during 2013/14 to consider the remuneration of the Non-executives and the Chairman.

The first meeting was in June 2013 to review the appraisal of the Chairman and the Non-executives.

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. Attendance at the meeting included the Lead Governor, Professor M Chiswick; Dr E McInnis – staff governor (other clinical); Cllr R Akbar – Nominated Governor (Manchester City Council); Mr R Jenkins – Public Governor and Ms L Richmond – Public Governor. The Council of Governors approved the recommendation from the Committee in July 2013.

The second meeting was held in August 2013 to review the pay of the Chairman and the Non-executives.

Benchmarking with Trusts of a similar size was used as the basis for the recommendation which was approved by the Council of Governors in October 2013. Attendance at the meeting included Professor M Chiswick; Dr E McInnis – staff governor (other clinical); Ms S Webster – public governor and Cllr R Akbar – Nominated Governor (Manchester City Council).

The Remuneration Committee of the Board of Directors has met during the year as required to determine the remuneration of the Executive Directors and very Senior Managers. 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 to determine pay uplifts. Executive Directors undergo annual appraisals which monitor their performance against the Trust's key priorities.

Statement of Chief Executive's Responsibilities as the Accounting Officer of Central Manchester University Hospitals NHS Foundation Trust

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

Under the NHS 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 its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the account, 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;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable 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
29th May 2014

Annual Governance Statement

1st April 2013 to 31st March 2014

Scope of Responsibility

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

The purpose of the System of Internal Control

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

- identify and prioritise the risks to the achievement of the policies, aims and objectives of 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 2014 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 to the committee. Risk reports are received from each responsible Director and each Executive Director with details of the controls in place and actions planned against which assessment is made by the Committee.

The Audit Committee monitors assurance processes and seeks assurance across all risks in order to provide independent assurance to the Board of Directors that risks have been properly identified and appropriate 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 Effectiveness Team which includes an Associate Medical Director (Clinical Effectiveness), Director of Clinical Effectiveness, Associate Director of Clinical Effectiveness, Trust Assurance Manager 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 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. We have developed robust mechanisms for recording untoward events and learning from them. As part of our Clinical Effectiveness 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 organisation. The Trust is also represented on a number of National and Regional Working Groups.

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.

The Trust's management structure has established accountability arrangements through a scheme of delegation covering both corporate and clinical divisional 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:

- **Executive Director of Finance**

  Has responsibility for the wide range of inter-related work programmes 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 the Annual Plan submission to Monitor and maintains ongoing Compliance relationship with Monitor, through monitoring submissions and exception reporting as required.

  Has regular meetings with local commissioners and with the North West Specialised Commissioning Team, maintaining dialogue across service delivery and planning issues including forward projections, significant developments within individual services 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.

  The post-holder is the Senior Information Risk Officer for the Trust.

- **Medical Director**

  This post has 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 2013/14. 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.

The Postholder is the Caldicott Guardian for the Trust.

- **Director of Patient Services/Chief Nurse**
  Has responsibility for the professional nursing agenda, patient experience work, and facilities management.

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

- **Director of Human and Corporate Resources**
  The Director of Human and Corporate Resources provides strategic direction and leadership on a range of corporate functions in support of the achievement of overall Trust strategy to enable the delivery of the highest quality of services to patients.

  The post-holder provides strategic advice to the Chief Executive and Board of Directors on all employment matters. Developing, implementing and monitoring a comprehensive HR Strategy ensuring that employee recruitment, retention, leadership, motivation and effectiveness are maximised.

  Has responsibility at Board level for effective internal and external communications ensuring at all time the appropriate positive projection of the Trust through the media etc.

  Has responsibility to the Board for its secretariat function, governor and membership, to include support for its various meetings and internal processes.

- **Chief Operating Officer**
  The Chief Operating Officer is responsible for the successful delivery of clinical operations in the Trust. The post-holder plays an active role in the determination and implementation of corporate strategies and plans.

  This is a new Board level post with responsibility for four key elements:

  - Operational leadership of all clinical Divisions and Directorates
  - Performance management and delivery of all national and local targets
  - Modernisation and process redesign of Trust clinical and business processes
  - Business continuity management (including emergency planning)

  The post-holder provides effective management of the Trust on a day-to-day basis, ensuring the provision of appropriate, effective high quality patient-centred care, which meets the needs of patients and can be achieved within the revenues provided.

  The post-holder is expected to contribute to the development and delivery of the wider Trust agenda, including implementation of the Trusts strategic vision.

  Responsibilities will be discharged in the light of the Central Manchester University Hospitals NHS Foundation Trust tri-partite mission to support high quality research, teaching and service delivery.

The Risk Management Strategy provides us with a framework for the management of risk including the process of risk identification, evaluation and planning that has formed an assurance framework. The process involves layers of risk identification and analysis for all individual management units e.g. directorates, departments, functions or sites for significant projects and for the organisation as a whole. Analysis of the severity and likelihood of the risk occurring determines the overall risk ranking of the hazard identified. This assists in the assessment of risk throughout the organisation with a common currency and methodology being used. The strategy clearly sets out the individual and corporate responsibilities for the management of risk within the organisation. Implementation of the strategy ensures the Board is informed about significant 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 every two years.

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, internal Quality Reviews 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 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 2013/14 in its Head of Internal Audit Opinion.

All Divisions report on all categories of risk to both the Trust Risk Management Committee, chaired by the Chief Executive 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.

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 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 both locally agreed guidance and external guidance such as that prepared by NICE and Royal Colleges.

Approximately 600 audits are registered annually with their results disseminated and action taken in response where required.

Quality Governance

The Trust's Quality Report 2013/14 describes all the key elements of the organisation's quality governance arrangements from measuring the patient experience through the improving quality programme to the initiatives for measuring clinical effectiveness, compliments, complaints and patient safety. Compliance with CQC registration is monitored by the Clinical Standards Committee and Clinical Effectiveness Committee. All Divisions report against each of the standards via an electronic system and risks are escalated up to the Risk Management Committee above a score of 15. The Board also undertake an annual self-assessment against registration compliance.

Quality Reviews

Darzi 2008, Francis February 2013, Keogh July 2013 and Berwick August 2013 all share one key finding; that we must constantly seek to improve the quality of care being delivered. Boards must drive that quality of care by fully understanding clinical outcomes and addressing problems as soon as they arise.

The purpose of the Quality Review is first to ensure that the organisation can be fully assured of the quality of care being delivered and that it can identify, quickly, and respond effectively where improvement is required.

To that end, the Board of Directors commissioned an internal Quality Review to strengthen clinical quality assurance information. This review has been led by the Medical Director and Chief Nurse/Deputy Chief Executive.

The CQC has helpfully set out five questions against which they intend to review clinical care going forward:

- is care safe?
- is care effective?
- are staff caring?
- is the organisation responsive?
- is the organisation well led?

The process for the Quality Review was aligned with those questions and sought to provide organisational assurance on quality of care. The Quality Review was also designed utilising the Trust values and behaviours framework and this very much formed part of the training and the ethos for the review.

Most importantly, the findings and resulting action should provide confidence going forward to all patients and service users that they will receive the best experience and the best care at the right time.

Terms of reference

These were simple and designed to give an understanding and balanced view of the way we deliver care to patients. The approach is straight forward and largely based on that used by Professor Keogh:

- to understand how we deliver care
- to identify areas of good practice and share these
- determine whether there are any sustained failings in quality of care or treatment
- identify whether these problems are known to the Division and whether appropriate action is planned and underway
- identify and advise on any additional remedial action required
- identify and escalate and areas of serious concern relating to safety or quality of care.

The visits were completed during October 2013 - January 2014.

Outcome of the Quality Reviews

The reviews have provided an in-depth picture of the quality of care across all of our services; we have found evidence of excellent practice in different areas, such as:

- learning from harm to improve safety
- use of the safe surgery checklist in Dental Services
- great patient feedback on friendly and caring staff
- staff working well together as multi-disciplinary teams and being proud of what they do
- reduction in falls and pressure ulcers
- improvements in the risk assessment of patients for venous thromboembolism
- excellent school and education facilities for children in hospital
- teams working well with the safeguarding team to protect vulnerable adults and children from harm

However, as expected, the reviews have also provided information on areas where improvement is required. These include:

- the use of paper records and the need to improve standards of record keeping
- changes to out of hours working to ensure consistency of care 24 hours a day, 7 days a week
- the transition of care from the Children's Hospital to the adult services
- consistent use of pathway documents and checklists across all clinical areas
- making sure incidents and complaints are properly fed back to all staff following investigation
- improvements to signposting across all of our hospitals
- making sure patients and visitors are happy with the choice of food available

The findings from the reviews have been used to inform our work plans for 2014/15 and they will also be repeated next year.

Central Manchester University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully registered with no conditions. Central Manchester University Hospitals NHS Foundation Trust has had no conditions on registration.

The Care Quality Commission has not taken enforcement action against Central Manchester University Hospitals NHS Foundation Trust during 2013/14.

Central Manchester University Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC in 2013/14.

Divisional Review Process

The Divisional Review Process informs the Board of Directors, the Risk Management Committee and the Divisional Clinical Effectiveness 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 key priorities.

Internal Audit

The Head of Internal Audit Opinion provides an independent opinion of the effectiveness of the Trust's internal control systems. In 2013/14 the opinion of the Trust was one of "significant assurance".

Information Governance

We have taken a number of steps in 2013/14 to assess our information governance practices and further reduce any risks.

To support standardisation an Information Governance divisional meeting has also taken place on a bi monthly basis. This has improved communication directly regarding the toolkit work programme but also equally as important in a general sense around raising the awareness and profile of Information Governance amongst operational and clinical staff. The reporting structure for Information Governance has been strengthened during 2013/14 to ensure that that there is greater oversight of information governance risks throughout the organisation.

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.

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.

Table 1 – Incidents classified at SIRI Level 2

Summary of serious incident requiring investigations involving personal data as reported to the Information Commissioner's Office in 2013-14				
Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
November	Lost In Transit (hardcopy reports)	Microbiology reports containing name, address, sex, date of birth, NHS number and a limited number including highly sensitive HIV and STI results.	39	Individuals notified by telephone and by post
March	Lost or stolen hardware (inadequately protected USB stick).	Full name, date of birth, ethnicity, student ID number and area recruited from.	132	Individuals notified by post
Further action on information risk	There are on-going investigations in relation to the above incidents and the organisation continues to monitor and assess its information risks, in light of the events noted above, in order to identify and address any weaknesses and ensure continuous improvement of its systems. The Trust has since been notified by the Information Commissioners Office that the incident in November 13 will be progressed through Salford Royal as they have been confirmed as the Data Controller in this case.			

Table 2 - Incidents classified at lower severity level

The table below includes all incidents assessed as a level 1 or below in line with the Health and Social Care Information Centre's (HSCICs) Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation. These figures include near misses and incidents assessed at Level 0.

Summary of other personal data related incidents in 2013-14		
Category	Breach Type	Total
A	Corruption or inability to recover electronic data	2
B	Disclosed in Error	17
C	Lost in Transit	-
D	Lost or stolen hardware	-
E	Lost or stolen paperwork	24
F	Non-secure Disposal – hardware	-
G	Non-secure Disposal – paperwork	2
H	Uploaded to website in error	-
I	Technical security failing (including hacking)	2
J	Unauthorised access/disclosure	57
K	Other	23

Significant internal control issues

The Trust has identified the following significant internal control issues also known as significant risks during 2013/14 which have been or are being addressed through robust monitoring at the bi-monthly Risk Management Committee chaired by the Chief Executive:

A&E Performance – Clinical

Periods Q1, Q2 delivered the 4 hour standard for 2013/14. As compliance with the 4 hour A&E standard was not achieved in Quarter 3, exhaustive operational efforts to plan for the usual pressures associated with winter have been implemented during Quarter 4, 2013/14 resulting in a performance of 95.5% with a full year performance of 95.1%.

Infection Control – Clinical

We have continued to robustly monitor performance during 2013/14 on all aspects of infection prevention and control. The MRSA target of 6 cases was breached with 8 reported cases. This was reported to Monitor who informed the Trust that on reviewing the action plans, together with the excellent track record, escalation would not take place. The standard for managing C.Difficile was achieved and the Trust was under trajectory.

The targets set against the number of patients treated remains very challenging.

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 with a particular focus on areas where cases of MRSA have occurred. We also commissioned an external peer review of its infection control practices and implemented the recommendations from this.

Major Trauma – System Readiness - Organisational

The GM MTCC (adults) was re-accreditated for a further 12 month period with effect from 1st April 2013 onwards. This was subject to the collaborative demonstrating that it is financially viable. The financial modelling requested by specialist commissioners has now been completed together with an options appraisal process. We are awaiting the outcome of this work.

Regulatory Framework – Clinical

Following the cessation of the NHSLA assessment process, the Trust will now be assessed against standards provided by the CQC and Monitor. The Trust is currently in the banding of 6 (based on a 1-6 scale with 1 = highest risk organisation and 6 = lowest risk organisation).

A programme of planned quality reviews are now underway to make an assessment of all Divisions against set key lines of enquiry. It is envisaged that this will provide assurance going forward against the CQC fundamental standards of care. Nine out of the Ten planned review visits have now been undertaken and feedback is being disseminated.

Trustwide HSMR and SHMI - Clinical

The Trust Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Indicator Ratio (HSMR) although reducing still remain too high for the Trust.

A significant programme of work has been underway to ensure that clinical quality assurance and data quality assurance can be provided by all clinicians. A Mortality Review Group, chaired by an Associate Medical Director is working towards a consistent approach to mortality review across the entire organisation.

Trafford Diagnostic Review – Clinical

The Trust, upon acquisition of Trafford Hospital, instigated a Clinical Diagnostic Review to ensure that the quality and safety of care provided was of the highest level.

81 of the 99 actions that were identified as part of the review are now classified as Green and audits are now commencing to ensure that systems and processes are fully embedded. 14 actions are now Amber and are in progress and 2 actions are continue to be Red which relate to the values and behaviours workstream for which a bespoke programme is planned with Trafford receiving support from HR, and consultant leave arrangements which is now being managed by the respective Divisions.

Patient Records – Organisational

The Trust has identified through a series of audits that the current patient record within the Trust needs to be improved in terms of quality of content and the management of the record ie tracking, storage and filing. The Trust has now implemented professional standards for record keeping along with the appropriate training. The Patients Records Board which includes representation from medical, nursing, informatics and clinical effectiveness is overseeing this improvement work.

Never Events – Clinical

The Trust has reported 3 Never Events (as defined by the NPSA) in the year 2013/14 and 8 in 2012/13. A programme of work has now been put in place to mitigate this risk which is being led by the Associate Medical Director. The work programme has identified four areas as the root causes of harm and has now established four groups to improve these areas. These are: the implementation of the WHO safe surgery check list; the administration of waiting lists and patient booking; the management of operating theatre lists and the management of devices.

Communication of Diagnostic Test and Screening Results - Clinical

The Trust identified a number of risks in relation to the communication of diagnostic and screening test results and has since implemented a programme of work to mitigate these. A group has been established and this group has developed and agreed a policy, the principles of which were agreed at the Trust's Clinical Effectiveness Committee. The policy requires Divisions to review diagnostic and screening tests and identify those which pose the greatest risk in respect of failure to communicate, act or interpret.

Risk of failure to meet statutory Equality and Diversity Obligations - Organisational

A robust Equality & Diversity work programme has been established to mitigate this risk.

An integrated governance framework has been established through the Equality Implementation Group.

Specialist advice has also been implemented on the delivery of the work programme covering both employment and service delivery. The Trust has agreed to appoint an Associate Director of Equality and Diversity to drive this work forward. The Trust has also agreed the following 5 High Impact Changes:

1. Every employee having an equality and diversity objective
2. Coaching/mentoring by 150 top leaders of an individual with a protected characteristic with mentoring by the coachee of the leader in equality and diversity
3. Every clinical department to hold one engagement session per year with a patient group representing one or more protected characteristics. Every non clinical department to do the same for an internal customer or as a community participation exercise
4. Specific patient and staff audit/questionnaires to be undertaken annually, on equality and diversity with an action plan being produced on the results
5. Positive action being taken around recruitment building on the success of the supported apprenticeships.

Trading Gap Delivery – Financial

The trading gap requirement for 2014/15 has been assessed at £27.7m, together with £10m of accumulated 'backlog' of delivery against four Divisions. The expected annual efficiency challenge arising in 2015/16 has been assessed at £32m. However, additional material risk exists for 2015/16 (and beyond) of insufficient funds within the wider health economy to commission adequately in relation to on-going and forecast demand across the full spectrum of our services.

Plans to deliver the £38m of trading gap savings in 2014/15 are now almost entirely finalised (with less than £3m remaining to be identified) and moving through implementation. This reflects really strong progress across all Divisions. Divisional targets for 2015/16 will be shared with Divisions in May 2014 and in view of the deeper nature of the challenge for 2015/16 and beyond, a greater emphasis will be needed on service transformation, for which several significant programmes of change have already started.

Commissioning Risk - Financial

There remains, as always, the potential for disparity

between the Trust and its commissioners when agreeing the contract each year. The normal process of engagement and meetings with Commissioners is ongoing and continues to seek to mitigate these and arrive at outcomes that are mutually positive.

Trafford Service Redesign - Organisational

The delivery of the Trafford Project, from the acquisition process through to the implementation of the revised service model, is now substantially complete. The Risk Management Committee has successfully mitigated the risks associated with the acquisition process, the development and approval of the new service model, and subsequently the full range of organisational changes needed to ensure effective implementation.

The only high risk that was identified as at January 2014 related to the flow of patients not matching the planning assumptions. It is now clear that the way that Trafford patients are accessing healthcare services under the new service model is close to the planned activity flows. There are variances from the planning assumptions, but these are not sufficiently significant to cause a major risk to the Trust in their own right.

The Trust will continue to monitor progress and any issues that may arise as part of its internal programme of work which is being led by the Chief Operating Officer.

Informatics Trafford Hospitals Infrastructure - Organisational

The Trust commissioned a review of the Informatics infrastructure from its internal auditors which highlighted a number of issues including; service environment, data network, governance and management information.

A detailed action plan in response to the review has been produced and agreed. All actions are currently on track.

The principal risks to compliance with the NHS foundation trust condition 4 (FT Governance)

The principal risks to compliance with the NHS FT Condition 4 are outlined below although the action taken by the Trust to mitigate these risks in the future is outlined elsewhere in the Annual Governance Statement.

Compliance with Outcome 21 Records of the Care Quality Commission Essential Standards of Safety and Quality

The Board is able to assure itself of the validity of its Corporate Governance Statement, as required under NHS Foundation Trust Condition 4(8)(b) through a process of discussion with the Board and the identification of evidence to support each statement.

Compliance with the NHS Pension Scheme

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

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.

Compliance with Carbon Reduction Delivery Plans

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

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

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

The review of effectiveness section provides full details of the role of the Board and the infrastructure to support this.

The sub committees that support the Board are as follows:

- Audit Committee
- Remuneration Committee
- Finance Scrutiny Committee
- Clinical Effectiveness Scrutiny Committee
- Clinical Effectiveness Committee
- Risk Management Committee
- Human Resources Committee
- Research Governance Committee
- Safeguarding Committee

The Trust maintains a record of attendance at the Board and details of this for 2013/14 can be found in our Annual Report.

The Audit Committee produces an annual report of its effectiveness which is included in the Annual Report together with an overview of the work of the remuneration and nomination committees.

The Trust is compliant with the principles and provisions of the NHS Foundation Trust Code of Governance following an annual review with Board Members. The Board's statement on compliance is contained in detail in the Annual Report.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of the 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 Quality Report.

The Trust has robust data quality procedures in place that ensure the robustness used in the Quality Report.

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 or 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 Report 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 Report 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 Report 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 compliant with all the Care Quality Commission's essential standards of quality and safety with the exception of Outcome 21 Records. The Trust has an action plan to address the risks with compliance as described in the Significant Internal Control Issues section of this report.

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. 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, Clinical Effectiveness Committee and the Risk Management Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

- Internal Audit Reports
- Head of Internal Audit Opinion
- External Audit Reports
- Clinical Audit Reports
- Patient Surveys
- Staff Survey
- Royal College accreditation
- Health and Safety Executive Inspection Reports
- Care Quality Commission Intelligent Monitoring Standards
- PLACE assessments
- Senior Leadership Walk-rounds
- Clinical Pathology Accreditation
- Care Quality Commission - registration without conditions
- Equality and Diversity Reports
- General Medical Council Reports

The Trust has identified over 50 External Agencies who may visit the Trust.

The Trust applies a robust process for maintaining and reviewing the effectiveness of the system of internal control. The roles of key committees and assurance processes 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 key priorities.

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.

The inclusion of patient stories now forms part of the agenda of the Committee.

Human Resources Committee

The Human Resources Committee is responsible for reviewing the Trust workforce and HR strategy and monitors implementation. The Committee ratifies approved HR policies in line with the Trust Recognition agreement. The HR annual corporate objectives are developed and reviewed through the committee.

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 key priorities.

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.

Safeguarding Effectiveness Committee

The Safeguarding Effectiveness Committee oversees the strategic direction for the safeguarding of all users of the Trust's services, irrespective of age. It provides the Board with assurance that there are robust effective safeguarding arrangements in place, incorporating the structures, systems and processes it needs in order to achieve its safeguarding responsibilities, and that these are performance managed.

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 Clinical Effectiveness Groups on aspects of all risks identified through the analysis of incidents, complaints, clinical audit, concerns and claims reported throughout the Trust.

Internal Quality Reviews

The Trust has established the Quality Review process this year on the back of findings from the gap analysis undertaken on the recommendations set out by Francis 2013, Keogh 2013 and Berwick 2013.

Internal reviews have been informed by extensive data packs which pull together key indicators reflecting the quality of care for each Division. These include, but are not limited to:

- Complaints
- Patient and staff surveys
- Activity information
- External review findings (such as Deanery reports)
- Never events analysis
- SHMI

The packs have been used to develop key lines of enquiry (KLOE) on which the review teams have based their approach.

One of the findings from the original gap analysis undertaken on the various reports was a need to further strengthen Board assurance in relation to quality of clinical care. The challenge for this organisation is to develop further the Intelligent Board tool, providing in-depth information, without losing the key messages in overly complex data.

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 key priorities.

Conclusion

All significant internal control issues have been identified in this statement as part of the Risk and Control Framework section.

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, our own information on serious incidents, patterns of complaints), Central Manchester University Hospitals 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 our patients.

Mike Deegan, Chief Executive Officer
June 2014

Independent Auditor's Report

to the Board of Governors and Board of Directors of Central Manchester University Hospitals NHS Foundation Trust

We have audited the financial statements of Central Manchester University Hospitals NHS Foundation Trust for the year ended 31st March 2014 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and Statement of Cashflows and the related notes 1 to 46. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor - Independent Regulator of NHS Foundation Trusts.

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Central Manchester University Hospitals NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on 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 us to comply with the Auditing Practices 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 group's and the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with,

the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the group's and the Trust's affairs as at 31st March 2014 and of the group's and the Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor - Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- proper practices have not been observed in the compilation of the financial statements; or
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.

David Wilkinson FCA
(Senior Statutory Auditor}
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Newcastle, UK
29th May 2014

Annual Accounts

FOREWORD TO THE ACCOUNTS

These Accounts for the period ended 31st March 2014 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 Act 2006, in the form in which Monitor, the Independent Regulator of NHS Foundation Trusts, has, with the approval of the Treasury, directed.

These Accounts have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Group Accounting

With effect from this financial year (2013/14), the Trust is now preparing Group Accounts, to reflect its position as the Corporate Trustee to Central Manchester University Hospitals NHS Foundation Trust Charity. The Trust has assessed its relationship to the Charity and determined it to be a subsidiary, because the Trust has the sole power to govern the financial and operating policies of the Charity, so as to obtain benefits from the Charity's activities for itself, its patients and its staff. For comparability, these Accounts therefore disclose Group results for the prior year (2012/13), as well as for this financial year. More detail on this change in Accounting Policy is given in Note 1.3 to these Accounts.

After making enquiries, the Directors have a reasonable expectation that the Trust and the Group have 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.

A D Roberts, Executive Director of Finance
29th May 2014

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes.

In 2013/14, 87% (86% in 2012/13) of the Trust's income was from the provision of health services and as such has met the above requirement.

There has been no impact on the provision of health services provided by the Trust as a result of other income it has received.

STATEMENT OF COMPREHENSIVE INCOME

FOR THE PERIOD ENDED 31st MARCH 2014

	NOTE	2013/14 Trust £000	2013/14 Group £000	2012/13 Trust £000	2012/13 Group £000
Operating Income from Continuing Operations	2	**919,013**	**921,952**	884,252	886,859
Operating Expenses of Continuing Operations	3	**(885,714)**	**(892,432)**	(845,386)	(850,837)
Operating Surplus		**33,299**	**29,520**	38,866	36,022
Finance Costs:					
Finance Income	8	**307**	**926**	282	994
Finance Expense - Financial Liabilities	9	**(28,917)**	**(28,917)**	(28,511)	(28,511)
Finance Expense - Unwinding of Discount on Provisions		**(33)**	**(33)**	(31)	(31)
Public Dividend Capital Dividends Payable		**(3,060)**	**(3,060)**	(3,313)	(3,313)
Net Finance Costs		**(31,703)**	**(31,084)**	(31,573)	(30,861)
Gain / (Loss) from Transfer by Absorption	43.1	**(405)**	**(405)**	70,981	70,981
Surplus / (Deficit) for the Year		**1,191**	**(1,969)**	**78,274**	**76,142**
Other Comprehensive Income					
Amounts that will not be reclassified subsequently to income:					
Revaluation Reserve Movements		**(315)**	**(315)**	(211)	(211)
Other Reserve Movements	43.2	**5**	**5**	(7)	355
Amounts that will subsequently be reclassified to income and expenditure:					
Other Reserve Movements		**0**	**23**	0	915
Total Comprehensive Income / (Expense) for the Period		**881**	**(2,256)**	78,056	77,201

The loss of £405k arising from Transfer by Absorption in 2013/14 relates to the transfer of services provided by the National Technology Adoption Centre, to the National Institute of Clinical Excellence.

The Trust and the Group Surplus for 2012/13 includes £70.98m arising from the "Absorption" of Trafford Healthcare NHS Trust from 1 April 2012. This entry reflects the value of the Net Assets of Trafford Healthcare NHS Trust on transfer, and before this item the Trust made a surplus of £7.29m in that year; the surplus of the Group was £5.53m before this item.

The Notes on Pages 5 to 40 form part of these Accounts.

STATEMENT OF FINANCIAL POSITION

AS AT 31st MARCH 2014

		31 March 2014	31 March 2014	31 March 2013	31 March 2013	1 April 2012	1 April 2012	1 April 2012
		Trust	Group	Trust	Group	Trust	Charity Consol Adjs	Group
	NOTE	£000	£000	£000	£000	£000	£000	£000
Non-Current Assets								
Intangible Assets	11	1,032	1,032	795	795	1,213	0	1,213
Property, Plant and Equipment	12	519,789	519,789	517,538	517,538	453,581	0	453,581
Investments	16	602	14,011	0	13,386	0	12,471	12,471
Trade and Other Receivables	22	2,144	2,144	3,510	3,510	5,246	0	5,246
Total Non-Current Assets		523,567	536,976	521,843	535,229	460,040	12,471	472,511
Current Assets								
Inventories	21	10,522	10,522	10,133	10,133	8,762	0	8,762
Trade and Other Receivables	22	42,480	42,687	36,299	36,507	35,343	252	35,595
Non-Current Assets Held for Sale	18	1,335	1,335	6,475	6,475	5,350	0	5,350
Cash and Cash Equivalents	25	75,506	80,105	86,132	93,329	60,306	9,348	69,654
Total Current Assets		129,843	134,649	139,039	146,444	109,761	9,600	119,361
Current Liabilities								
Trade and Other Payables	26	(90,163)	(90,725)	(83,027)	(83,028)	(76,558)	(426)	(76,984)
Borrowings	27	(14,017)	(14,017)	(15,246)	(15,246)	(14,285)	0	(14,285)
Provisions	31	(2,509)	(2,509)	(3,137)	(3,137)	(7,084)	0	(7,084)
Total Current Liabilities		(106,689)	(107,251)	(101,410)	(101,411)	(97,927)	(426)	(98,353)
Total Assets less Current Liabilities		546,721	564,374	559,472	580,262	471,874	21,645	493,519
Non-Current Liabilities								
Trade and Other Payables	26	(4,396)	(4,396)	(4,292)	(4,292)	(4,310)	0	(4,310)
Borrowings	27	(346,343)	(346,343)	(360,360)	(360,360)	(363,677)	0	(363,677)
Provisions	31	(6,348)	(6,348)	(6,398)	(6,398)	(5,648)	0	(5,648)
Total Non-Current Liabilities		(357,087)	(357,087)	(371,050)	(371,050)	(373,635)	0	(373,635)
Total Assets Employed		189,634	207,287	188,422	209,212	98,239	21,645	119,884
Financed by Taxpayers' and Others' Equity								
Public Dividend Capital		192,403	192,403	192,072	192,072	179,945	0	179,945
Revaluation Reserve	33	33,575	33,575	33,890	33,890	16,102	0	16,102
Income and Expenditure Reserve		(36,344)	(36,344)	(37,540)	(37,540)	(97,808)	0	(97,808)
Charitable Fund Reserves		0	17,653	0	20,790	0	21,645	21,645
Total Taxpayers' and Others' Equity		189,634	207,287	188,422	209,212	98,239	21,645	119,884

As outlined in Notes 1.3 and 1A to these Accounts, the Trust has implemented a change in Accounting Policy with effect from 2013/14, to produce Group Accounts for the Trust, and its subsidiary the Central Manchester University Hospitals NHS Foundation Trust Charity, combined. As required by International Accounting Standards Nos. 1, Presentation of Financial Standards, and 8, Accounting Policies, Changes in Accounting Estimates and Errors, the Trust and the Group have therefore disclosed above their Statement of Financial Position figures for 1 April 2012 (the start of the Prior Year), in addition to those for the Prior Year End (31 March 2013) and Current Year End (31 March 2014).

STATEMENT OF CHANGES IN EQUITY

	Public Dividend Capital	Reval-uation Reserve	Income and Expenditure Reserve	Total	Charity Reserve	Total
	Trust	Trust	Trust	Trust		Group
	£000	£000	£000	£000	£000	£000
2013/14						
Taxpayers' and Others' Equity at 1 April 2013	**192,072**	**33,890**	**(37,540)**	**188,422**	**20,790**	**209,212**
Surplus / (Deficit) for the Year	0	0	1,191	1,191	(3,160)	(1,969)
Transfers by Modified Absorption: Gains on 1 April 2013 Transfers from Demising Bodies	0	0	5	5	0	5
Impairments	0	(315)	0	(315)	0	(315)
Public Dividend Capital Received	331	0	0	331	0	331
Other Reserve Movements	0	0	0	0	23	23
Taxpayers' and Others' Equity at 31 March 2014	**192,403**	**33,575**	**(36,344)**	**189,634**	**17,653**	**207,287**
2012/13						
Taxpayers' and Others' Equity at 1 April 2012	**179,945**	**16,102**	**(97,808)**	**98,239**	**21,645**	**119,884**
Surplus / (Deficit) for the Year	0	0	78,274	78,274	(2,132)	76,142
Transfers by Absorption: Transfers Between Reserves	0	17,999	(17,999)	0	0	0
Impairments	0	(211)	0	(211)	0	(211)
Revaluations	0	0	0	0	915	915
Public Dividend Capital Received	12,127	0	0	12,127	0	12,127
Other Reserve Movements	0	0	(7)	(7)	362	355
Taxpayers' and Others' Equity at 31 March 2013	**192,072**	**33,890**	**(37,540)**	**188,422**	**20,790**	**209,212**

Descriptions of the nature and purpose of each of the above Reserves is given at Note 44 to these Accounts.

Revaluations for the Trust typically relate to Property,Plant and Equipment, whereas those of the Charity are always in respect of Investments.

STATEMENT OF CASH FLOWS

FOR THE PERIOD ENDED 31st MARCH 2014

	2013/14 Trust £000	2013/14 Group £000	2012/13 Trust £000	2012/13 Group £000
Cash Flows From Operating Activities				
Operating Surplus from Continuing Operations	**33,299**	**29,520**	38,866	36,022
Operating Surplus	**33,299**	**29,520**	38,866	36,022
Non-Cash Income and Expense				
Depreciation and Amortisation	**28,437**	**28,437**	28,578	28,578
Impairments	**7,973**	**7,973**	15,300	15,300
Loss on Disposal	**29**	**29**	0	0
Non-Cash Donations/Grants Credited to Income	**(1,536)**	**(1,536)**	(1,526)	(1,526)
Interest Accrued and Not Paid	**0**	**0**	94	94
(Increase) / Decrease in Trade and Other Receivables	**(4,824)**	**(4,823)**	1,082	1,488
Increase in Inventories	**(389)**	**(389)**	(1,371)	(1,371)
Increase in Trade and Other Payables	**5,532**	**6,093**	3,657	3,232
Decrease in Provisions	**(711)**	**(711)**	(3,197)	(3,197)
Other Movements in Operating Cash Flows	**0**	**0**	9	9
Net Cash Generated From Operations	**67,810**	**64,593**	81,492	78,629
Cash Flows From Investing Activities				
Interest Received	**307**	**926**	282	994
Purchase of Financial Assets	**(602)**	**(602)**	0	0
Purchase of Intangible Assets	**(94)**	**(94)**	0	0
Purchase of Property, Plant and Equipment	**(36,292)**	**(36,292)**	(31,574)	(31,574)
Sale of Property, Plant and Equipment	**5,533**	**5,533**	6	6
Net Cash Used In Investing Activities	**(31,148)**	**(30,529)**	(31,286)	(30,574)
Cash Flows From Financing Activities				
Public Dividend Capital Received	**331**	**331**	12,127	12,127
Loans Received	**0**	**0**	11,500	11,500
Loans Repaid	**(8,356)**	**(8,356)**	(9,268)	(9,268)
Capital Element of Private Finance Initiative Obligations	**(6,890)**	**(6,890)**	(7,061)	(7,061)
Interest Paid	**(1,571)**	**(1,571)**	(1,755)	(1,755)
Interest Element of Private Finance Initiative Obligations	**(27,346)**	**(27,346)**	(26,850)	(26,850)
Public Dividend Capital Dividend Paid	**(2,940)**	**(2,940)**	(3,751)	(3,751)
Cash Flows Used In Other Financing Activities	**(111)**	**(111)**	(31)	(31)
Net Cash Used In Financing Activities	**(46,883)**	**(46,883)**	(25,089)	(25,089)
Increase / (Decrease) in Cash and Cash Equivalents	**(10,221)**	**(12,819)**	25,117	22,966
Cash and Cash Equivalents at Start of Financial Year (April 1st)	**86,132**	**93,329**	60,306	69,654
Cash and Cash Equivalents Changes Due to Transfers by Absorption	**(405)**	**(405)**	709	709
Cash and Cash Equivalents at End of Period (31st March)	**75,506**	**80,105**	86,132	93,329

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.1 Accounting Policies and Other Information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (ARM), which shall be agreed with the Treasury. Consequently, the following financial statements have been prepared in accordance with the 2013/14 NHS Foundation Trust ARM 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 NHS Foundation Trusts, as determined by the Treasury, which is advised by the Financial Reporting Advisory Board, and the FRAB's financial Reporting Manual (FReM). 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 and the Group (see Note 1.3 below in respect of Consolidation and Group Accounting), for the purpose of giving a true and fair view, has been selected. The particular policies adopted by the Trust and the Group are described below. They have been applied consistently in dealing with items considered material in relation to these Accounts.

1.2 Accounting Convention

These Accounts have been prepared under the Historical Cost Convention, modified to account for the revaluation of Intangible Assets; Property, Plant and Equipment; and Investments, at their value to the business by reference to their most recent valuations.

1.3 Consolidation of Subsidiaries and Group Accounting

The Trust is the Corporate Trustee to Central Manchester University Hospitals NHS Foundation Trust Charity (CMUH NHSFT Charity). The CMUH NHSFT Charity is a registered charity (No. 1049274) with the independent regulator, the Charities Commission, to whom it is accountable. The Trust has assessed its relationship to the Charity and determined it to be a subsidiary, because the Trust has the sole power to govern the financial and operating policies of the Charity, so as to obtain benefits from the Charity's activities for itself, its patients and its staff. As a consequence, for 2013/14 the CMFT Charity has been consolidated into these Accounts of the Trust for the first time, in accordance with International Accounting Standard (IAS) 27, representing a change in Accounting Policy. (Until March 2013, the Treasury had directed that IAS 27 should not be applied to NHS Charities. However, that direction has now been removed, and IAS 27 is therefore applicable to NHS bodies and NHS Charities from April 2013.) Notes 45 and 46 to these Group Accounts give the original Accounts figures of the Charity, and show how these have been changed to reach the values used as Consolidating adjustments.

These Accounts therefore disclose the Trust's financial position alongside that of the Group (which is the Trust and the CMFT Charity combined). The basis of arriving at the Group figures is as follows:- The Charity's own Accounts figures are adjusted firstly for one difference in Accounting Policy (relating to expenditure accrued by the Charity for future commitments - such accruals are not permitted under the Trust's and the Group's Accounting Conventions, as set out above). And secondly the Charity's Accounts figures are adjusted in respect of transactions and balances between the 2 bodies, which are eliminated on Consolidation. The resulting figures for Income and Expenditure; gains and losses; assets and liabilities; reserves; and cashflows, are then consolidated with those of the Trust, to form the Group Accounts.

These Accounting Policies apply to both the Trust and the Group, with effect from 1 April 2013. The Charity's latest audited Accounts, which have been prepared in accordance with the Charities Statement of Recommended Practice (SORP), can be obtained from the Charity Commission website. The Trust's prior year (2012/13) results figures, and its opening Statement of Financial Position as at 1 April 2012, have been restated within these Accounts to aid comparability with the 2013/14 results - more detail on this is given in Note 1A to these Accounts. Accounts for financial year ending 31st March 2014 have also been prepared and will be submitted to the Charities Commission, as in previous years.

The Central Manchester University Hospitals NHS Foundation Trust Charity is based at the following address:- The Lodge, Oxford Road, Manchester. M13 9WL.

As a subsidiary of the Trust, the Charity is able to transfer funds to the Trust providing it is over and above what the NHS would normally provide and is in line with the objects of the charity.

Appropriate adjustments are made on Consolidation where a subsidiary's Accounting Date is before 1st January or after 30th June each year, although this does not apply to the Trust's Consolidation with the CMUH NHSFT Charity, whose Accounting Date is the same as that of the Trust - 31st March.

1.4 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 (see also Note 1.33).

1.5 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

In the application of the Trust's and the Group's Accounting Policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities, and for other areas, where precise information is not readily apparent from any source. The estimates and associated assumptions are based on historical experience and other factors which are considered to be relevant. Actual results may differ from those estimates, and the estimates and underlying assumptions are continually reviewed and updated. 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 this is required.

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, which 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

Independent valuers have provided valuations of the Trust's and the Group's land and building assets (estimated financial value and estimated remaining useful life), applying a Modern Equivalent Asset method of valuation. The Central site and Trafford sites are due for quinquennial valuations 31 March 2015 and 30 September 2016 respectively. The Trust has reviewed Price Indices available at 31 December 2013, published by the Department of Business Innovation and skills and has concluded that there is no requirement to commission revaluation of the Trust property for the financial year 2013/14. future revaluations of the Trust's asset base may result in further material change to the carrying value of non-current assets.

Financial Value of Provisions for Liabilities and Charges

The Trust and the Group make financial provisions 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, and where necessary the values of the provisions are amended. More detail on this area is given in Note 1.20 below.

Actuarial Assumptions for Costs Relating to the NHS Pension Scheme

The Trust and the Group report, as operating expenditure, employer contributions to staff pensions. These employer contributions are based on national NHS Pensions actuarial estimates of the required contributions to meet the scheme's liabilities, and prescribed contributions to the National Employment Savings Trust (NEST - see Note 1.7). These are expenses which are subject to change in the future, and therefore carry an element of uncertainty.

Property, Plant and Equipment - Useful Economic Lives

The Trust and the Group use best judgement to determine the most appropriate life for each asset or class of assets - see Note 14.

1.6 Income

Income is accounted for applying the accruals convention - therefore income in respect of services provided is recognised when, and to the extent that, performance occurs, and is mesured at the Fair Value of the consideration receivable. The main source of income for the Trust and the Group is from NHS 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.

Ordinarily, where Income is received for a specific activity which is to be delivered in future years, that Income will be 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 and the Group receive 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 and the Group receive 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 and the Group recognise the Income when notification is received from the Department of Work and Pensions' 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.

1.7 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 and Group policy that holidays are taken in the year in which they accrue, and therefore no accrual is made for untaken leave at the Financial Year End.

Pension Costs
Past and present employees are covered by the provisions of either the NHS Pension Scheme or the National Employment Savings Trust (NEST). Details of the benefits payable under these scheme provisions are can be found on the respective websites - http://www.nhsbsa.nhs.uk/pensions; and https://www.nestpensions.org.uk.

The NHS Pension Scheme is an unfunded, defined benefit scheme which covers NHS employers, GP 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 which 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 Trust and the Group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements in respect of the NHS Pension Scheme do not differ materially from those which would be determined at the reporting date by a formal actuarial valuation, the Treasury's Financial Reporting Manual (FReM) requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these valuations, and also the Scheme Provisions, follows:-

a) Accounting Valuation - NHS Pension Scheme
A valuation of the scheme liability is carried out annually by the Scheme Actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period, in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014 is based on the valuation data as 31 March 2013, updated to 31 March 2014 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 the Treasury, have also been used.

The latest assessment of the liabilities of the scheme is contained in the Scheme Actuary's Report, which forms part of the NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full Actuarial (Funding) Valuation - NHS Pension Scheme
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 published 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 were suspended by the Treasury on value for money grounds whilst consideration is given to recent changes to public service pensions, and also while future scheme terms are developed as part of the upcoming reforms to public service pension provision, due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of the Treasury, and also after consideration of the advice of the Scheme Actuary, as well as employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out as at March 2012, and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme Provisions - Both Schemes
The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all of the benefits provided by the Scheme, or the specific conditions which must be met before these benefits can be obtained.

The NHS Pension Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of, and on the best of the last three years' pensionable pay for, each year of service for the "1995 section"; and 1/60th of reckonable pay per year of membership for the "2008 section". Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the applicable pensionable service.

With effect from 1 April 2008 NHS Pension Scheme 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 provision of the Scheme is known as "pension commutation".

Within the NHS Pension Scheme, 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 30th September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has replaced the Retail Prices Index (RPI) in calculating these increases.

Under the Provisions of the NHS Pension Scheme, 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: the additional costs of such

early retirements are borne by the Scheme. A death gratuity of twice the final year's pensionable pay for death in service, or five times the annual pension for death after retirement, is payable to members of the NHS Pension Scheme. For early retirements other than those due to ill health the additional pension liabilities are not funded by the NHS Scheme: the full amount of the liability for the additional costs is charged to the employer. No additional pension liabilities fall to the Trust or the Group in respect of early retirees who are members of NEST.

Members can purchase additional service in the NHS Pension Scheme and contribute to money purchase Additional Voluntary Contributions (AVCs) run by the Scheme's approved providers, or by other Free Standing AVC (FSAVC) providers.

Employer's pension cost contributions for both schemes are charged to operating expenses as and when they become due. In 2013/14 these contributions amounted to £45,245,000 (2012/13 - £42,400,000).

Senior Employees' Remuneration
Details of senior employees' remuneration can be found in the Remuneration Report (within the "Board of Directors" section of the Trust and the Group's Annual Report).

1.8 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 always measured (at least initially) at the cost 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 (see Note 1.9 below).

1.9 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 or the Group;
- 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 based on similar asset lives, and the groups (categories) are treated as separate assets and depreciated over their own individual useful economic lives.

Valuation
All property, plant and equipment is 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 and the Group's services or for administrative purposes are disclosed in the Statement of Financial Position at their revalued amounts, being the fair value at the most recent date of revaluation, less any subsequent depreciation and/or impairment write downs. Revaluations are undertaken with sufficient regularity to ensure that the carrying amounts are not materially different to those which 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 31st March 2009, the depreciated replacement cost of specialised buildings was estimated based on an exact replacement of the asset in its present location. The 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 and the Group's Central Site building assets were first revalued on the basis of a modern equivalent asset valuation as at 31st March 2010, by the District Valuation Service. The Trust's and the Group's Trafford properties have also been valued by DTZ on the same basis, as at 30th September 2011. All building assets have subsequently been revalued (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.

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 (SoCI).

In accordance with the FT ARM, impairments which are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the Revaluation Reserve to the Income and Expenditure Reserve of an amount equal to the lower of (i) The impairment charged to operating expenses, and (ii) The balance in the Revaluation Reserve attributable to that asset before the impairment.

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.

1.10 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 and the Group'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 and the Group; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Software which is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, 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.

Measurement
Intangible Assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point at which it is capable of operating in the manner intended by management. Subsequently Intangible Assets are measured at Fair Value. Revaluation Gains, Losses and Impairments are treated in the same manner as Property, Plant and Equipment (see Note 1.9 above). Intangible Assets Held for Sale are measured at the lower of their carrying amount or "Fair Value less costs to sell" (see also Note 1.14 below). 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 identifed, the expenditure in question is written off through the Statement of Comprehensive Income, in the period in which it is incurred. Internally-developed software is held at Historic Cost to reflect the opposing effects of increases in development costs, versus technological advances.

1.11 Depreciation, Amortisation and Impairments

Freehold land is not depreciated, as it is considered to have an infinite life. Property, Plant and Equipment which has been reclassified as "Held for Sale" ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Otherwise, depreciation and amortisation are charged to write off the cost or valuation, less any residual value, of Property, Plant and Equipment and Intangible Non-Current Assets, over their estimated useful lives, in a manner which 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 and the Group expect to obtain economic benefits or service potential from the asset. This life is specific to the Trust and the Group, 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. Note 14.2 gives details of the Useful Economic Lives of the Trust's and the Group's Property, Plant and Equipment assets.

All assets begin to be depreciated in the month following the month in which they are brought into use - either when transferred from Assets Under Construction, or when directly purchased.

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 which 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.

1.12 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.

1.13 Government and Other 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 Granted Assets are treated in the same manner as Donated Assets (as outlined above), and in accordance with the principles of IAS 20.

1.14 Non-Current Assets Held for Sale

In general, the following conditions must be met for an asset to be classified as Held for Sale:-

- Management is committed to a plan to sell;
- The asset is available for immediate sale in its present condition;
- An active programme to locate a buyer has been 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; and
- Actions required to complete the planned sale 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.

1.15 Leases

Finance Leases

Where substantially all of the risks and rewards of ownership of a leased asset are borne by the Trust or the Group, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both the asset and the liability 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 return on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the arrangement is discharged or cancelled, or when it expires. The annual rental is split between the repayment of the liability and a Finance Cost. This 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

Leases other than Finance 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 treated as a reduction to the lease rentals and reflected in Operating Expenses over the life of the lease.

Leases of Land and Buildings

Where a lease is for land and buildings, the land component is separated from the building component, and the classification for each is assessed separately. Leased land is treated as an Operating Lease.

1.16 Private Finance Initiative (PFI) Transactions

The Treasury has determined that Public Bodies shall account for infrastructure PFI schemes, where the Public 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 and requirements of IFRIC 12. The Trust and the Group therefore recognise their PFI asset as an item of Property, Plant and Equipment, together with a Finance Lease Liability to pay for it.
The annual PFI 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, known as "lifecycle replacement".

Services Received

The Fair Value of services received in the year is recorded under the relevant expenditure headings within Operating Expenses.

PFI Assets
The Trust's 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 and the Group'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 which 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
An element of the annual Unitary Payment is allocated to Lifecycle Replacement, and is pre-determined for each year of the contract, by reference to the operator's planned programme of lifecycle replacement.

Components of the asset replaced by the operator during the contract (Lifecycle Replacement) are capitalised where they meet the Trust's and the Group'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.

Assets Contributed by the Trust and the Group to the Operator
Assets contributed (e.g. cash payments, surplus property) by the Trust and the Group 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 and the Group, the prepayment is treated as an initial payment towards the Finance Lease Liability, and is set against the carrying value of the liability.

1.17 Inventories
Inventories (Stocks) are valued at the lower of cost and Net Realisable Value, with the exception of both Pharmacy Inventories, which are valued at average cost, and Inventories recorded and controlled via the Materials Management System, which are valued at current cost. This is considered to be a reasonable approximation to Fair Value due to the high turnover of Stocks. The cost of Inventories is measured using the First In, First Out (FIFO) method.

1.18 Cash and Cash Equivalents
Cash is defined as cash in hand, and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments which mature in 3 months or less from the date of acquisition, and which are readily convertible to known amounts of cash with insignificant risk of change in value.

1.19 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 or the Group. A Contingent Asset is disclosed at Note 32 to these Accounts where an inflow of economic benefits is possible.

Contingent Liabilities are not recognised in the Statement of Financial Position but, as with Contingent Assets above, are disclosed in Note 32 to these Accounts, 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 or the Group'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.

Where the time value of money is material, Contingencies are disclosed at their present value.

1.20 Provisions

The Trust and the Group provide for legal or constructive obligations which are of uncertain timing or amount at the Statement of Financial Position date, on the basis of the best possible reliable estimate of the expenditure required to settle the obligation - as long as it is considered probable that there will be a future outflow of resources in respect of the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using one or more of the Discount Rates published and mandated by the Treasury. In 2013/14 the only such Discount Rate applicable to the Trust or the Group was 1.8% (2012/13 - 2.35%) for Post Employment Benefits - specifically the costs of Pensions and Injury Benefits, for which the Trust and the Group are obliged to pay.

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme (the Clinical Negligence Scheme for Trusts or CNST), under which the Trust and the Group pay 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 and the Group. The total value of Clinical Negligence provisions carried by the NHSLA on behalf of the Trust and the Group is disclosed at Note 31.3.

1.21 Non-Clinical Risk Pooling

The Trust and the Group participate in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust and the Group pay an annual contribution to the NHSLA, and in return receive assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims, are charged to operating expenses as and when the liability to make payment arises.

Other commercial insurance held by the Trust and the Group includes that for (building) contract works, motor vehicles, personal accidents, and group travel (for clinical staff required to work off-site, as well as overseas travel). The annual premia and any excesses payable are charged to Operating Expenses as and when the liability arises.

1.22 Financial Instruments: Financial Assets and Financial Liabilities

The Trust and the Group do not (in common with most Public Bodies) generally hold any Financial Assets or Liabilities, the exceptions 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, except for amounts receivable more than 12 months after the Statement of Financial Position date, which are classified as Non-Current Assets. The Trust's and the Group's Loans and Receivables comprise: Cash and Cash Equivalents; Trade and Other Receivables (not including Prepayments); and Investments held both by the Trust and the Charity. Loans and Receivables are recognised initially at Fair Value, net of transaction costs, and are measured subsequently at amortised cost, using the Effective Interest Method. The Effective Interest Rate is the rate which discounts exactly the 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.

Financial Liabilities
All 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 which discounts exactly the 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. Financial Liabilities are included in Current Liabilities, except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as Non-Current 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 and the Group assess 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/have 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 and the Group 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 Non-Current Assets. Where Output Tax is charged or Input VAT is recoverable, the amounts are stated net of VAT in these Accounts.

1.24 Foreign Currencies

The Trust's and the Group's functional and presentational currency is Sterling. The Trust and the Group do 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 as assets in these Accounts since the Trust and the Group have no beneficial interest in them. Details of Third Party Assets are given in Note 25.

1.26 Public Dividend Capital (PDC) and PDC Dividend

Public Dividend Capital (PDC) represents Taxpayers' Equity in the Trust and the Group. 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 only, is payable to the Department of Health as PDC Dividend. The charge is calculated at the real rate set by the Treasury (currently 3.5%) on the Average Net Relevant Assets, which are defined as the average carrying amount of all assets less all liabilities, except for both donated assets and average cash balances held with the Government Banking Service. The average carrying amount of assets is calculated as a simple average of opening and closing Net Relevant Assets.

Where the average of Net Relevant Assets is negative, no Dividend will be payable.

1.27 Losses and Special Payments

Losses and Special Payments are items which Parliament would not have contemplated when it agreed funds for the Health Service, or passed legislation. By their nature they are items which 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 in which individual cases are handled.

Losses and Special Payments are charged to the relevant functional headings in Operating Expenditure, as per Note 3 to these Accounts, on an accruals basis, including losses which would have been made good through insurance cover had the Trust and the Group not been bearing their own risk (with insurance premia then being included as normal revenue expenditure). However Note 42 to these Accounts, disclosing the Trust's and the Group's Losses and Special Payments, is compiled directly from the Losses and Compensations Register, which reports financial 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 and the Group in conjunction with one or more other parties, but which are not performed through a separate entity. The Trust and the Group record their share of the income and expenditure; gains and losses; assets and liabilities; and cashflows, arising from Joint Operations, in these Accounts.

1.29 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 and the Group are 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 the Group (and not entrepreneurial), and therefore not subject to Corporation Tax. Any tax liability will be accounted for within the relevant tax year.

1.30 Accounting Standards Which Have Been Issued But Have Not Been Adopted

There are no Accounting Standards issued by the International Accounting Standards Board (IASB) or the International Financial Reporting Interpretations Committee (IFRIC), which are applicable to the Trust and/or the Group which have been adopted by the FT ARM, but which have not been adopted within these Accounts. However, the following Standards have been issued or amended by the IASB or IFRIC up to the date of publication of the FT ARM, but have not yet been adopted by the FT ARM, and therefore also not yet adopted by the Trust and/or the Group:-

Change Published	Published by IASB	Financial Year for Which the Change First Applies
IFRS 9 Financial Instruments	October 2010	Uncertain. Not likely to be adopted by the EU until the IASB has finished the remainder of its Financial Instruments Project
IFRS 10 Consolidated Financial Statements	May 2011	Effective from 2014/15*
IFRS 11 Joint Arrangements	May 2011	Effective from 2014/15*
IFRS 12 Disclosure of Interests in Other Entities	May 2011	Effective from 2014/15*
IFRS 13 Fair Value Measurement	May 2011	Effective date of 2013/14 but not adopted by the Treasury
IAS 27 Separate Financial Statements	May 2011	Effective from 2014/15*
IAS 28 Associates and Joint Ventures	May 2011	Effective from 2014/15*
IAS 32 Financial Instruments: Presentation - Amendment Offsetting Financial Assets and Liabilities"	December 2011	Effective from 2014/15

* This reflects the EU-Adopted Effective Date rather than the Effective Date in the Standard

1.31 Accounting Standards Issued Which Have Been Adopted Early

No Accounting Standards issued have been adopted early.

1.32 Operating Segments

Under IFRS 8, the Trust and the Group are required to disclose financial information across significant Operating Segments, which reflect the way the management runs the organisation. A significant Segment is one which:-

i) Represents 10% or more of the income or expenditure of the entity; or
ii) Has a surplus or deficit which is 10% or more of the greater, in absolute amount, of the combined surplus of all Segments reporting a surplus, or the combined deficit of all Segments reporting a deficit; or
iii) Has assets of 10% or more of the combined assets of all Operating Segments.

Significant central management and support services underpin all Trust activities, and the majority of activities are similar in nature. Research and Training (both less than 10% of turnover) similarly support the Trust's activities (with Training being integral to the provision of healthcare). The Trust therefore considers itself to operate with one segment, being the provision of healthcare services. This view is further supported by the fact that routine Finance Reports are presented to the Board on a Trust-wide basis, analysed by Pay, Non-Pay and Capital.

With regard to the Trust's subsidiary, the Central Manchester University Hospitals NHS Foundation Trust Charity, for Group Accounting purposes the Charity is considered to be a separate Operating Segment. The financial results of the Charity are separately disclosed in Note 45 to these Accounts, and these statements meet the IFRS 8 requirements for Operating Segment disclosures.

1.33 Transfers of Functions to and From Other NHS Bodies: Transfers by Absorption

For functions which have been transferred to the Trust and/or the Group from another NHS body, the assets and liabilities transferred are recognised in these Accounts as at the date of transfer. The assets and liabilites are not adjusted to Fair Value prior to recognition. The net gain or loss arising, corresponding to the net assets or liabilities transferred, is normally recognised within the Statement of Comprehensive Income under "Normal Absorption Accounting". However, for 2013/14 a net gain of £5,000, corresponding to assets transferred from the former Heywood, Middleton and Rochdale Primary Care Trust, is recognised within the Income and Expenditure Reserve, under "Modified Absorption Accounting", because the transfer related to the reorganisation of the NHS which was effective from 1 April 2013.

For functions which the Trust or the Group has transferred to another NHS body, the assets and liabilities transferred are derecognised from the Accounts as at the date of transfer. The net loss or gain, corresponding to the net assets or liabilities transferred, is recognised as Non-Operating Expenses or Income, and is titled a Gain or Loss from Transfer by (Normal) Absorption, in the Statement of Comprehensive Income.

More details on Transfers by Absorption are given in Note 43.

1A Prior Period Adjustments

As outlined in Note 1.3 to these Accounts, with effect from 1 April 2013 the Trust is required to apply a change in Accounting Policy and prepare Consolidated Group Accounts, encompassing its own activites and those of the Central Manchester University Hospitals NHS Foundation Trust Charity, to which the Trust is the Corporate Trustee. As a consequence of this, under the provisions of IAS 8, the Trust has restated its prior year (2012/13) results, as well as the 1 April 2012 Statement of Financial Position, in these Accounts - adding in an additional column of data for "Group" alongside the original Trust-only figures where Group results are different to those of the Trust alone, or else now heading the 2012/13 results as "Trust and Group". This is to aid comparability between financial years, by reflecting the changes which Consolidation with the CMUH NHSFT Charity into a Group (as now accounted for from 2013/14) would have made to the opening Statement of Financial Position on 1 April 2012, and in the 2012/13 Accounts, had the Group already been accounted for from the start of the prior year, ie. from 1 April 2012.

2.1 Operating Income (by Classification)

	2013/14 Trust £000	**2013/14 Group £000**	2012/13 Trust £000	2012/13 Charity Consol Adjs £000	2012/13 Group £000
Income from Activities					
Elective Income	**113,620**	**113,620**	111,153	0	111,153
Non-Elective Income	**137,449**	**137,449**	136,371	0	136,371
Out-patient Income	**103,854**	**103,854**	111,020	0	111,020
A&E Income	**22,509**	**22,509**	21,205	0	21,205
Other NHS Clinical Income	**414,694**	**414,694**	374,833	0	374,833
Private Patient Income	**2,810**	**2,810**	2,617	0	2,617
Other Clinical Income	**2,747**	**2,747**	2,602	0	2,602
Total Income from Activities	**797,683**	**797,683**	759,801	0	759,801
Other Operating Income					
Research and Development	**17,893**	**17,893**	18,762	0	18,762
Education and Training	**50,008**	**50,008**	52,371	0	52,371
Charitable and Other Contributions to Expenditure	**6,158**	**4,622**	3,652	(1,528)	2,124
Non-Patient Care Services to Other Bodies	**26,995**	**26,995**	30,300	0	30,300
Other Income	**20,276**	**24,751**	19,366	4,135	23,501
Total Other Operating Income	**121,330**	**124,269**	124,451	2,607	127,058
Total Operating Income	**919,013**	**921,952**	884,252	2,607	886,859

Commissioner requested services

The Trust is required by its Commissioners to provide services which ensures that service users have continued access to vital NHS services, known as Commissioner requested services. Of the £798,683k income from activities received in financial year, 99% was commissioner requested (99% in 2012/13).

2.2 Operating Lease Income

The Trust and the Group did not receive any Operating Lease Income in either 2013/14 or 2012/13.

2.3 Operating Income (by Source)

Income From Activities	2013/14 Trust £000	2013/14 Group £000	2012/13 Trust £000	2012/13 Group £000
Foundation Trusts	**1,710**	**1,710**	1,145	1,145
NHS Trusts	**262**	**262**	1,274	1,274
Clinical Commissioning Groups and NHS England	**763,522**	**763,522**	0	0
Primary Care Trusts	**0**	**0**	711,393	711,393
Strategic Health Authorities	**0**	**0**	29,381	29,381
Local Authorities	**22,050**	**22,050**	6,908	6,908
Department of Health	**0**	**0**	0	0
NHS Other	**0**	**0**	0	0
Non-NHS:				
Private Patients	**2,810**	**2,810**	2,617	2,617
Overseas Patients (Non-Reciprocal)	**508**	**508**	85	85
NHS Injury Costs Recovery Scheme	**2,747**	**2,747**	2,602	2,602
Non-NHS Other	**4,074**	**4,074**	4,396	4,396
	797,683	**797,683**	759,801	759,801

As a result of reorganisation in the NHS effective from 1st April 2013, the Trust and the Group now receive income for patient care from Clinical Commissioning Groups (CCGs) and Local Authorities. Prior to 1st April 2013, the comparative income was received from Primary Care Trusts (PCTs).

Other Operating Income	2013/14 Trust £000	2013/14 Group £000	2012/13 Trust £000	2012/13 Group £000
Research and Development	**17,893**	**17,893**	18,762	18,762
Education and Training	**50,008**	**50,008**	52,371	52,371
Charitable and Other Contributions to Expenditure	**6,158**	**4,622**	3,652	2,124
Non-Patient Care Services to Other Bodies	**26,995**	**26,995**	30,300	30,300
Income in Respect of Staff Costs Where Accounted on Gross Basis	**2,609**	**2,609**	2,436	2,436
Car Parking	**3,018**	**3,018**	2,718	2,718
Estates Recharges	**622**	**622**	669	669
Pharmacy Sales	**62**	**62**	161	161
Accommodation Rentals	**160**	**160**	104	104
Crèche Services	**751**	**751**	719	719
Clinical Excellence Awards	**4,501**	**4,501**	4,985	4,985
Catering	**635**	**635**	555	555
Property Rentals	**2,086**	**2,086**	2,482	2,482
Other Income	**5,832**	**10,307**	4,537	8,672
Total Other Operating Income	**121,330**	**124,269**	124,451	127,058
Total Operating Income	**919,013**	**921,952**	884,252	886,859

The figures included in the above Note for 2012/13 have been restated to aid comparability of Research and Development Income received from the Department of Health (£5,087k in 2012/13), which was previously included as 'Income From Activities' in the 2012/13 Audited Accounts.

3 Operating Expenses

	2013/14 Trust £000	2013/14 Group £000	2012/13 Trust £000	2012/13 Group £000
Services from Other Foundation Trusts	**5,126**	**5,126**	4,387	4,387
Services from NHS Trusts	**1,744**	**1,744**	3,021	3,021
Services from PCTs	**0**	**0**	263	263
Services from CCGs and NHS England	**9**	**9**	0	0
Services from Other NHS Bodies	**253**	**253**	1,956	1,956
Purchase of Healthcare from Non-NHS Bodies	**6,053**	**6,053**	6,573	6,573
Employee Expenses - Executive Directors	**1,245**	**1,245**	1,036	1,036
Employee Expenses - Non-Executive Directors	**171**	**171**	171	171
Employee Expenses - Staff	**515,538**	**516,814**	487,433	487,763
Supplies and Services - Clinical (Excluding Drug Costs)	**105,863**	**105,863**	96,664	96,664
Supplies and Services - General	**6,650**	**6,650**	6,170	6,170
Establishment	**9,693**	**9,693**	10,708	10,708
Research and Development - Non Pay Costs	**5,525**	**5,525**	5,946	5,946
Research and Development - Employee Expenses	**12,007**	**12,007**	10,647	10,647
Transport	**4,127**	**4,127**	2,506	2,506
Premises	**71,734**	**71,734**	71,167	71,167
Increase/(Decrease) in Provision for Impairment of Receivables	**1,249**	**1,249**	(375)	(375)
Change in Provisions Discount Rate(s)	**162**	**162**	0	0
Inventories Written Down (Net, Including Inventory Drugs)	**0**	**0**	(43)	(43)
Drug Costs (Non Inventory Drugs Only)	**1,701**	**1,701**	1,864	1,864
Drugs Inventories Consumed	**80,448**	**80,448**	71,696	71,696
Rentals Under Operating Leases - Minimum Lease Payments	**1,589**	**1,589**	1,676	1,676
Depreciation on Property, Plant and Equipment	**27,955**	**27,955**	27,136	27,136
Amortisation on Intangible Assets	**482**	**482**	1,442	1,442
Impairments of Property, Plant and Equipment	**7,973**	**7,973**	15,300	15,300
External Audit Fees for Services - Statutory Audit	**88**	**99**	90	101
External Audit Fees for Services - Regulatory Reporting	**0**	**0**	0	0
Clinical Negligence scheme for Trusts	**10,264**	**10,264**	9,346	9,346
Loss on Disposal of Land and Buildings	**29**	**29**	0	0
Legal Fees	**990**	**990**	621	621
Consultancy Costs	**3,227**	**3,227**	2,833	2,833
Training, Courses and Conferences	**2,367**	**2,367**	3,516	3,516
Patient Travel	**423**	**423**	380	380
Redundancy (Not Included in Employee Expenses)	**128**	**128**	1	1
Early Retirements (Not Included in Employee Expenses)	**90**	**90**	0	0
Insurance	**233**	**233**	272	272
Other - Trust	**578**	**578**	983	983
Other - Charity	**0**	**5,431**	0	5,110
Total	**885,714**	**892,432**	845,386	850,837

The Trust's Operating Expenses include payments made in respect of Operating Leases as set out in Note 5.1.
For details of Redundancy and Termination Benefits please see Note 4.5.

4 Employee Expenses and Numbers

4.1 Employee Expenses

	2013/14			2013/14			2012/13	
	Permanently Employed Trust	Other Trust	Total Trust	Permanently Employed Group	Other Group	Total Group	Total Trust	Total Group
	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and Wages	425,983	2,239	428,222	426,645	2,853	429,498	408,511	408,841
Social Security Costs	28,638	0	28,638	28,638	0	28,638	27,221	27,221
Pension Costs:								
Employer's Contributions to NHS Pensions	45,245	0	45,245	45,245	0	45,245	42,400	42,400
Pension Cost - Other Contributions	12	0	12	12	0	12	0	0
Agency / Contract Staff	0	26,673	26,673	0	26,673	26,673	20,984	20,984
Total	499,878	28,912	528,790	500,540	29,526	530,066	499,116	499,446

Staff costs for 2013/14 of £12.008m in respect of Research and Development are included within the Research and Development Costs at Note 3 (2012/13 £10.647m).

4.2 Average Number of People Employed

	2013/14			2013/14			2012/13	
	Permanently Employed Trust	Other Trust	Total Trust	Permanently Employed Group	Other Group	Total Group	Total Trust	Total Group
	£000	£000	£000	£000	£000	£000	£000	£000
Medical and Dental	945	409	1,354	945	421	1,366	1,319	1,319
Administration and Estates	2,378	8	2,386	2,390	13	2,403	2,297	2,297
Healthcare Assistants and Other Support Staff	1,130	0	1,130	1,130	0	1,130	1,060	1,060
Nursing, Midwifery and Health Visiting Staff	4,086	420	4,506	4,086	421	4,507	4,341	4,341
Scientific, Therapeutic and Technical Staff	2,029	18	2,047	2,029	22	2,051	1,935	1,935
Agency / Contract Staff	0	507	507	0	507	507	361	361
Other	33	6	39	33	6	39	26	26
Total	10,601	1,368	11,969	10,613	1,391	12,003	11,339	11,339

4.3 Early Retirements Due to Ill-Health

During 2013/14 there were 18 (2012/13: 20) early retirements from the Trust (and the Group) agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £974k (for 2012/13: £988k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

4.4 Analysis of Termination Benefits

In 2013/14 51 Staff Exit Packages were agreed by the Trust and the Group (2012/13 - 37 Packages), at a cost of £1,093k (2012/13 - £1,498k). Details of these Terminations are given in Notes 4.5 and 4.6.

4.5 Staff Exit Packages

2013/14	Number of Compulsory Redundancies	Number of Other Departures Agreed	Total Number of Exit Packages by Cost Band	Total Cost of Exit Packages £000
Exit Package Cost Band:	Trust and Group	Trust and Group	Trust and Group	Trust and Group
Less than £10,000	0	37	37	121
£10,000 - £25,000	0	5	5	77
£25,001 - £50,000	0	2	2	79
£50,001 - £100,000	0	3	3	219
£100,001 - £150,000	0	3	3	383
£150,001 - £200,000	0	0	0	0
Over £200,000	0	1	1	214
Total Departures	**0**	**51**	**51**	**1,093**

2012/13	Number of Compulsory Redundancies	Number of Other Departures Agreed	Total Number of Exit Packages by Cost Band
Exit Package Cost Band:	Trust and Group	Trust and Group	Trust and Group
Less than £10,000	2	7	9
£10,000 - £25,000	2	7	9
£25,001 - £50,000	1	8	9
£50,001 - £100,000	0	7	7
£100,001 - £150,000	0	1	1
£150,001 - £200,000	0	2	2
Over £200,000	0	0	0
Total Departures	5	32	37
Total Cost (£000)	**77**	**1,421**	**1,498**

Please Note:-

1) The figures for Costs of Exit Packages in the above tables are the total cash payments made in the respective years. Some of these payments relate to redundancies, but the figures above differ from those disclosed in Note 3 to these Accounts (Operating Expenses) for Redundancy Costs, because Provisions were made in the 2011/12 and 2013/14 (NB: not 2012/13) financial years for the future costs of redundancy payments. Therefore a number of the above cash payments have been charged against the Provision - see Note 31.2 - and not against Operating Expenses.
2) As detailed below, a number of the departures reported above also relate to circumstances other than redundancies - these costs are included within Other Expenditure in Note 3.

4.6 Exit Packages: Other (Non-Compulsory) Departure Payments

2013/14	Payments Agreed Trust and Group	Total Value of Agreements Trust and Group
	Number	£000
Voluntary Redundancies Including Early Retirement Contractual Costs	10	868
Contractual Payments in Lieu of Notice	38	159
Exit Payments Following Employment Tribunals or Court Orders	3	66
Total	**51**	**1,093**

2012/13	Payments Agreed Trust and Group	Total Value of Agreements Trust and Group
	Number	£000
Voluntary Redundancies Including Early Retirement Contractual Costs	15	1,190
Contractual Payments in Lieu of Notice	57	218
Exit Payments Following Employment Tribunals or Court Orders	5	90
Total	**77**	**1,498**

(Analysis for 2012/13 above to follow as audit adjustments - new Note in 2013/14.)

4.7 Directors' Remuneration and Benefits

The aggregate amount of Directors' remuneration for 2013/14 was £1.173m (£1.012m for 2012/13). The Trust and the Group made a contribution to the NHS Pension Scheme, a defined benefit scheme, of £99k in respect of five Directors in 2013/14 (2012/13: £74k in respect of three Directors).

4.8 Better Payment Practice Code - Measure of Compliance

	2013/14	**2013/14**	2012/13	2012/13
	Trust and Group	**Trust and Group**	Trust and Group	Trust and Group
	Number	**£000**	Number	£000
Total Non-NHS Trade Invoices Paid in the Year	**147,904**	**411,952**	144,524	372,545
Total Non-NHS Trade Invoices Paid Within Target	**138,402**	**373,756**	137,933	344,813
Percentage of Non-NHS Trade Invoices Paid Within Target	**94%**	**91%**	95%	93%
Total NHS Trade Invoices Paid in the Year	**7,374**	**97,033**	6,659	93,229
Total NHS Trade Invoices Paid Within Target	**4,854**	**71,727**	4,978	75,305
Percentage of NHS Trade Invoices Paid Within Target	**66%**	**74%**	75%	81%
Total of All Trade Invoices Paid in the Year	**155,278**	**508,985**	151,183	465,774
Total of All Trade Invoices Paid Within Target	**143,256**	**445,483**	142,911	420,118
Percentage of All Trade Invoices Paid Within Target	**92%**	**88%**	95%	90%

The Better Payment Practice Code requires the Trust and the Group to aim to pay all undisputed invoices by the due date, or within 30 days of receipt of goods or a valid invoice, whichever is later.

4.9 Management Costs

	2013/14	2012/13
	Trust and Group	Trust and Group
	£000	£000
Management Costs	**25,200**	23,863
Income	**919,013**	884,252
Management Costs as a Proportion of Income (%)	**2.74%**	2.70%

5.1 Operating Lease Expenditure

	2013/14	2012/13
	£000	£000
Lease Payments	**1,589**	1,676
	1,589	1,676

5.2 Arrangements Containing an Operating Lease

	2013/14	2012/13
	Trust and Group	Trust and Group
	£000	£000
Future Minimum Lease Payments Due:		
Not later than one year	**1,685**	1,280
Later than one year and not later than five years	**3,732**	2,204
Later than five years	**929**	39
Total	**6,346**	3,523

The future minimum lease payments are in respect of 62 operating leases (64 at 31 March 2013), of varying contract values and terms, giving an average payment per lease during the next twelve months of £22k (£20k at 31 March 2013).

5.3 Auditor's Liability

There is no specified clause in the Trust's or the Group's contract with the External Auditors, Deloitte LLP, which provides for any limitation of the Auditor's liability.

5.4 The Late Payment of Commercial Debts (Interest) Act 1998

No payments were made under the Late Payment of Commercial Debts (Interest) Act in either 2013/14 or 2012/13.

5.5 Audit Remuneration

In addition to statutory and regulatory audit services, our External Auditors, Deloitte LLP, provided property surveying services. This was provided by Deloitte Real Estate and the total amount expended in 2013/14 was £30k (£36k in 2013/14). Apart from these costs which were capitalised, no other services were provided to the Trust by Deloitte LLP. Remuneration details for statutory and regulatory services are disclosed at Note 3.

6 Discontinued Operations

There were no Discontinued Operations during 2013/14 or 2012/13.

7 Corporation Tax

There was no Corporation Tax payable or receivable during 2013/14 or 2012/13.

8 Finance Income

	2013/14 Trust £000	2013/14 Group £000	2012/13 Trust £000	2012/13 Group £000
Interest on Bank Accounts	**228**	**285**	218	309
Interest on Held-to-Maturity Financial Assets	**79**	**79**	64	64
Other - Dividend Income	**0**	**562**	0	621
Total	**307**	**926**	282	994

9 Finance Costs

	2013/14 Trust and Group £000	2012/13 Trust and Group £000
Interest on Loans from the Foundation Trust Financing Facility	**1,571**	1,589
Interest on Loans from the Department of Health	**0**	72
Interest on Obligations under PFI Contracts:		
- Main Finance Cost	**19,207**	19,623
- Contingent Finance Cost	**8,139**	7,227
Total	**28,917**	28,511

10 Impairment of Assets (Property, Plant & Equipment and Intangibles)

	2013/14 Trust and Group £000	2012/13 Trust and Group £000
Impairment	**8,288**	15,511
Total Impairments	**8,288**	15,511

In accordance with International Accounting Standard 16 the Trust and the Group undertake regular valuations of all property in use - these are carried out by an independent valuer, and are completed on the basis of a Modern Equivalent Asset valuation.

11 Intangible Assets

11.1 Intangible Assets Current Year

2013/14:	Software Licences - Purchased	Development Expenditure (Internally Generated)	Total
	Trust and Group £000	Trust and Group £000	Trust and Group £000
Gross Cost at 1 April 2013	**10,783**	**1,361**	**12,144**
Additions - Purchased	94	0	94
Reclassifications from Property, Plant and Equipment	625	0	625
Gross Cost at 31 March 2014	**11,502**	**1,361**	**12,863**
Amortisation at 1 April 2013	**9,988**	**1,361**	**11,349**
Provided During the Period	482	0	482
Amortisation at 31 March 2014	**10,470**	**1,361**	**11,831**

11.2 Intangible Assets Prior Period

2012/13:	Software Licences - Purchased	Development Expenditure (Internally Generated)	Total
	Trust and Group £000	Trust and Group £000	Trust and Group £000
Gross Cost at 1 April 2012	**6,374**	**0**	**6,374**
Transfers by Absorption	4,385	1,361	5,746
Additions - Purchased	24	0	24
Gross Cost at 31 March 2013	**10,783**	**1,361**	**12,144**
Amortisation at 1 April 2012	**5,161**	**0**	**5,161**
Transfers by Absorption	3,663	1,083	4,746
Provided During the Year	1,164	278	1,442
Amortisation at 31 March 2013	**9,988**	**1,361**	**11,349**

11.3 Intangible Assets Financing

2012/13:	Software Licences - Purchased	Development Expenditure (Internally Generated)	Total
	Trust and Group £000	Trust and Group £000	Trust and Group £000
Net Book Value			
Purchased as at 31 March 2014	1,012	0	1,012
Donated as at 31 March 2014	20	0	20
Total at 31 March 2014	**1,032**	**0**	**1,032**
Net Book Value			
Purchased as at 31 March 2013	764	0	764
Donated as at 31 March 2013	31	0	31
Total at 31 March 2013	**795**	**0**	**795**
Net Book Value			
Purchased as at 1 April 2012	1,198	0	1,198
Donated as at 1 April 2012	15	0	15
Total at 1 April 2012	**1,213**	**0**	**1,213**

12 Property, Plant and Equipment

12.1 Property, Plant and Equipment 2013/14

	Land	Buildings Excluding Dwellings	Dwellings	Assets Under Construction and Payments on Account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	Trust and Group	Trust and Group	Trust and Group	Trust and Group	Trust and Group	Trust and Group	Trust and Group	Trust and Group	Trust and Group
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or Valuation at 1 April 2013	**23,600**	**446,963**	**9**	**25,174**	**154,819**	**287**	**12,817**	**19,713**	**683,382**
Transfers by Absorption	0	0	0	0	5	0	0	0	5
Additions Purchased	0	6,834	0	27,945	2,709	0	512	0	38,000
Additions - Donations of Physical Assets (Non-Cash)	0	373	0	0	1,142	0	21	0	1,536
Impairments	(315)	(405)	0	(7,563)	(5)	0	0	0	(8,288)
Reclassifications	0	7,228	0	(11,266)	30	0	3,383	0	(625)
Transferred to Disposal Group as Asset Held for Sale	(135)	(75)	0	0	0	0	0	0	(210)
Disposals	0	0	0	(212)	0	0	0	0	(212)
Cost or Valuation at 31 March 2014	**23,150**	**460,918**	**9**	**34,078**	**158,700**	**287**	**16,733**	**19,713**	**713,588**
Accumulated Depreciation as at 1 April 2013	**0**	**14,435**	**9**	**0**	**124,256**	**287**	**10,333**	**16,524**	**165,844**
Provided During the Year	0	14,400	0	0	11,548	0	1,346	661	27,955
Depreciation at 31 March 2014	**0**	**28,835**	**9**	**0**	**135,804**	**287**	**11,679**	**17,185**	**193,799**

12.2 Property, Plant and Equipment 2012/13

	Land	Buildings Excluding Dwellings	Dwellings	Assets Under Construction and Payments on Account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	Trust and Group	Trust and Group	Trust and Group	Trust and Group	Trust and Group	Trust and Group	Trust and Group	Trust and Group	Trust and Group
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or Valuation at 1 April 2012	**19,810**	**381,558**	**9**	**12,702**	**139,927**	**160**	**9,168**	**18,744**	**582,078**
Transfers by Absorption	4,015	61,272	0	452	11,780	127	3,521	773	81,940
Additions Purchased	0	14,493	0	18,071	1,622	0	122	196	34,504
Additions Donated	0	0	0	0	1,496	0	6	0	1,502
Impairments	0	(15,511)	0	0	0	0	0	0	(15,511)
Reclassifications	0	6,051	0	(6,051)	0	0	0	0	0
Transferred to Disposal Group as Asset Held for Sale	(225)	(900)	0	0	0	0	0	0	(1,125)
Disposals	0	0	0	0	(6)	0	0	0	(6)
Cost or Valuation at 31 March 2013	**23,600**	**446,963**	**9**	**25,174**	**154,819**	**287**	**12,817**	**19,713**	**683,382**
Accumulated Depreciation as at 1 April 2012	**0**	**0**	**9**	**0**	**105,018**	**159**	**7,924**	**15,387**	**128,497**
Transfers by Absorption	0	607	0	0	7,836	127	1,114	527	10,211
Provided During the Period	0	13,828	0	0	11,402	1	1,295	610	27,136
Depreciation at 31 March 2013	**0**	**14,435**	**9**	**0**	**124,256**	**287**	**10,333**	**16,524**	**165,844**

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
	Trust and Group	Trust and Group	Trust and Group	Trust and Group	Trust and Group	Trust and Group	Trust and Group	Trust and Group	Trust and Group
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net Book Value - 31 March 2014	**22,925**	**97,323**	**0**	**34,078**	**18,898**	**0**	**4,977**	**2,502**	**180,703**
On-Balance Sheet PFI Contracts and Other Service Concession Arrangements	0	332,306	0	0	0	0	0	0	332,306
Government Granted	0	88	0	0	613	0	0	10	711
Donated	225	2,366	0	0	3,385	0	77	16	6,069
NBV Total at 31 March 2014	**23,150**	**432,083**	**0**	**34,078**	**22,896**	**0**	**5,054**	**2,528**	**519,789**
Net Book Value - 31 March 2013									
Owned	23,375	85,366	0	23,389	24,464	0	2,409	3,147	162,150
On-Balance Sheet PFI Contracts and Other Service Concession Arrangements	0	340,673	0	0	0	0	0	0	340,673
Government Granted	0	2,565	0	1,785	1,183	0	2	21	5,556
Donated	225	3,924	0	0	4,916	0	73	21	9,159
NBV Total at 31 March 2013	**23,600**	**432,528**	**0**	**25,174**	**30,563**	**0**	**2,484**	**3,189**	**517,538**
Net Book Value - 1 April 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 1 April 2012	**19,810**	**381,558**	**0**	**12,702**	**34,909**	**1**	**1,244**	**3,357**	**453,581**

13 Intangible Assets Acquired by Government Grant Funding

This information is no longer required by Monitor to be disclosed.

14.1 Economic Life of Intangible Assets

	Minimum Life Years	Maximum Life Years
Purchased, Donated or Granted	**Trust and Group**	**Trust and Group**
Software	3	7

14.2 Economic Life of Property, Plant and Equipment

Purchased, Donated or Granted	Minimum Life Years Trust and Group	Maximum Life Years Trust and Group
Buildings (Excluding Dwellings)	1	90
Plant and Machinery	5	10
Transport Equipment	5	7
Information Technology	5	5
Furniture and Fittings	2	10

15 Analysis and Net Book Values of Property, Plant and Equipment

This information is no longer required by Monitor to be disclosed.

16 Invxestments

16.1 Investments 2013/14

	Trust £000	Group £000
Carrying Value as at 1 April 2013	**0**	**13,386**
Acquisitions in Year - Other	**602**	**602**
Movement in Fair Value	**0**	**23**
Disposals	**0**	**0**
Carrying Value as at 31 March 2014	**602**	**14,011**

16.2 Investments 2012/13

	Trust £000	Group £000
Carrying Value as at 1 April 2012	0	12,471
Acquisitions in Year - Other	0	0
Movement in Fair Value	0	915
Disposals	0	0
Carrying Value as at 31 March 2013	0	13,386

16.3 Investment Property Expenses

Neither the Trust nor the Group had any Investment Property Expenses in 2013/14 or 2012/13.

16.4 Investment Property Income

Neither the Trust nor the Group had any Investment Property Income in 2013/14 or 2012/13.

17 Associates and Jointly Controlled Operations

Neither the Trust nor the Group held any assets or liabilities in respect of Associates or Jointly Controlled Operations in either 2013/14 or 2012/13.

18 Non-Current Assets Held for Sale in Disposal Groups

As at 31 March 2014 the Trust and the Group held two Non-Current Assets for sale, valued at £1.335m - in respect of land at the Altrincham General Hospital site (£1.125m), and one property (land and buildings) in Manchester (£210k). (As at 31 March 2013 - two Non-Current Assets for sale, valued at £6.475m - in respect of land at both the former Booth Hall Hospital site (£5.35m), and at the Altrincham General Hospital site (£1.125m).)

The Trust and the Group have not been exposed to liabilities in respect of disposal groups in either 2013/14 or 2012/13.

19 Other Assets

The Trust and the Group did not have any Other Assets at 31 March 2014 or 31 March 2013.

20 Other Financial Assets

The Trust and the Group did not have any Other Financial Assets at 31 March 2014 or 31 March 2013.

21 Inventories

21.1 Inventory Movements - 2013/14

	Drugs	Consumables	Energy	Total
	Trust and Group	Trust and Group	Trust and Group	Trust and Group
	£000	£000	£000	£000
Carrying Value at 1 April 2013	2,778	6,975	380	10,133
Additions	80,511	26,547	0	107,058
Inventories Consumed (Recognised in Expenses)	(80,448)	(26,175)	(46)	(106,669)
Total	**2,841**	**7,347**	**334**	**10,522**

21.2 Inventory Movements - 2012/13

	Drugs	Consumables	Energy	Total
	Trust and Group	Trust and Group	Trust and Group	Trust and Group
	£000	£000	£000	£000
Carrying Value at 1 April 2012	3,290	5,210	262	8,762
Transfers by Absorption	377	890	139	1,406
Additions	71,680	28,408	0	100,088
Inventories Consumed (Recognised in Expenses)	(71,696)	(27,533)	(21)	(99,250)
Write-Down of Inventories Recognised as an Expense	(28)	0	0	(28)
Reversal of any Write Down of Inventories Resulting in a Reduction of Recognised Expenses	71	0	0	71
Other	(916)	0	0	(916)
Total	**2,778**	**6,975**	**380**	**10,133**

22 Trade and Other Receivables

Current	31 March 2014		31 March 2013		1 April 2012	
	Trust	**Group**	Trust	Group	Trust	Group
	£000	**£000**	£000	£000	£000	£000
NHS Receivables	**16,798**	**16,844**	14,527	14,527	16,223	16,223
Other Receivables With Related Parties	**3,072**	**3,072**	1,349	1,349	896	896
Provision for the Impairment of Receivables	**(1,750)**	**(1,758)**	(960)	(960)	(1,343)	(1,343)
Prepayments	**3,650**	**3,650**	4,232	4,232	3,591	3,591
Accrued Income	**4,555**	**4,679**	4,613	4,767	4,070	4,265
PDC Dividend Receivable	**182**	**182**	302	302	0	0
VAT Receivable	**3,132**	**3,132**	2,834	2,834	3,018	3,018
Other Receivables - Revenue	**12,684**	**12,684**	9,356	9,410	8,888	8,945
Other Receivables - Capital	**157**	**202**	46	46	0	0
Total Current Trade and Other Receivables	**42,480**	**42,687**	36,299	36,507	35,343	35,595

Non-Current	31 March 2014	31 March 2013	1 April 2012
	Trust and Group	Trust and Group	Trust and Group
	£000	£000	£000
Provision for the Impairment of Receivables	**(558)**	(476)	(124)
Accrued Income	**2,702**	2,434	2,264
Other Trade Receivables	**0**	1,552	3,106
Total Non-Current Trade and Other Receivables	**2,144**	3,510	5,246

23.1 Provision for Impairment of Receivables (Bad Debt Provision)

Non-Current	31 March 2014	31 March 2013
	Trust and Group	Trust and Group
	£000	£000
At 1 April	**1,436**	1,467
Transfer by Absorption	**0**	344
Increase in Provision	**1,299**	201
Amounts Utilised	**(377)**	0
Unused Amounts Reversed	**(50)**	(576)
At 31 March	**2,308**	1,436

Income received from the Department of Work and Pensions, under the NHS Injury Cost Recovery Scheme (see Note 1.6), is subject to a Provision for Impairment of Receivables of 15.8%, to reflect expected rates of collection.

23.2 Analysis of Impaired and Non-Impaired Receivables

	31 March 2014	31 March 2013	1 April 2012
	Trust and Group	Trust and Group	Trust and Group
	£000	£000	£000
Ageing of Impaired Trade Receivables (Bad Debt Provision):-			
0 - 30 Days	**0**	0	0
30 - 60 Days	**0**	0	0
60 - 90 Days	**4**	0	9
90 - 180 Days	**868**	268	126
Over 180 Days	**1,436**	1,168	1,332
Total	**2,308**	1,436	1,467
Ageing of Non-Impaired Trade Receivables Past Their Due Date:-			
0 - 30 Days	**964**	10,086	6,296
30 - 60 Days	**2,771**	2,790	2,530
60 - 90 Days	**376**	876	1,112
90 - 180 Days	**648**	696	616
Over 180 Days	**420**	537	838
Total	**5,179**	14,985	11,392

24 Finance Leases

Neither the Trust nor the Group held any Finance Leases in either 2013/14 or 2012/13.

25 Cash and Cash Equivalents

	31 March 2014		31 March 2013		31 March 2012	
	Trust	**Group**	Trust	Group	Trust	Group
	£000	**£000**	£000	£000	£000	£000
Balance at 1 April	**86,132**	**93,329**	60,306	69,654	35,231	0
Transfer by Absorption	**(405)**	**(405)**	1,809	2,171	0	44,997
Net Change in Year	**(10,221)**	**(12,819)**	24,017	21,504	25,075	0
Balance at 31 March	**75,506**	**80,105**	86,132	93,329	60,306	44,997
Comprising:-						
Commercial Banks and Cash in Hand	**1,186**	**1,186**	735	7,932	139	9,487
Cash With the Government Banking Service	**74,320**	**78,919**	85,397	85,397	60,167	60,167
Cash and Cash Equivalents as per Statement of Financial Position	**75,506**	**80,105**	86,132	93,329	60,306	69,654
Bank Overdraft	**0**	**0**	0	0	0	0
Cash and Cash Equivalents as per Statement of Cashflows	**75,506**	**80,105**	86,132	93,329	60,306	69,654
Third Party Assets Held by the NHS Foundation Trust	**5**		7		17	

Third Party Assets held by the Trust, as noted above, are excluded from the Trust's Cash and Cash Equivalents figures, as disclosed in Note 25 above.

26.1 Trade and Other Payables

Current	31 March 2014		31 March 2013		1 April 2012	
	Trust	Group	Trust	Group	Trust	Group
	£000	£000	£000	£000	£000	£000
Receipts in Advance	**9,035**	**9,035**	8,305	8,305	14,262	14,262
NHS Payables	**8,464**	**8,464**	10,446	10,446	10,865	10,865
Amounts Due to Other Related Parties	**6,456**	**6,789**	9,882	9,903	8,049	8,049
Trade Payables - Capital	**5,589**	**5,589**	3,881	3,881	951	951
Other Payables	**38,691**	**38,707**	28,091	28,035	20,445	20,772
Accruals	**21,928**	**22,141**	22,422	22,458	21,850	21,949
PDC Dividend Payable	**0**	**0**	0	0	136	136
Total Current Trade and Other Payables	**90,163**	**90,725**	83,027	83,028	76,558	76,984

Receipts in Advance includes the deferral of income in respect of Research funds received during the year and for which work has yet to be completed. There are no unfulfilled conditions or obligations arising from this.

Non-Current	31 March 2014	31 March 2013	1 April 2012
	Trust and Group	Trust and Group	Trust and Group
	£000	£000	£000
Receipts in Advance	**1,298**	1,194	1,212
Other Payables	**3,098**	3,098	3,098
Total Non-Current Trade and Other Payables	**4,396**	4,292	4,310

26.2 Early Retirement Costs

Early Retirement costs included in Note 26.1 above were £45k at the 31 March 2014 (31 March 2013: £59k).

27 Borrowings

Current	31 March 2014	31 March 2013	1 April 2012
	Trust and Group	Trust and Group	Trust and Group
	£000	£000	£000
Loans From:			
Foundation Trust Financing Facility	**8,112**	8,112	7,224
Other Loans*	**154**	244	0
Obligations Under Private Finance Initiative Contracts	**5,751**	6,890	7,061
Total	**14,017**	15,246	14,285

Non-Current	31 March 2014	31 March 2013	1 April 2012
	Trust and Group	Trust and Group	Trust and Group
	£000	£000	£000
Loans From:			
Foundation Trust Financing Facility	**32,104**	40,216	36,828
Other Loans*	**31**	185	0
Obligations Under Private Finance Initiative Contracts	**314,208**	319,959	326,849
Total	**346,343**	360,360	363,677

* "Other Loans" relates to a Salix Energy Loan, which is interest free and used to support the Trust and the Group in implementing/installing energy saving features. The obligations under the Loan transferred from the former Trafford Healthcare NHS Trust as part of the transfer of services which took place on 1st April 2012.

28 Prudential Borrowing Limit

Prudential Borrowing Limit disclosures are no longer required, the Prudential Borrowing Code having been repealed by the Health and Social Care Act 2012.

29 Other Liabilities

Neither the Trust nor the Group had any "Other Liabilities" at 31 March 2014 or 31 March 2013.

30 Other Financial Liabilities

Neither the Trust nor the Group had any "Other Financial Liabilities" at 31 March 2014 or 31 March 2013.

31.1 Provisions for Liabilities and Charges

	Current			Non-Current		
	31 March 2014	31 March 2013	1 April 2012	**31 March 2014**	31 March 2013	1 April 2012
	Trust and Group	Trust and Group	Trust and Group	**Trust and Group**	Trust and Group	Trust and Group
	£000	£000	£000	**£000**	£000	£000
Pensions Relating to Former Directors	**10**	9	9	**101**	102	107
Pensions Relating to Other Staff	**170**	226	207	**1,453**	1,417	1,539
Other Legal Claims	**675**	1,086	263	**0**	0	0
Agenda for Change	**161**	243	60	**481**	482	0
Restructurings	**971**	991	5,929	**0**	0	0
Other	**522**	582	616	**4,313**	4,397	4,002
Totals	**2,509**	3,137	7,084	**6,348**	6,398	5,648

31.2 Provisions for Liabilities and Charges Analysis

	Pensions Relating to Former Directors	Pensions Relating to Other Staff	Other Legal Claims	Agenda for Change	Restruc-turings	Other	Totals
	Trust and Group	Trust and Group	Trust and Group	Trust and Group	Trust and Group	Trust and Group	Trust and Group
	£000	£000	£000	£000	£000	£000	£000
As at 1 April 2013	111	1,643	1,086	725	991	4,979	9,535
Change in Discount Rate	4	51	0	0	0	107	162
Arising During the Year	3	155	157	0	444	138	897
Utilised During the Year	(9)	(170)	(401)	(42)	(464)	(408)	(1,494)
Reversed Unused	0	(68)	(167)	(41)	0	0	(276)
Unwinding of Discount	2	12	0	0	0	19	33
At 31 March 2014	111	1,623	675	642	971	4,835	8,857
Expected Timing of Cashflows:							
- Not Later Than 1 Year	10	170	675	161	971	522	2,509
- Later Than 1 Year and Not Later Than 5 Years	31	581	0	481	0	1,951	3,044
- Later Than 5 Years	70	872	0	0	0	2,362	3,304
Total	111	1,623	675	642	971	4,835	8,857

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 2014 is £134.461m in respect of Clinical Negligence liabilities of the Trust and the Group (31 March 2013 £119.943m).

32 Contingent Liabilities and Assets

32.1 Contingent Liabilities

	31 March 2014	31 March 2013
	Trust and Group	Trust and Group
	£000	£000
Gross Value of Contingent Liabilities	**(170)**	(292)
Amounts Recoverable Against Liabilities	**0**	0
Net Value of Contingent Liabilities	**(170)**	(292)

For each Provision included in Note 31.3, 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 and the Group held no Contingent Assets at the 31 March 2014 (31 March 2013 nil).

33.1 Revaluation Reserve 2013/14

	Revaluation Reserve - Property, Plant and Equipment
	Trust and Group
	£000
Revaluation Reserve at 1 April 2013	**33,890**
Impairments	(315)
Revaluation Reserve at 31 March 2014	**33,575**

33.2 Revaluation Reserve 2012/13

Revaluation Reserve at 1 April 2012	**16,102**
Transfers by Absorption	17,999
Impairments	(211)
Revaluation Reserve at 31 March 2013	**33,890**

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 have undertaken any material transactions with Central Manchester University Hospitals NHS Foundation Trust.

The Chairman is a Member of the 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 another Non-Executive Director is the Deputy President of The University of Manchester, and a Non-Executive Director of Manchester Science Parks Ltd. (which is majority owned by Bruntwood 2000 Holdings Ltd.) The Trust has entered into a significant number and value of transactions with both The University of Manchester (net expenditure of £5.7m) and Bruntwood 2000 Holdings Ltd., and these are all considered to be "at arm's length".

The Department of Health is regarded as a related party. During the year the Trust has had a significant number of material transactions, to the value of £6.3m (£5.087m in 2012/13) 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 or Expenditure with the Trust or the Group greater than £6m, are listed below.

The transactions and balances with these bodies for 2013/14 and 2012/13 were:-

	Net Income/(Expenditure)		Net Receivables/(Payables)	
	2013/14	2012/13	**2013/14**	2012/13
	Trust	Trust	**Trust**	Trust
	£000	£000	**£000**	£000
Manchester PCT	**0**	247,516	**0**	1,197
Western Cheshire PCT	**0**	192,388	**0**	57
Trafford PCT	**0**	111,170	**0**	1,242
North West Strategic Health Authority	**0**	49,976	**0**	(4)
Salford PCT	**0**	31,908	**0**	246
London Strategic Health Authority	**0**	26,952	**0**	1,382
Tameside and Glossop PCT	**0**	23,603	**0**	654
Stockport PCT	**0**	22,800	**0**	240
Bury PCT	**0**	11,542	**0**	186
Oldham PCT	**0**	10,706	**0**	58
Bolton PCT	**0**	10,639	**0**	242
Heywood, Middleton and Rochdale PCT	**0**	9,116	**0**	(46)
Central and Eastern Cheshire PCT	**0**	8,628	**0**	274
Ashton, Leigh and Wigan PCT	**0**	7,961	**0**	83
Cheshire, Warrington & Wirral Area Team	**320,357**	0	**1,001**	0
NHS Central Manchester CCG	**116,654**	0	**1,165**	0
NHS Trafford CCG	**95,988**	0	**780**	0
Health Education England	**48,411**	0	**72**	0
NHS North Manchester CCG	**40,238**	0	**627**	0
NHS South Manchester CCG	**35,237**	0	**282**	0
Greater Manchester Area Team	**33,233**	0	**1,806**	0
NHS Salford CCG	**26,939**	0	**368**	0
NHS Tameside And Glossop CCG	**20,379**	0	**116**	0
NHS Stockport CCG	**18,385**	0	**586**	0
NHS Bury CCG	**7,815**	0	**43**	0
NHS Oldham CCG	**7,736**	0	**325**	0
NHS Heywood, Middleton And Rochdale CCG	**6,714**	0	**145**	0
NHS Eastern Cheshire CCG	**6,186**	0	**35**	0
NHS Litigation Authority (Clinical Negligence scheme for Trusts)	**(10,807)**	0	**(9,791)**	0
Bruntwood Group	**(4,790)**	(2,048)	**157**	46

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 amounts relating to Manchester City Council, HM Revenue and Customs, and the NHS Business Services Authority (Pensions Division).

35 Contractual Capital Commitments

Commitments under Capital Expenditure contracts at 31 March 2014 were £12.287m (31 March 2013: £21.818m).

36 Finance Lease Obligations

Neither the Trust nor the Group had any obligations under Finance Leases in either 2013/14 or 2012/13, except for the PFI Scheme - see Note 37.

37 On-Statement of Financial Position Private Finance Initiative (PFI) Contracts

37.1 Total Obligations for On-Statement of Financial Position PFI Contracts

In December 2004 the Trust entered into a 38 year arrangement with Catalyst Healthcare (Manchester) Ltd under the Government's Private Finance Initiative (PFI). The scheme involved the build and operation of four hospital developments on the Trust's main site at an overall cost of approximately £500m. At the end of the agreement ownership of the four properties transfers to the Trust.

	31 March 2014	31 March 2013
	Trust and Group	Trust and Group
	£000	£000
Gross PFI Liabilities	**666,163**	692,260
Of Which Liabilities are Due:		
Not Later Than One Year	**24,567**	26,097
Later Than One Year, Not Later Than Five Years	**98,118**	98,255
Later Than Five Years	**543,478**	567,908
Less Finance Charges Allocated to Future Periods	**(346,204)**	(365,411)
Net PFI Liabilities	**319,959**	326,849
Net PFI Obligation		
Not Later Than One Year	**5,751**	6,890
Later Than One Year, Not Later Than Five Years	**26,433**	25,069
Later Than Five Years	**287,775**	294,890
	319,959	326,849

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 2014 Total	31 March 2013 Total
	Trust and Group	Trust and Group
	£000	£000
Within One Year	**29,151**	28,174
2nd to 5th Years (Inclusive)	**127,078**	122,816
Later Than 5 Years	**1,244,998**	1,278,411
Total	**1,401,227**	1,429,401

38 PFI Schemes Deemed to be Off-Statement of Financial Position

At 31 March 2014 and 31 March 2013, neither the Trust nor the Group had any PFI Schemes deemed to be Off-Statement of Financial Position.

39 Events Following the Statement of Financial Position Date

There were no events following the Statement of Financial Position date, either requiring disclosure, or resulting in a change to the financial statements of the Trust or the Group.

40 Financial Instruments

International Financial Reporting Standard 7 requires disclosure of the role which Financial Instruments have had during the period in creating or changing the risks which a body faces in undertaking its activities. Because of the continuing service provider relationship which the Trust has with its Commissioners, and the way in which those Commissioners 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 for the Trust 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. For the Group, the CMUH NHSFT Charity does hold investments, and is therefore exposed to a degree of financial risk. This risk is carefully managed by pursuing a cautious, low risk Investment Strategy, and by monthly reviews of the performance of investments.

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. Similarly, for the Group the Treasury Management of the CMUH NHSFT Charity's investments is carried out by the Charity Finance Team, following the policies set down by the Trustee, and subject to the approval of the Charitable Funds Committee. The Trust's and the Group's treasury activities are also subject to review by Internal Audit.

Liquidity Risk

Net operating costs of the Trust are funded under annual Service Agreements with NHS Commissioners, 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 (currently three) has been arranged with the Foundation Trust Financing Facility to support major capital developments. The Trust is, therefore, exposed to liquidity risks from the loan funding - however these risks are approved, and comply with Monitor's Risk Assessment Framework. For the Group, the CMUH NHSFT Charity finances all of its expenditure from the resources which have been donated to it, and therefore faces no liquidity risk.

Currency Risk

The Trust and the Group are principally domestic organisations with the overwhelming majority of their transactions, assets and liabilities being in the UK and Sterling based. The Trust and the Group have no overseas operations, and therefore have 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. For the Group, the Charity has interest bearing bank balances, which are subject to variable rates of interest. However, all other financial assets, and 100% of financial liabilities, of the Charity carry nil rates of interest. The Charity's bank balances represent approximately 2.9% of the Group's total Net Assets, and so the Group is not exposed to significant interest rate risk.

Credit Risk

The majority of the Trust's Income comes from contracts with other public sector bodies, and therefore the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2014 is within Receivables from customers, as disclosed in the Trade and Other Receivables Note to these Accounts (No. 22). For the Group, the Charity's Income comes only from Donations, Legacies and Investment Income. Therefore the position of the Group is as for the Trust - the maximum exposure to Credit Risk is in respect of Receivables.

40.1 Financial Assets by Category

	Loans and Receivables	
	Trust	Group
	£000	£000
Per Statement of Financial Position:-		
Trade and Other Receivables Not Including Non-Financial Assets	**40,974**	**41,181**
Other Investments	**602**	**14,008**
Cash and Cash Equivalents	**75,506**	**80,105**
Total at 31 March 2014	**117,082**	**135,294**
Trade and Other Receivables Not Including Non-Financial Assets	35,577	35,785
Other Investments	0	13,383
Cash and Cash Equivalents	86,132	93,329
Total at 31 March 2013	121,709	142,497

40.2 Financial Liabilities by Category

	Other Financial Liabilities	
	Trust	Group
	£000	£000
Per Statement of Financial Position:-		
Borrowings Not Including Finance Leases and PFI Obligations	**40,401**	**40,401**
Obligations Under PFI Contracts	**319,959**	**319,959**
Trade and Other Payables Not Including Non-Financial Liabilities	**84,226**	**84,788**
Provisions Under Contract	**8,857**	**8,857**
Total at 31 March 2014	**453,443**	**454,005**
Borrowings Not Including Finance Leases and PFI Obligations	48,757	48,757
Obligations Under PFI Contracts	326,849	326,849
Trade and Other Payables Not Including Non-Financial Liabilities	77,820	77,821
Provisions Under Contract	9,535	9,535
Total at 31 March 2013	462,961	462,962

40.3 Fair Values of Financial Assets at 31 March

Fair Values at 31 March 2014	Book Value Trust £000	Fair Value Trust £000	Book Value Group £000	Fair Value Group £000
Non-Current Trade and Other Receivables Excluding Non-Financial Assets	**2,144**	**2,144**	**2,144**	**2,144**
Other Investments	**602**	**602**	**14,008**	**14,008**
Total at 31 March 2014	**2,746**	**2,746**	**16,152**	**16,152**

Fair Values at 31 March 2013	Book Value Trust £000	Fair Value Trust £000	Book Value Group £000	Fair Value Group £000
Non-Current Trade and Other Receivables Excluding Non-Financial Assets	3,510	3,510	3,510	3,510
Other Investments	0	0	13,383	13,383
Total at 31 March 2013	3,510	3,510	16,893	16,893

40.4 Fair Values of Financial Liabilities at 31 March

Fair Values at 31 March 2014	Book Value Trust £000	Fair Value Trust £000	Book Value Group £000	Fair Value Group £000
Non-Current Trade and Other Payables Not Including Non-Financial Liabilities	**3,098**	**3,098**	**3,098**	**3,098**
Provisions Under Contract	**8,857**	**8,857**	**8,857**	**8,857**
Loans	**40,401**	**40,401**	**40,401**	**40,401**
PFI Obligations	**319,959**	**319,959**	**319,959**	**319,959**
Total at 31 March 2014	**372,315**	**372,315**	**372,315**	**372,315**

Fair Values at 31 March 2013	Book Value Trust £000	Fair Value Trust £000	Book Value Group £000	Fair Value Group £000
Non-Current Trade and Other Payables Not Including Non-Financial Liabilities	3,098	3,098	3,098	3,098
Provisions Under Contract	9,535	9,535	9,535	9,535
Loans	48,757	48,757	48,757	48,757
PFI Obligations	326,849	326,849	326,849	326,849
Total at 31 March 2013	388,239	388,239	388,239	388,239

As allowed under IFRS 7, Current Trade Receivables and Payables have been excluded from Notes 40.3 and 40.4 above on the basis that their Fair Values approximate to their carrying values.

40.5 Maturity of Financial Liabilities

	31 March 2014	31 March 2014	31 March 2013	31 March 2013
	Trust	Group	Trust	Group
	£000	£000	£000	£000
In One Year or Less	**97,654**	**98,216**	91,910	91,911
In More Than One Year But Not More Than Two Years	**17,235**	**17,235**	19,543	19,543
In More Than Two Years But Not More Than Five Years	**39,301**	**39,301**	34,324	34,324
In More Than Five Years	**299,253**	**299,253**	317,184	317,184
Total	**453,443**	**454,005**	462,961	462,962

41 Pensions - Defined Benefit Obligations

Neither the Trust nor the Group held any on-Statement of Financial Position Defined Benefit Pension Schemes during 2013/14 or 2012/13.

42 Losses and Special Payments

42.1 Losses and Special Payments Incurred

	2013/14		2012/13	
	Number of Cases	Value of Cases	Number of Cases	Value of Cases
	Trust and Group	Trust and Group	Trust and Group	Trust and Group
	Number	£000	Number	£000
Bad Debts and Claims Abandoned	**321**	**378**	172	259
Compensation Payments Under Legal Obligation	**0**	**0**	11	281
Ex Gratia Payments	**31**	**10**	15	6
Special Severance Payments	**3**	**66**	0	0
Totals	**355**	**454**	198	546

Losses and Special Payments are reported on an accruals basis, but provisions for future losses are not made.

42.2 Recovered Losses

There were no Recovered Losses in either 2013/14 or 2012/13.

43 Transfers by Absorption

43.1 First Transfer by Absorption

This Trust and this Group divested £405k of funding for services provided by the National Technology Adoption Centre (NTAC), to the National Institute for Clinical Excellence (NICE). This transaction is classed as a "Loss From (Normal) Transfer by Absorption" (see Note 1.33), and had retrospective effect from 1 April 2013.

43.2 Second Transfer by Absorption

This Trust and this Group received £5k of Non-Current Assets upon the dissolution of the former Heywood, Middleton and Rochdale Primary Care Trust (PCT). This transaction is classed as a "Gain From Modified Transfer by Absorption", and was effective from 1 April 2013.

44 Taxpayers' Equity

44.1 Public Dividend Capital

Public Dividend Capital (PDC) represents the Department of Health's equity interest in the Trust, i.e. it is a form of long term Government finance which was initially provided to the Trust when its 2 predecessor organisations were founded as NHS Trusts in 1991, enabling it to acquire its assets from the Secretary of State for Health at that time. Exceptional circumstances such as the merger with the former Trafford Healthcare NHS Trust in 2012, and occasionally specific Capital Expenditure, can be funded by additional PDC being issued to the Trust. As outlined at Note 1.26 to these Accounts, a PDC Dividend of 3.5% per year is payable by the Trust to the Department of Health in respect of the value of the Trust's Average "Net Relevant Assets".

44.2 Revaluation Reserve

The Revaluation Reserve represents differences between the latest valuations of the Trust's land and buildings and their cost, less depreciation to date of the buildings, as outlined in Note 1.9.

44.3 Income and Expenditure Reserve

The Income and Expenditure Reserve represents the accumulation of all surpluses and deficits made by the Trust since its inception.

44.4 Charitable Fund Reserves

The Charitable Fund Reserves are made up as follows:-
Restricted Endowment Funds are those funds which have been donated, with specific purposes stipulated for the use of the Funds.
Unrestricted Income Funds are those Funds which have been donated, and can be used for any appropriate purpose.
The Revaluation Reserve is the difference between the latest valuation of the Charity's Investments, and the original sums of money invested.

45 Central Manchester University Hospitals NHS Foundation Trust Charity - Primary Annual Financial Statements 2013/14 and 2012/13

45.1 Statement of Financial Activities for the Period Ended 31st March 2014

	Per Charity Accounts 2013/14	Per Charity Accounts 2012/13
	Total Funds	Total Funds
	£000	£000
Incoming Resources		
Incoming Resources from Generated Funds		
Voluntary Income:		
Donations	**3,768**	2,708
Legacies	**426**	357
Sub Total: Voluntary Income	**4,194**	3,065
Investment Income	**619**	712
Incoming Resources from Charitable Activities	**0**	0
Total Incoming Resources	**4,813**	3,777
Resources Expended		
Costs of Generating Funds	**719**	596
Charitable Activities:		
Clinical Care and Research Posts	**971**	1,347
Patient Education, Welfare & Amenities	**1,799**	788
Staff Welfare, Education & Amenities	**790**	657
New Building & Refurbishment	**399**	123
Purchase of Medical Equipment	**1,230**	1,668
Purchase of IT and Computer Equipment	**1,050**	75
Purchase of New Equipment	**182**	142
Sub Total: Charitable Activities	**6,421**	4,800
Governance Costs	**101**	90
Total Resources Expended	**7,241**	5,486
Net Outgoing Resources Before Transfers and Other Recognised Gains	**(2,428)**	(1,709)
Net Outgoing Resources Before Transfers	**(2,428)**	(1,709)
Transfers to other NHS Charities	**5**	53
Net Outgoing Resources After Transfers	**(2,433)**	(1,762)
Unrealised Gains on Investment Assets	**23**	915
Net Decrease in Funds	**(2,410)**	(847)
Total Funds Brought Forward	**17,570**	18,055
Transfer of Trafford Healthcare NHS Trust Charity	**0**	362
Total Funds Carried Forward	**15,160**	17,570

45.2 Statement of Financial Position as at 31st March 2014

	Total at 31 March 2014	Total at 31 March 2013
	£000	£000
Fixed Assets		
Investments	**13,409**	13,386
Total Fixed Assets	**13,409**	13,386
Current Assets		
Debtors	**207**	510
Cash at Bank and in Hand	**4,599**	7,197
Total Current Assets	**4,806**	7,707
Current Liabilities		
Creditors Falling Due Within One Year	**(562)**	(303)
Provision for Liabilities and Charges	**(1,400)**	(364)
Net Current Assets	**2,844**	7,040
Total Assets before Non-current Liabilities	**16,253**	20,426
Non - Current Liabilities		
Provision for Liabilities and Charges	**(1,093)**	(2,856)
Total Net Assets	**15,160**	17,570
Funds of the Charity		
Restricted Income Funds	**157**	0
Unrestricted Income Funds	**13,597**	16,184
Revaluation Reserve	**1,406**	1,386
Total Charity Funds	**15,160**	17,570

45.3 Cash Flow Statement for the Period Ended 31 March 2014

	2013/14 £000	2012/13 £000
Cash Outflow from Operating Activities	**(3,217)**	(3,225)
Returns on Investments		
Interest - Cash Received	**619**	712
Net Cash Inflow from Returns on Investments	**619**	712
Decrease in Cash	**(2,598)**	(2,513)
Opening Cash at Bank and in Hand	**7,197**	9,348
Decrease in Cash	**(2,598)**	(2,513)
Transfer from Trafford Healthcare NHS Trust Charity	**0**	362
Closing Cash at Bank and in Hand	**4,599**	7,197

46 Consolidation of Charitable Funds - Reconciliation of Charity Accounts to Consolidation Figures

46.1 Statement of Financial Activities / Statement of Comprehensive Income

	Per Charity Accounts 2013/14	Consolidation Adjustments 2013/14	Figures Used in Consolidated Accounts 2013/14	Per Charity Accounts 2012/13	Consolidation Adjustments 2013/14	Figures Used in Consolidated Accounts 2013/14
	Total Funds	Total Funds	Total Funds	Total Funds	Total Funds	Total Funds
	£000	£000	£000	£000	£000	£000
Incoming Resources						
Incoming Resources from Generated Funds						
Voluntary Income:						
Donations	**3,768**	**(1,255)**	**2,513**	2,708	(458)	2,250
Legacies	**426**	**0**	**426**	357	0	357
Sub Total: Voluntary Income	**4,194**	**(1,255)**	**2,939**	3,065	(458)	2,607
Investment Income	**619**	**0**	**619**	712	0	712
Incoming Resources from Charitable Activities	**0**	**0**	**0**	0	0	0
Total Incoming Resources	**4,813**	**(1,255)**	**3,558**	3,777	(458)	3,319
Resources Expended						
Costs of Generating Funds	**719**	**0**	**719**	596	0	596
Charitable Activities:						
Clinical Care and Research Posts	**971**	**0**	**971**	1,347	0	1,347
Patient Education, Welfare & Amenities	**1,799**	**(528)**	**1,271**	788	(88)	700
Staff Welfare, Education & Amenities	**790**	**0**	**790**	657	0	657
New Building & Refurbishment	**399**	**0**	**399**	123	0	123
Purchase of Medical Equipment	**1,230**	**0**	**1,230**	1,668	0	1,668
Purchase of IT and Computer Equipment	**1,050**	**0**	**1,050**	75	0	75
Purchase of New Equipment	**182**	**0**	**182**	142	0	142
Sub Total: Charitable Activities	**6,421**	**(528)**	**5,893**	4,800	(88)	4,712
Governance Costs	**101**	**0**	**101**	90	0	90
Total Resources Expended	**7,241**	**(528)**	**6,713**	5,486	(88)	5,398
Net Outgoing Resources Before Transfers and Other Recognised Gains	**(2,428)**	**(727)**	**(3,155)**	(1,709)	(370)	(2,079)
Net Outgoing Resources Before Transfers	**(2,428)**	**(727)**	**(3,155)**	(1,709)	(370)	(2,079)
Transfers to other NHS Charities	**5**	**0**	**5**	53	0	53
Net Outgoing Resources After Transfers	**(2,433)**	**(727)**	**(3,160)**	(1,762)	(370)	(2,132)
Unrealised Gains on Investment Assets	**23**	**0**	**23**	915		915
Net Decrease in Funds	**(2,410)**	**(727)**	**(3,137)**	(847)	(370)	(1,217)
Total Funds Brought Forward	**17,570**	**3,220**	**20,790**	18,055	3,590	21,645
Transfer of Trafford Healthcare NHS Trust Charity	**0**	**0**	**0**	362	0	362
Total Funds Carried Forward	**15,160**	**2,493**	**17,653**	17,570	3,220	20,790

46.2 Statement of Financial Position

	Per Charity Accounts	Consolidation Adjustments	Figures Used in Consolidated Accounts	Per Charity Accounts	Consolidation Adjustments	Figures Used in Consolidated Accounts	Per Charity Accounts	Consolidation Adjustments	Figures Used in Consolidated Accounts
	31 March 2014	31 March 2014	31 March 2014	31 March 2013	31 March 2013	31 March 2013	31 March 2012	31 March 2012	31 March 2012
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Fixed Assets									
Investments	**13,409**	**0**	**13,409**	13,386	0	13,386	12,471	0	12,471
Total Fixed Assets	**13,409**	**0**	**13,409**	13,386	0	13,386	12,471	0	12,471
Current Assets									
Debtors	**207**	**0**	**207**	510	(302)	208	252	0	252
Cash at Bank and in Hand	**4,599**	**0**	**4,599**	7,197	0	7,197	9,348	0	9,348
Total Current Assets	**4,806**	**0**	**4,806**	7,707	(302)	7,405	9,600	0	9,600
Current Liabilities									
Creditors Falling Due Within One Year	**(562)**	**0**	**(562)**	(303)	302	(1)	(426)		(426)
Provision for Liabilities and Charges	**(1,400)**	**1,400**	**0**	(364)	364	0	(963)	963	0
Net Current Assets	**2,844**	**1,400**	**4,244**	7,040	364	7,404	8,211	963	9,174
Total Assets before Non-current Liabilities	**16,253**	**1,400**	**17,653**	20,426	364	20,790	20,682	963	21,645
Non - Current Liabilities									
Provision for Liabilities and Charges	**(1,093)**	**1,093**	**0**	(2,856)	2,856	0	(2,627)	2,627	0
Total Net Assets	**15,160**	**2,493**	**17,653**	17,570	3,220	20,790	18,055	3,590	21,645
Funds of the Charity									
Restricted Income Funds	**157**	**0**	**157**	0	0	0	0	0	0
Unrestricted Income Funds	**13,597**	**2,493**	**16,090**	16,184	3,220	19,404	18,055	3,590	21,645
Revaluation Reserve	**1,406**	**0**	**1,406**	1,386	0	1,386	0	0	0
Total Charity Funds	**15,160**	**2,493**	**17,653**	17,570	3,220	20,790	18,055	3,590	21,645

Central Manchester University Hospitals NHS
NHS Foundation Trust

WE WOULD LIKE TO THANK EVERYONE WHO HAS CONTRIBUTED TO PRODUCING THIS ANNUAL REPORT.

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