University Hospital of South Manchester NHS
NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2010/11

UHSM
Your Hospital

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University Hospital of South Manchester NHS Foundation Trust Annual Report and Accounts 2010-11.

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

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01 About the Foundation Trust and Summary of 2010/11

The Board of Directors of the University Hospital of South Manchester NHS Foundation Trust (UHSM) presents this, its fifth formal Annual Report, to its Members, Governors and other stakeholders. The Report describes the organisation – and the Board's stewardship of it – from April 1, 2010 until March 31, 2011.

As a self-governing Foundation Trust, the Board of Directors has ultimate responsibility for the management of UHSM but is accountable for its stewardship to the Council of Governors and Members. UHSM performance is also scrutinised by the Foundation Trust regulator, Monitor, and the Care Quality Commission (CQC). UHSM is also accountable to Primary Care Trusts (PCTs) through legally binding contracts for both the level and quality of patient care services provided.

UHSM is a major acute teaching hospital providing services for adults and children at Wythenshawe Hospital and Withington Community Hospital. It is recognised as a centre of clinical excellence providing district general hospital services and specialist tertiary services to the local community and patients from across the north of England and beyond.

More people are choosing UHSM than ever before. In 2010/11 more than 550,000 patients were treated by our A&E department, attended as inpatients or as day-cases, or needed UHSM's outpatient services. These figures have risen considerably over the past two years.

UHSM was able to report compliance with the key regulatory targets throughout 2010/11. UHSM met the Emergency 4-Hour waiting time for the year despite significant increases both in attendance and admissions. During the same period, UHSM has achieved the referral-to-treatment targets for both non-admitted and admitted patients. UHSM is continuing to achieve the 18-Week targets during 2011-12. UHSM also met all the national cancer targets during 2010/11.

UHSM has, once again, reduced the number of hospital-acquired MRSA bloodstream infections or 'bacteraemias' (five cases against a limit of eight) and achieved a further significant reduction in cases of *C.difficile*, with 81 cases during the year. The limits for the year (2011/12) are challenging - no more than 3 MRSA bacteraemia and no more than 64 cases of *C.difficile*.

UHSM has implemented action plans, including increased screening for all admissions, a major award winning communications campaign to raise awareness of infection prevention among staff and the local community, and a thorough review of hand washing facilities, in pursuit of a strategy to eradicate all hospital-acquired infections.

UHSM's specialist expertise include cardiology and cardiothoracic surgery, heart and lung transplantation, respiratory conditions, burns and plastics, cancer and breast care services. These services are provided not only for the people of South Manchester, but help patients from across the North West and beyond.

UHSM is recognised in the region and nationally for the quality of teaching and professional development and in January 2010 launched the UHSM Academy. The Academy is the only organisation in the UK that has been created to pioneer a vision of education in health care that breaks down divisions between professions and brings together training and education.

UHSM is recognised as a centre of excellence for multidisciplinary research and development, and is proud to be a founding member of MAHSC (Manchester Academic Health Science Centre). Major research programmes focus on cancer, lung disease, wound management and medical education. UHSM clinicians are among the best in their fields. They

published more than 300 peer reviewed papers last year and made pioneering breakthroughs in key areas of treatment and prevention which are well documented within this Report.

Strengthening communications internally and building stronger links with the community we serve has been a priority for UHSM. Strong partnership arrangements have been established at senior executive level with Manchester City Council, Trafford MDC, the Northwest Regional Development Agency and Manchester Airport Group to ensure that that UHSM plays a key role in the social and economic regeneration of the Greater Manchester area. Over the past 12 months management has worked closely with Governors to promote UHSM's work and services. Relationships with local schools have been developed, particularly to raise awareness of infection prevention messages and good hand hygiene, especially during the time swine flu incidence was increasing. UHSM placed greater emphasis on partnerships with stakeholders on the annual Open Day, held in September, and attracted more than 1,500 visitors to the Wythenshawe Hospital site. UHSM has also introduced a monthly Farmers' Market, held within the hospital. And these are proving popular with patients, staff and the local community.

UHSM's long term strategy *Towards 2015* is designed to eradicate poor areas of performance for good. UHSM will ensure that every patient receives an outstanding level of quality and service when they need it. Over the past 12 months UHSM has been listening closely to what patients say and telling them what UHSM is doing to respond to complaints and suggestions. Staff are encouraged to make suggestions for improvements which are implemented wherever possible.

UHSM has approximately 5,500 valued staff, including those employed by Private Finance Initiative partner South Manchester Healthcare Limited. In recent years UHSM has consistently demonstrated sound financial management and during that last 12 months generated an annual revenue surplus of £4.46m. This surplus will be re-invested in UHSM services.

In the rest of this Report the Board of Directors explain how UHSM has performed during 2010-11 and its plans for 2011-12.

02 Chairman's Statement

UHSM has had a very good year. Colleagues across the Trust built on all the hard work of the previous twelve months and have secured significant improvements in services to patients in an increasingly challenging financial environment.

For the past three quarters of the year the Trust has been green rated for governance and hit all its targets. Hospital acquired MRSA infections have been reduced to 5 for the year and, despite a steep rise in the number of patients requiring emergency care, waiting times in A&E continue to be kept down to acceptable levels. The team's efforts have been widely recognised in an unprecedented number of awards which included being voted the overall winner of the Guardian Group's national public service awards. The overwhelming number of patients told us they received excellent care and treatment. But there were still a few people for whom the experience was less good which means there is still more to do to ensure every patient receives excellent care, every time.

UHSM is building a culture in which everyone is constantly looking for ways of improving what we do and how we do it. The leadership team is now dominated by doctors and nurses, who are taking on more and more of the decision-making, supported by a special business and leadership programme which UHSM has developed in partnership with the Manchester Business School.

Research and education are playing an increasingly important part in the life of the Trust. The more high quality research we do, the better the range of treatments we can offer to patients by teams of clinicians and other health professionals who are trained in the UHSM Academy which has expanded to offer the widest possible range of teaching and education to staff at every level within the Trust.

In 2009/10 the UHSM team laid the foundations for an integrated health care system shaped by the needs of the community but centred on the needs of the individual. During the past year we have begun to deliver this new vision.

We are already working with local GPs to treat more and more people outside of the hospital, and since April 2011, when we welcomed new colleagues from NHS Manchester's community services provider, we are integrating acute and community services. Joining forces with the community health team gives the Trust the opportunity to deliver many more of our services out in the community closer to patients' homes.

The new multi million pound maternity unit is only one of a number of major developments delivered in the past year to improve our patients' experience of the hospital. A centralised admissions lounge, GP assessment units, which enable GPs concerned about a patient to by pass A&E, are making significant improvements in the speed and efficiency with which we treat people. The radiology department has been totally modernised and transformed to ensure that the majority of patients receive their results on the day they have a scan or xray. The IT and Estate departments are constantly coming up with new ways of helping clinicians to deliver services more efficiently and effectively. Both have won awards for their innovations; as a result of the Estates programme to reduce energy costs, UHSM has been formally acknowledged as Britain's Greenest Hospital.

The hugely popular monthly farmer's market, live music on the stroke wards and many other imaginative schemes are bringing fun and laughter into the hospital to the great delight of patients and staff. Many of these initiatives are made possible by the tireless efforts of our 500 volunteers.

UHSM is fortunate to have an army of volunteers and charities all working to help make UHSM everyone's first choice.

Many colleagues have been busy helping others outside their normal jobs. Several members of staff returned recently from helping to run the world's busiest trauma centre at Camp Bastion in Afghanistan where they treated as many locals, especially children, as soldiers. Others have been out in Gulu, Northern Uganda where UHSM has teamed up with the local medical school to teach their young doctors and nurses.

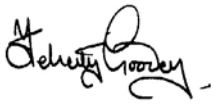
Our Governing Council plays a major role in helping to ensure that the services UHSM provides are meeting the needs of the communities we serve. The Council and its committees are valuable sources of ideas and advice as well as ensuring that the Board is accountable to the communities we serve.

The Board was sorry to lose one of its members Professor Chris Griffiths who had to stand down when he took on a new academic position. We have been fortunate to secure another clinical academic, Professor Martin Gibson, who joined the Board in November.

Much has been achieved but there remains a lot more to do. Like most acute hospitals, we face increasing financial pressures and I want to thank all colleagues for the way in which they have helped to drive down costs and inefficiencies at the same time as looking for more ways to enhance patient care. Some colleagues have left the Trust over the past year as we redesign and streamline our services. We will continue to look for ways to reduce costs but never at the expense of patient care. The Board has made it very clear that there must always be the right number and quality of staff to guarantee excellent patient care.

We are all aware of the many challenges and changes facing the NHS. I am particularly grateful to the Executive Team, for its leadership and commitment over recent months. UHSM's Chief Executive Julian Hartley was injured in a road traffic accident on 16 February 2011, and has been away convalescing for several months. His phased return to work begins in June. In the interim period NoraAnn Heery, already designated as the Deputy Chief Executive, has acted up as Acting Chief Executive and Acting Accounting Officer and the Deputy Director of Finance, David Jago, as Acting Director of Finance. This has brought significant pressures upon the executive Team, which has responded magnificently.

The Board is confident that the UHSM team, to be led again shortly by Chief Executive Julian Hartley, is equal to the challenge of delivering excellent care in the most challenging economic circumstances.



Felicity Goodey CBE, DL
Chairman

03 UHSM Strategy – '*Towards 2015'*

2010/11 was the second year of the delivery of our strategy 'Towards 2015' – a strategy designed to move UHSM towards becoming one of the best healthcare providers in the NHS.

'Towards 2015' describes how UHSM is no longer simply a centre of healthcare, but as a pioneer of health and well-being, building on UHSM's reputation for clinical excellence and working with local partners to improve and develop infrastructure. UHSM recognises that since the strategy 'Towards 2015' was developed in 2008/09, the operating environment in which UHSM finds itself has changed significantly. The NHS is facing the challenge of providing increasingly high quality care for less money; some of our partners, particularly in local government and the third sector, are facing even steeper challenges. However UHSM is confident that the key tenets of 'Towards 2015' can still be achieved in this changed environment.

- We see patient safety, quality and experience – 'Patient Care at Our Heart' as at the centre of all we do. This is the key theme of 'Towards 2015'. Our rates of infection have continued to tumble and our quality measures show continued improvement. Our patient feedback ranks us amongst the best in the NHS.
- Our colleagues are at the heart of our success, our 'One Talented Team'; which includes our partners in Sodexo and Atkins. We want to create a working environment which attracts and retains the best. In 2010 our rates of attendance, appraisal and training have all reached challenging targets. We have also continued the development and implementation of 'The South Manchester Way – the way we do things around here'. By articulating our core beliefs through 'The South Manchester Way', we are creating a new culture in UHSM, aligned to our ambition to become one of the best healthcare providers in the NHS.
- We strive for quality care which costs less – improving our processes, working with our colleagues to encourage innovation and service improvement. In 2010/11 we have continued to deliver significant improvements in the way we work, whilst at the same time reducing our costs. We have also seen the successful negotiation and transfer of over 400 members of community staff and their services into UHSM. These new colleagues, who work predominantly in the south of the city, will have a key role to play with our teams, shifting the emphasis of our care from hospital into the community.
- We want to improve our infrastructure and environment – investing where possible to enhance the patient experience. In 2010/11 we have invested over £16.5 million in new buildings, equipment and our environment, including the continued phased improvement of our new Maternity Unit. Our accolade as the 'Greenest Hospital in the NHS' was awarded following our investments in a range of sustainable energy sources and the efforts of colleagues across UHSM.
- We want to offer an unrivalled education and research offer, working with partners in Manchester Academic Health Science Centre and Manchester Universities and through our own UHSM Academy. In 2010/11 UHSM topped the Greater Manchester league table for the numbers of patients involved in research projects.

'Towards 2015' also articulated an ambition to look outside the walls of our traditional business for opportunities which would enhance the delivery of our core priority; outstanding patient care, helping us to become one of the best healthcare providers in the NHS. A key success in 2010/11 has been the announcement in the Budget of 2011, of the creation of a new Enterprise Zone, in which UHSM has a recognised role. Working with Manchester City Council, Manchester Airports Group and a number of local businesses, we have created a vision for a new biotechnology or 'Medi-Park' as part of 'Manchester Airport City'. This builds on existing research and education

strengths and place UHSM at its geographic heart. This is an exciting venture and one which fits comfortably with our ambitions in ‘Towards 2015’.

When we developed ‘Towards 2015’ we spent a significant amount of time listening to our partners, Governors and Members, as well as our patients, carers and local population. They were overwhelmingly positive about UHSM and the services we offer – but articulated an ambition which we reflected in our strategy for further improvement and investment.

Given this engagement, which continues through UHSM’s active Council of Governors, the Membership and local population, we believe that ‘Towards 2015’ remains a strong strategy which despite the challenges of an uncertain financial environment continues to be at the centre of how UHSM plans and operates.

The public sector is facing an unprecedented challenge to improve efficiency, reduce waste and meet an increasing demand for the services it offers. Whilst the NHS has not seen the large real term reductions in budget which other parts of the public sector are facing, our increasingly elderly patient population and the rising costs of new treatments and procedures mean that even with the small overall increases in the NHS budget, each organisation is faced with delivering high levels of efficiency. UHSM is not immune from these pressures and we take them extremely seriously.

We recognise that the financial climate may mean that we are not able to invest in all the improvements we would like to. Hence in 2011/12 we will formally review our progress against our ‘Towards 2015’ strategy in the light of the constraints and challenges we face and look to refine it within the new environment offered by the Health and Social Care Bill, to ensure it remains ‘fit for purpose’.

Since 2009, we have been developing a culture of awareness and action to prepare the organisation for the strategic challenges it faces. This has strong links into, 'The South Manchester Way; we are striving to build a culture where colleagues feel empowered to make improvements to the services they run, streamlining decision making and bureaucracy wherever possible. Under the banner, 'High Quality Care Costs Less', we have communicated widely with our colleagues and stakeholders; including patients and our local population; that by reducing waste, duplication, preventing infection and error, we can reduce our costs at the same time as improving and protecting the quality of the service we offer. In 2010/11, we set ourselves and achieved a target of delivering £12 million in efficiency savings - a target 70% higher than the previous year. The programme of efficiencies covered each part of the Trust, looking at process, procurement and our valuable workforce.

We embarked on a widespread and deep programme of communication and engagement highlighting that each action has a cost associated with it. From energy efficiency to better procurement, we have been able to reduce costs, without resorting to compulsory redundancies. Our programme continues in 2011/12 where we have a more ambitious target to deliver £17.5 million of cost savings. We have developed and communicated our plans with our colleagues and are confident we can work together to deliver these efficiencies going forward.

Operational improvements achieved through *Towards 2015* in 2010-11

Admission Lounge

Project commenced March 2010 – admission lounge became operational December 2010.

The primary objective of the Admission Lounge is to provide a facility in which patients can be safely prepared for surgery and transferred to theatre in a timely manner. It was also recognised that it would provide other benefits which included:

Improve the patient experience through the provision of a central location in which all patients would be reviewed by multi-disciplinary teams immediately prior to theatre transfer

- Improve the process for clinical teams providing an appropriate environment for the examination of patients.
- Enables ward staff to focus on discharges in the mornings, ensuring that beds are released at the earliest opportunity for both elective and non-elective patients
- Reduce the number of late starts in theatres and list over-runs.
- Reduce the number of cancellations on the day due to bed unavailability.

Since opening in December 2010 more than 2900 patients have been admitted to the lounge, either being directly transferred to theatre from there, or for those patients who are required to be admitted on the day before surgery, to a ward.

It is evident from feedback from clinical teams that the development of the Admission Lounge has had a positive impact. David Tansey (Consultant Anaesthetist) commented that *"My ongoing experience of the lounge has subsequently been very positive. I would say that seeing patients pre-operatively is a much easier process overall than the previous setup on the wards. The issues of capacity I anticipated seem to have been managed by good organisation. You and your staff are to be commended for achieving this"*

Mrs Anjali Alhuwalia (Consultant Obstetrician & Gynaecologist Clinical Director for Women and Children) commented: *"It is brilliant ! I do not have to go looking for patients on the ward, look for notes, worry about beds and am able to get on and see them all in one place rather than multiple wards. Patients come to theatre quickly as it is just round the corner Also it is a great opportunity to check WHO and VTE. Well done"*

In addition, the call reminder service for those patients who are expected to attend for admission has helped to ensure that 'Do Not Attends' and last minute cancellations are minimised. Developing the admission lounge supports the delivery of improvements for patients on a scheduled pathway of care. Effective admission processes that ensure patients are prepared for theatre in a safe and timely manner support the more efficient use of theatres.

The Productive Operating Theatre

Project commenced November 2010 – anticipated date of completion January 2012

As part of this programme each of the theatre teams identified the main factors which would support them in achieving a perfect theatre list. The top three issues that prevented them from doing this were identified and will become the focus of improvement over the forthcoming months. Specific theatres have been identified within each theatre suite and these theatres will be the pilot areas for improvement and allow testing of ideas/processes before this is shared more widely.

Each area has a *Knowing How We Are Doing Board* which contains information and allows staff to assess the impact of the changes made, in addition to providing data about theatre performance.

Two theatre teams have been undertaking a patient satisfaction questionnaire to better understand the patient experience of the admission process and their experience of theatre.

All theatre areas have begun to re-organise the way in which anaesthetic rooms are set out. This will ensure standardisation of these areas making it easier for staff to find items more quickly, manage stock levels more effectively and reduce the risk of equipment not being available. The costs savings that can be achieved through better management of stock and equipment are becoming more apparent. One of the nurses in Acute Theatres has identified savings of £19k per annum through rationalising the stock that is provided on one theatre tray alone.

Productive Ward Programme

Programme commenced May 2008 – anticipated date of completion Dec 2011

The aim of the Productive Ward programme is to release nursing time from activities that add less value to the quality of care that our patients experience, and re-direct this towards the delivery of direct care.

All ward areas have now commenced this programme of work and are in the process of implementing the various modules that will enable the teams to deliver care more effectively. A number of wards have completed all modules and can demonstrate that changing the ways in which the teams work has had a positive impact. A performance tool has been developed which is available on the intranet to enable progress to be monitored. A snapshot of some of the data being collated is provided in Table 3.1 below.

Table 3.1

Ward Code	Patient Satisfaction (baseline)	Patient Satisfaction (latest)	Staff well-being (baseline)	Staff well-being (latest)	Direct care time (baseline)	Direct care time (latest)
AA	72%	90%	57%	74%	63%	80%
BB	56%	65%	72%	76%	48%	71%
CC	65%	80%	38%	80%	35%	47%
DD	30%	85%	65%	66%	35%	62%

One ward has released approximately 1 hour direct patient care time per day following the implementation of the handover module. Before implementation staff on this ward were taking approx 45 minutes to complete the handover as shifts change. This has now been significantly reduced by introducing walk round handovers and incorporating the new tool into the handover process named Situation Background Assessment Recommendation (SBAR) which ensures that vital information is communicated whilst unnecessary duplication is avoided.

Another ward has implemented the admissions and discharge module of the Productive Ward Programme. The ward staff were able to identify delays with discharges and created a new role to assist nursing staff in the planning of safe and timely discharges. This allowed nursing staff to deliver more direct patient care and has lead to a reduction in length of stay from 22 days to 9.3 days for some patient groups.

In a third ward the working environment has been improved by completing the well organised ward module. Staff now find it quicker and easier to locate items, as everything has a place; this is reflected in the increase of patient direct care time from 48 to 71%.

The first team to complete the Productive Ward programme was nominated for Team of the Year in the 2010-11 Staff Awards.

Enhanced Recovery Programme

Project commenced December 2010 –anticipated date of completion December 2011

The Enhanced Recovery Programme (ERP) is about improving patient outcomes and speeding up a patient's recovery after surgery. It results in benefits to both patients and staff. The programme focuses on making sure that patients are active participants in their own recovery process. Outcomes of the enhanced recovery programme are:

- Better outcomes and reduced length of stay
- Increased numbers of patients being treated (if there is demand) or reduced level of resources necessary

The Colorectal Team at UHSM has been working on this initiative for since inception and launched the pathway for this group of patients in November 2010. Since then 60 patients have been treated on this pathway. The clinical team have collected comprehensive data on this group

of patients and are in the process of reviewing the outcomes. Early indications suggest a reduction in length of stay, which has been shown to enhance the speed and quality of recovery for patients, who prefer to be discharged as soon as possible.

These are just some of the improvements made for UHSM patients recently. We look forward to reporting in 12 months time on the additional improvements made.

04 Quality Report

Contents

The Quality Report[1] 2010/11 is an annual review of the quality of NHS healthcare services provided by the University Hospital of South Manchester NHS Foundation Trust (UHSM) during 2010/11 as well as the key priorities for quality improvement in 2011/12.

The Quality Report comprises three distinct sections. ***Section 4.1*** is a statement about what quality means to UHSM, signed by the Chief Executive. ***Section 4.2*** highlights the Trust's performance in 2010/11 compared to the priorities that were published in UHSM's second Quality Report, in 2009/10, as part of the Annual Report and Accounts. Priorities for improving the quality of services in 2011/12 that were agreed by the Board in consultation with stakeholders are set out in ***Section 4.2***. Legislated statements of assurance from the Board of Directors complete this section. The key priorities for quality improvement in 2011/12 are presented in ***Section 4.3***. Each priority is sub-divided into specific indicators and initiatives, which have been chosen to address local and national quality challenges.

A draft version of the Quality Report 2010/11 was shared with the external stakeholders in April 2011 as part of the assurance process. The stakeholders are: the host Primary Care Trust, NHS Manchester; Manchester Local Involvement Network (LINk) and Manchester City Council's Health and Wellbeing Overview and Scrutiny Committee. Each organisation was asked to review the draft report and provide a written statement for publication (unedited) in ***Annex One*** of this Quality Report. In the case of the host Primary Care Trust this is a statutory requirement.

The Statement of Directors' Responsibilities in respect of the Quality Report is published as ***Annex Two*** of this report.

The external auditor has provided a Limited Scope Assurance Report on the content of the Quality Report, as required by Monitor, the Independent Regulator of foundation trusts. The external auditor's report is included in ***Annex Three***.

[1] The Independent Regulator of NHS Foundation Trusts, Monitor requires the Trust to publish an annual report of its Quality Account (referred to as the Quality Report) as part of the Trust's Annual Report and Annual Accounts

4.1 Chief Executive's Statement

During 2010/11 we have continued to deliver our Strategy 'Towards 2015', which places quality of care, safety of care and an excellent patient experience at the core of our activities over the next few years. We deliver high-quality and safe care at UHSM, working to continually improve and to be a leading hospital within the NHS for quality and safety.

I make this statement to the best of my knowledge that the information contained in this report is accurate.

At the beginning of 2010/11 UHSM developed a monthly Quality Account, which enables the Board of Directors, the Council of Governors and the organisation to consistently monitor the quality of care that we provide to our patients. The Board of Directors endorsed the three priorities of **Patient Safety**, **Clinical Effectiveness** and **Improving the Patient Experience** that are set out in this report.

Our patients are at the centre of the Strategy for UHSM. They are at the heart of **The South Manchester Way**, the programme which sets the culture for UHSM and in which we are clear about the values and behaviours of our staff towards our patients and each other.

We aim to deliver healthcare services that are open to all, in an environment characterised by high-quality care, dignity and mutual respect. We are determined to ensure that we provide a flexible, responsive and accessible service to individual patients, which addresses health inequalities and the public health agenda.

In developing the Quality Account, we have engaged with our **staff**, **Governors** (as patient and community representatives) and **Local Involvement Network (LINk)** to ensure that we have a shared approach to our understanding of quality and safety and our actions to improve it.

In 2010/11UHSM made significant achievements in the quality of care we provide to our patients. We significantly reduced our infection rates and delivered the performance outcomes in relation to this. We introduced safer surgical checklists to all our surgical specialities and continued to implement our patient safety and experience programmes, which has seen our mortality rate continuously reduce.

The Trust is registered with the Care Quality Commission (CQC) and throughout 2010/11 remained compliant with the essential standards for safety and quality. In addition UHSM achieved all the governance indicators in Monitor's (the Trust's regulator) revised *Compliance Framework* for each quarter in 2010/11. The Trust's current governance risk rating is 'green' (no material concerns). The NHS Litigation Authority's (NHSLA) risk management standards are designed to improve the safety of care for patients and staff and address a range of organisational, clinical and Health & Safety risks identified through litigation. The Trust was re-assessed by the NHSLA during 2010/11 and achieved a planned Level 2 for Maternity Services and retained Level 3 for acute services demonstrating a high-level commitment to improve the safety of care and reduce risk.

Although we are pleased with our achievements we strive continuously to improve both the quality and safety of our care and want to share with you our story of continuous improvement in our annual Quality Account. I hope that you will see that we care about, and are improving, the things that you would wish to see improved at **'Your Hospital'**.

26th May 2011 Nora Ann Heery

…….. Date …… Signature

Nora Ann Heery
Acting Chief Executive, University Hospital of South Manchester NHS Foundation Trust
Signed for, and on behalf of the Board of Directors

4.2 Priorities for Improvement and Statements of Assurance from the Board of Directors

In this section the Trust's performance in 2010/11 is reviewed compared to the priorities that were published in UHSM's Quality Account in 2009/10. Priorities for improving the quality of services in 2011/12 that were agreed by the Board in consultation with stakeholders are set out in this section. Legislated statements of assurance from the Board of Directors complete *Section 4.2.*

4.2.1 Performance against Improvement Priorities in 2010/11

In the Quality Account 2009/10, UHSM presented its quality improvement priorities for 2010/11, which were agreed following extensive consultation with key stakeholders. Sixteen individual quality indicators were chosen to deliver the three priorities of reducing mortality, reducing harm and improving the patient experience. A summary of the Trust's performance for each of the quality indicators is presented in ***Table 4.1***. The time period of the results is April 2010 to March 2011 (referred to as 2010/11), unless otherwise stated in the text.

Table 4.1: Summary of performance against the quality improvement priorities in 2010/11

REDUCING MORTALITY	2010/11 Quality goals	2010/11 Results	Achieved
Reducing mortality	• inpatient mortality lower than expected levels, i.e. less than 100 RAMI (2010) (as set by the Risk-Adjusted Mortality Model); and	86 RAMI (2010)	✓
	• further develop the mortality monitoring and review process.	good progress made	✓

REDUCING HARM	2010/11 Quality goals	2010/11 Results	Achieved
Reducing rates of infection	• no more than 8 cases of hospital-acquired MRSA bacteraemia;	5 cases	✓
	• no more than 148 cases of *Clostridium difficile*;	81 cases	✓
	• 100% of emergency and elective admissions are screened for MRSA (all emergency patients to be screened by 1st January 2011); and	164.5%	✓
	• maintain 'excellent' PEAT scores across food/ hydration, Privacy & Dignity and cleanliness.	*excellent* score across all three categories (a)	✓
Recognising and responding to the signs of critical illness	• reduce avoidable non-Intensive Care Unit (ICU) cardiac arrests; and	(b)	-
	• achieve 100% coverage of Outreach and Modified Early Warning Score (MEWS).	100%	✓
New tools to improve communication	• implement the Situation Background Assessment Recommendation (S.B.A.R.) Tool as the structure for communications at hand-over of care, transfer of care and escalation of care.	100% implemented	✓
Preventing medication errors	• achieve more than 85% of medicines reconciled for every patient within	87%	✓

	48 hours.		
Preventing venous thromboembolism (VTE)	• achieve the national target of 90% compliance with risk assessment of venous thromboembolism (VTE) for all inpatients on admission to UHSM (Quarter 4).	83.5%	✗
Preventing harm from falls	• 90% of adult patients will have a falls risk assessment on admission; • 80% of adult patients will receive appropriate preventative intervention; • 80% of patients considered to need a falls risk review will receive one; and • there will be a reduction in the number of falls resulting in moderate or more severe injury.	89.5% 78.3% 74.9% a slight increase	✗ ✗ ✗ ✗
The World Health Organization's (WHO) Surgical Safety Checklist	• more than 95% of inpatients will have the World Health Organization's (WHO) Surgical Safety Checklist completer (Quarter 4).	98% (c)	✓
Global Trigger Tool	• two years of baseline data collection will finish in August 2011.	-	-
Preventing hospital-acquired pressure ulcers	• all patients to be risk assessed for pressure ulcers; this will be documented according to the Trust policy; and • monthly monitoring of hospital-acquired pressure ulcers commencing in April 2010. Baseline recording will take place in 2010/11.	92% ongoing audit programme in place	✗ ✓

***Improving the* PATIENT EXPERIENCE**	**2010/11 Quality goals**	**2010/11 Results**	**Achieved**
Advancing Quality Programme	• demonstrate reliable care by achieving regionally set compliance standards for the six focus areas: o five established focused areas; o stroke measure (introduced in October 2010).	- -	✓ ✗
Nursing indicators, Clinical Rounds and Essence of Care	• nursing indicators utilised and piloted on all wards; and • monthly meeting led by the Chief Nurse to review nursing indicators with performance reported to the Board.	further indicators being trialled Infection Prevention indicator in place - others to follow	✓ ✓
Clinical Effectiveness	• reduce the risk-adjusted average length-of-stay by 1.0 day for medical specialties; and • reduce the re-admission rate below the clinical peer rate of 4.8%.	reduced by 0.8 days increased slightly to 6.2%	✗ ✗
The Productive Ward Programme	• all wards to have commenced the Productive Ward Programme by April	commenced on all wards	✓

('releasing time to care')	2011; and • utilise the *'releasing time to care'* indicator as the quality outcome.	not applicable	✓
Gaining feedback from patients/ Responding to patient feedback	• 80% of complaints responded to within 25 working days;	70.5%	✗
	• 50% increase in the number of patients surveyed for all areas;	more mechanisms for feedback introduced	✓
	• UHSM to be in the top 20% of trusts across all categories in the National Patient Survey; and	(d)	-
	• at least 96% of patients would recommend UHSM.	96%	✓
Treating patients with dignity & respect	• over 95% of respondents saying that they did not share sleeping areas with a patient of the opposite sex in the local Patient Perception Survey;	90.2% (e) 99.3% (f)	✗ ✓
	• the Trust's Privacy & Dignity Policy is operational in all departments; and	policy is in place	✓
	• implement a process to identify when a patient is nursed in a mixed-sex area, thus enabling immediate action (and learning) to take place.	completed	✓

Notes to ***Table 4.1***

(a) the Trust received scores of *excellent* for food/ hydration, *excellent* for Privacy & Dignity and *excellent* for cleanliness in the National Patient Environment Action Team (PEAT) Assessment.

(b) analysis of the avoidable non-Intensive Care Unit (ICU) cardiac arrests continues with the results available in July 2011.

(c) UHSM achieved the internal target of 95% for Quarter 4 in the application of the World Health Organization's (WHO) Safer Surgical Checklist, however the Commissioning for Quality and Innovation (CQUIN) scheme target set by NHS Manchester of 100% for Quarter 4 (2010/11) was not quite achieved.

(d) the Trust is awaiting the release of the national benchmarking tool, which supports the analysis of the National Inpatient Survey.

(e) Patients were asked the following question in the local Patient Perception Survey (note: the percentage relates to the number of patients that responded 'No' to the question):
When you were first admitted to a bed on a ward did you ever share a sleeping area (e.g. bay/ room) with patients of the opposite sex?

(f) Patients were asked the following question in the local Patient Perception Survey (note: the percentage relates to the number of patients that responded 'No' to the question):
When you were moved to another ward, did you ever share a sleeping area (e.g. bay/ room) with patients of the opposite sex?

4.2.2 Priorities for Quality Improvement in 2011/12

Extensive consultation was carried out with patients, Governors, managers and clinical staff to develop the priorities for quality improvement in 2011/12. Feedback was received from Governors via the Trust's Patient Experience Committee and Council meetings. Information from patients was gathered from complaints, concerns, and other forms of feedback. UHSM's risk system provided an indication of the issues reported by staff. This consultation facilitated the development of the Trust's Patient Safety, Quality and Patient Experience programmes which describe a five-year programme of activity.

During 2010/11 UHSM has been delivering this programme of work and progress against the priorities has been shared on a monthly-basis with the Board of Directors and published monthly on the Trust's Website (since January 2011). Progress has also been discussed at every Council of Governors' Meeting and, via UHSM's Patient Experience Report, with the governing council's Patient Experience Committee.

In the last year the Trust met regularly with Manchester Local Involvement Network (LINk) and shared progress against the 2010/11 priorities using the monthly Quality Account. Progress has also been discussed at the monthly Healthcare Governance Committee with the Trust's clinical directorates. UHSM agreed that some key indicators from the Quality Account should form part of the Commissioning for Quality and Innovation (CQUIN) framework and the Trust has discussed progress against these on a quarterly basis with NHS Manchester (the local Primary Care Trust).

UHSM has shared its proposed priorities for 2011/12 with NHS Manchester, Manchester LINk, Manchester City Council's Health and Wellbeing Overview and Scrutiny Committee and the governing council's Patient Experience Committee. The Trust has taken the feedback received into account when developing its priorities for quality improvement for 2011/12:

Priority 1	Patient safety
Priority 2	Clinical effectiveness
Priority 3	*Improving the* Patient experience

A number of initiatives have been developed to support the delivery of these high-level priorities. Paramount to improving quality and patient experience is patient safety and over the past year considerable progress has been made through the established Patient Safety & Quality Programme. The quality improvement initiatives in 2011/12 are summarised in ***Annex Four*** together with the associated goals and methods for monitoring and reviewing progress through the year.

PATIENT SAFETY

UHSM has chosen ten quality improvement initiatives in 2011/12 from the Patient Safety priority.

The Trust has consistently delivered lower than expected ***mortality***, but aims to further improve mortality performance through the initiatives of its Patient Safety & Quality Programme. This priority was ranked as the second most important quality initiative by Manchester Local Involvement Network (LINk). ***Reducing rates of infection*** has been a key priority for the NHS; a priority which was reiterated in the Government White Paper *'Equity and Excellence: Liberating the NHS'*. MRSA and *Clostridium difficile* can cause illness and sometimes death; reducing healthcare-associated infections will lead to improved outcomes for patients and provide cost savings for the Trust. The Trust has planned a number of new initiatives for the next year in order to further reduce infection rates.

'Never Events' are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'. In 2010/11, the Trust considered the eight national 'Never Events' and the local 'Never Events' (as determined by its main commissioner, NHS Manchester) as part of its processes for the management and investigation of incidents. The learning, which followed from the investigation of a number of 'Never Events' in 2010/11 informed the development of the Trust's patient safety, quality and patient experience programmes in 2011/12.

In February 2011, the Department of Health published a new list of 'Never Events' following a consultation with NHS organisations. In response to this publication UHSM will carry out a review of all applicable 'Never Events' during 2011/12 to ensure that systems and controls are in place to minimise the risk of them occurring. The Trust's Patient Safety & Quality Programme is already helping to address some of the specific 'Never Events' through, for example, the work of the Safer Surgery Group.

Recognising and responding to the signs of critical illness will continue to be a core part of the Patient Safety & Quality Programme in 2011/12. Improving adherence to the Trust's Modified Early Warning Score (MEWS) Escalation Policy for cases of cardiac arrests and reducing serious incidents will be objectives for 2011/12. This priority was ranked as the third most important quality initiative by Manchester LINk.

Medicines reconciliation will remain as part of the quality improvement priorities in 2011/12 and the ***high-risk medications*** element of the programme will be expanded to include those drugs classified as high-risk in the Department of Health's 'Never Events' list (including potassium-containing fluids, chemotherapy, injectable medicines, wrong-route administration of medicines intended for enteral/ oral administration and epidurals).

The risk to patients in hospital of ***venous thromboemoblism (VTE)*** - deep vein thrombosis and pulmonary embolism - is now widely recognised. A national Commissioning for Quality and Innovation (CQUIN) target has been set for the second year for trusts to help emphasise the importance of reducing the risk of VTE to patients. Along with other acute trusts UHSM will be required to risk assess 90% of adult inpatients for venous thromboembolism on admission; a target which the Trust failed to meet in 2010/11. The Trust will continue to enhance and improve its systems for VTE risk assessment in 2011/12. There will also be more in-depth investigation and analysis of those patients who acquire VTE to understand if this could have been prevented and how the programme for prevention can, if necessary, be improved.

Preventing harm from falls remains a priority for UHSM in 2011/12. In 2010/11, UHSM reported 4.22 falls per 1,000 bed days compared to 4.27 falls per 1,000 bed days in 2009/10. Trust performance in both years was lower than the national average of 5.6 falls per 1,000 bed days reported in 2008/09 (although any direct comparison with national data is difficult because of lack of clarity about the methodology used). In the year ahead the Trust will establish the new Falls Intervention Tool, introduced in 2010, and support this with a continuing programme of training. A key area for attention will be implementation of the requirements of the National Patient Safety Agency (NPSA) alert issued in 2011, '*Essential care after the inpatient fall',* to help support improvements in the management and care of patients following a fall within the Trust.

UHSM will focus on adapting and establishing ***the World Health Organization's (WHO) Surgical Safety Checklist*** in radiology, catheter laboratories, bronchoscopy, endoscopy and the breast unit in 2011/12. In light of the 'Never Events' publication that includes amongst the 25 revised events wrong-site surgery, wrong implant/ prosthesis and retained foreign object post-operation, the Safer Surgery Group will undertake a review of current policies and checking procedures to ensure that current controls are robust.

The Institute for Healthcare Improvement's (IHI) ***Global Trigger Tool (GTT)*** has been developed as a means of identifying unintentional harm events. Monthly retrospective reviews of twenty healthcare records have been conducted at UHSM since August 2009 to help measure the

overall organisational level of harm. The reviews have been conducted in duplicate by an experienced clinical, multi-professional group consisting of medical, nursing and pharmacy staff. At the end of August 2011 the Trust will be in a position to analyse the GTT data collected since 2009 and will utilise this information to support a review of the Patient Safety & Quality Programme in 2011/12.

The Trust introduced a number of measures to improve the detection and management of ***pressure ulcers*** in 2010/11. These include a review of the Trust-wide policy, the development of an ongoing programme of audit, the development of a multi-professional group to consider issues relating to pressure ulcers and the development of a robust performance-monitoring framework. This priority will remain in place in 2011/12, because the Trust acknowledges that further work is required and that understanding the incidence of pressure ulcers in the Trust's new community services is important.

CLINICAL EFFECTIVENESS

UHSM has chosen two over-arching quality improvement initiatives in 2011/12 from the Clinical Effectiveness priority.

Consistently offering predictable, evidence-based care to patients is vitally important to the Trust and continued participation in the North West Region's quality improvement initiative ***'Advancing Quality'*** allows the Trust to demonstrate that it provides high-quality care in the six focus areas (Acute Myocardial Infarction, Coronary Artery Bypass Graft, Hip & Knee Replacement, Pneumonia, Heart Failure and Stroke). Advancing Quality is included in the programme of clinical audit for 2011/12 and is also part of the Patient Safety & Quality Programme. Current data indicates that UHSM is on course to meet the targets against the original indicators for 2010/11, but is narrowly failing to meet the target for the new stroke indicator. Achievement of the Stroke indicator will be a particular focus for 2011/12.

The Trust will continue to focus on ***nursing indicators, clinical rounds and Essence of Care*** during 2011/12. The Trust's Senior Nurse Clinical Rounds have provided a valuable source of assurance regarding the care that is delivered to patients and will continue to be developed, including in the community settings, and audited during 2011/12. The Trust has not completed the development of ward indicators, so this work will be finalised in 2011/12 in order to ensure that wards are able to report effectively against a range of quality measures. A review of the revised Essence of Care standards was undertaken during 2010/11 to ensure that the Trust was addressing these core elements in practice. Where gaps were identified, action plans have been put in place for 2011/12.

Improving the PATIENT EXPERIENCE

UHSM has chosen two over-arching quality improvement initiatives in 2011/12 from the *Improving the* Patient Experience priority.

In 2010/11 the Trust did not meet its complaints target which is an important element of the ***gaining feedback from patients and responding to patient feedback*** indicator. The Trust made a number of structural changes during 2010/11 which it believes will improve performance in this area. 2011/12 will see the launch of the Patient Experience Strategy *'Patient Care at our Heart, it's Everyone's Responsibility'* and monitoring its impact is a Trust priority. This priority was ranked as the fourth most important quality initiative by Manchester LINk. The eradication of mixed-sex accommodation (unless clinically justified) continues to be a key focus of the Trust and a critical element of its ***treating patients with dignity and respect*** agenda. This priority was ranked as the most important quality initiative by Manchester LINk.

4.2.3 Statements of Assurance from the Board of Directors

Review of Services

During 2010/11 the University Hospital of South Manchester NHS Foundation Trust provided and/ or sub-contracted 55 NHS services.

The University Hospital of South Manchester NHS Foundation Trust has reviewed all the data available to them on the quality of care in 55 of these services.

The income generated by the NHS services reviewed in 2010/11 represents 100 per cent of the total income generated from the provision of NHS services by the University Hospital of South Manchester NHS Foundation Trust for 2010/11.

UHSM provided the Care Quality Commission (CQC) with a list of its services as part of its registration process in 2010. This list of services was used as the basis for completing the *'review of services'* statement above. The Trust acknowledges that the depth of review of its services is varied, but has chosen to define a 'review of the quality of care' as having participated in one or more of the following reviews:

- clinical audit activity;
- cancer peer review;
- NHS Litigation Authority (NHSLA) assessment;
- internal audit activity;
- review of clinical outcome data (e.g. inpatient mortality, re-admissions, etc.); and
- risk management systems (Hospital Incident Reporting System, Root Cause Analysis, Serious Untoward Incidents).

A summary of the Trust's review of services for each of its 55 services is presented in ***Table 4.2***. Each one of the Trust's 55 services was subject to at least one of the reviews highlighted above. 47 of the services were subject to clinical audit activity and 11 services were subject to Cancer Peer Review in 2010/11. Clinical outcome data was reviewed for 46 of the 55 services using the CHKS benchmarking tools. Internal audits carried out in 2010/11 covered some of the following areas:

- infection prevention;
- privacy and dignity;
- cancer targets;
- Board reporting;
- risk management;
- data security; and
- fire prevention.

In addition a number of the Trust's services were subject to external review in 2010/11 as follows:

(a)	CQC/ Ofsted safeguarding and looked after children services	*(April 2010)*
(b)	Regional breast screening quality assurance	*(May 2010)*
(c)	UNICEF baby friendly initiative	*(June 2010)*
(d)	MHRA - Blood safety and quality regulations	*(September 2010)*
(e)	Human Tissue Authority visit (2 inspections)	*(October & November 2010)*
(f)	CQC/ Ofsted - Inspection of safeguarding children and looked after children (Emergency Department)	*(November 2010)*
(g)	NHSLA Risk Management Standards for Acute Trusts (Maternity)	*(November 2010)*
(h)	NHSLA Risk Management Standards for Acute Trusts	*(January 2011)*

The dates in parenthesis (unless stated otherwise) refer to the site visit

The following self-assessment audits were conducted in 2010/11:

(i) CQC - Meeting the physical health needs of those with mental health needs and learning disabilities *(data submitted in May 2010)*

(j) NHS North West Major Trauma Services *(data submitted in May 2010)*

(k) Human Tissue Authority self-assessment *(June 2010)*

(l) Royal College of Physicians national audit of dementia *(data submitted in July 2010)*

(m) Department of Health (Royal College of Physicians) - national audit of depression screen and management of NHS Staff on long-term sickness absence *(data submitted in July 2010)*

(n) Dr. Foster Hospital Guide *(data submitted in September 2010)*

(o) Human Tissue Authority audit *(data submitted in September 2010)*

(p) National Confidential Enquiry into Patient Outcome and Death (NCEPOD) peri-operative care *(data submitted in March 2011)*

(q) CQC Support for families with disabled children *(data submitted in February 2011)*

The dates in parenthesis (unless stated otherwise) refer to the publication date of the report

A number of Trust-wide external reviews were carried out in 2010/11. These reviews are not considered sufficiently focused to constitute a review of the quality of care for particular services. Nonetheless, they detail reviews which took place in 2010/11 and cover elements of the quality of care across the Trust:

- National Inpatient Survey 2010/11 *(July 2010)*
- Internal PEAT assessment *(July, October, December 2010)*
- External PEAT assessment and external validation by a local hospital trust as per NPSA guidance *(February 2011)*
- Same-sex accommodation ward estate return *(data submitted in May 2010)*
- Internal Audit review of Privacy & Dignity *(July 2010)*
- Same-sex accommodation (Privacy & Dignity) - Strategic Health Authority audit *(November 2010)*

The dates in parenthesis (unless stated otherwise) refer to the publication date of the report

The Trust will use the list of services, provided to the CQC, as the basis for its review of services in future years thus ensuring that each service area is subject to an annual review of its quality of care.

Table 4.2: Summary of the quality of services review, 2010/11

	Service	Clinical Audit activity	Cancer peer review	NHSLA assessment	Internal Audit activity	Clinical outcome data	Risk management systems
1.	Allergy	●		●	●	●	●
2.	Anaesthetics	●		●	●	●	●
3.	Anticoagulant service	●		●	●	●	●
4.	Aspergillosis			●	●	●	●
5.	Audiology (non-consultant)			●	●		●
6.	Breast Surgery	●	●	●	●	●	●
7.	Cardiology	●		●	●	●	●
8.	Cardiothoracic Surgery	●		●	●	●	●
9.	Chemical Pathology			●	●	●	●
10	Clinical Haematology	●		●	●	●	●
11.	Clinical Immunology			●	●		●
12.	Clinical Oncology	●		●	●	●	●
13.	Clinical Psychology			●	●		●
14.	Dermatology		●	●	●	●	●
15.	Diabetic Medicine	●		●	●	●	●
16.	Dietetics	●		●	●	●	●
17.	Ear Nose and Throat	●	●	●	●	●	●
18.	Endocrinology	●		●	●	●	●
19.	Gastroenterology	●		●	●	●	●
20.	General Medicine	●		●	●	●	●
21.	General Surgery	●	●	●	●	●	●
22.	Geriatric Medicine	●		●	●	●	●
23.	Gynaecological Oncology	●	●	●	●	●	●
24.	Gynaecology	●	●	●	●	●	●
25.	Haematology	●		●	●	●	●
26.	Medical Oncology	●		●	●	●	●
27.	Midwifery	●		●	●	●	●
28.	Nephrology			●	●	●	●
29.	Neurology	●		●	●	●	●
30.	Obstetrics	●		●	●	●	●
31.	Occupational Therapy			●	●		●
32.	Oral Surgery	●	●	●	●	●	●
33.	Orthodontics	●		●	●	●	●
34.	Orthotics	●		●	●		●
35.	Paediatric Cardiology	●		●	●	●	●
36.	Paediatric Neurology	●		●	●	●	●
37.	Paediatric Surgery	●		●	●	●	●
38.	Paediatric Urology	●		●	●	●	●
39.	Paediatrics	●		●	●	●	●
40.	Pain Management	●		●	●	●	●
41.	Palliative Medicine	●		●	●	●	●
42.	Pharmacy	●		●	●		●
43.	Physiotherapy	●		●	●		●
44.	Plastic Surgery (incl. Burns)	●	●	●	●	●	●
45.	Radiology	●		●	●	●	●
46.	Respiratory Medicine	●	●	●	●	●	●
47.	Rheumatology	●		●	●	●	●
48	Speech & Language Therapy	●		●	●		●
49.	Thoracic Surgery	●	●	●	●	●	●
50.	Thyroid	●		●	●	●	●
51.	Transplantation Surgery	●		●	●	●	●
52.	Trauma & Orthopaedics	●		●	●	●	●
53.	Urology	●	●	●	●	●	●
54.	Vascular Surgery	●		●	●	●	●
55.	Voice	●		●	●		●

Participation in Clinical Audits

During 2010/11, 44 national clinical audits and 3 national confidential enquiries covered NHS services that University Hospital of South Manchester NHS Foundation Trust provides.

During 2010/11 University Hospital of South Manchester NHS Foundation Trust participated in 95.7% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries, which it was eligible to participate in.

The national clinical audits and national confidential enquiries that University Hospital of South Manchester NHS Foundation Trust was eligible to participate in during 2010/11 are as follows:

1. Perinatal Mortality (CEMACH)
2. Neonatal Intensive and Special Care (NNAP)
3. Paediatric Pneumonia (British Thoracic Society)*
4. Paediatric Asthma (British Thoracic Society)*
5. Paediatric Fever (College of Emergency Medicine)
6. Childhood Epilepsy (RCPH National Childhood Epilepsy Audit)
7. Diabetes (RCPH National Paediatric Diabetes Audit)
8. Emergency use of Oxygen (British Thoracic Society)
9. Adult Community Acquired Pneumonia (British Thoracic Society)
10. Non-Invasive Ventilation (British Thoracic Society)
11. Pleural Procedures (British Thoracic Society)
12. Cardiac Arrest (National Cardiac Arrest Audit)
13. Vital Signs in Majors (College of Emergency Medicine)
14. Adult Critical Care (Case Mix Programme)
15. Potential Donor Audit (NHS Blood and Transplant)
16. Diabetes (National Adult Diabetes Audit)
17. Heavy Menstrual Bleeding (RCOG National Audit of HMB)
18. Chronic Pain (National Pain Audit)
19. Ulcerative Colitis & Crohn's Disease (National IBD Audit)
20. Parkinson's Disease (National Parkinson's Audit)
21. COPD (British Thoracic Society/ European Audit)
22. Adult Asthma (British Thoracic Society)
23. Bronchiectasis (British Thoracic Society)
24. Hip, Knee and Ankle Replacement (National Joint Registry)
25. Elective Surgery (National PROMs Programme)
26. Cardiothoracic Transplantation (NHSBT UK Transplant Registry)
27. Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)
28. Peripheral Vascular Surgery (VSGBI Vascular Surgery Database)
29. Carotid Interventions (Carotid Intervention Audit)
30. CABG and Valvular Surgery (Adult Cardiac Surgery Audit)
31. Familiar Hypercholesterolaemia (National Clinical Audit of Mgt of FH)
32. Acute Myocardial Infarction & Other ACS (MINAP)
33. Heart Failure (National Heart Failure Audit)
34. Acute Stroke (SINAP)
35. Stroke Care (National Sentinel Stroke Audit)
36. Renal Colic (College of Emergency Medicine)
37. Lung Cancer (National Lung Cancer Audit)
38. Bowel Cancer (National Bowel Cancer Audit Programme)
39. Head & Neck Cancer (DAHNO)
40. Hip Fracture (National Hip Fracture Database)
41. Severe Trauma (TARN)
42. Fall and Non-hip Fractures (national Falls & Bone Health Audit)
43. National Audit of Dementia
44. O Neg Blood Use (National Comparative Audit of Blood and Transfusion)
45. Platelet Use (National Comparative Audit of Blood and Transfusion)

46. Surgery in Children Study (NCEPOD Study)
47. Perioperative Care Study (NCEPOD Study)
48. Cardiac Arrest Procedures Study (NCEPOD Study)

* notice of these audits came late to the Trust, and so participation in 2010/11 was not possible. The Trust has now registered for engagement and intends to fully participate in 2011/12.

The Trust has routinely submitted clinical data to the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and the Centre for Maternal and Child Enquiries (CMACE). Processes are established to respond to reports and key recommendations from these, and other national confidential enquiries.

The national clinical audits and national confidential enquiries that University Hospital of South Manchester NHS Foundation Trust participated in, and for which data collection was completed during 2010/11, 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.

*List of Acronyms to **Table 4.3:***

CEMACH	Confidential Enquiry into Maternal and Child Health
DAHNO	Data for Head and Neck Oncology
MINAP	Myocardial Ischaemia National Audit Project
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NHSBT	NHS Blood and Transplant
NICOR	National Institute for Clinical Outcomes Research
NNAP	National Neonatal Audit Programme
RCOG	Royal College of Obstetricians and Gynaecologists
RCPH	Royal College of Paediatrics and Child Health
SINAP	Stroke Improvement National Audit Programme
TARN	Trauma Audit and Research Network
VSGBI	Vascular Society of Great Britain and Ireland

Notes to Table 4.3:

(a) Recruitment of patients undergoing hernia repair and procedures for varicose veins to the national Patient Reported Outcome Measures (PROMs) study was a new initiative in 2010/11. Indentifying the appropriate step in the patient journey for patients to be introduced to the study initially proved difficult; this issue was not unique to UHSM. There was also reluctance on behalf of patients to participate in this study, due to the complex nature of the questionnaire and requirement for additional consent arrangements. These initial difficulties are now resolved. An appropriate step in the patient journey was identified and clinical staff were given additional support to address patient concerns. Take-up rates have now improved, as a consequence of this action, though they will always be dependent on patients agreeing to participate.

(b) Data provided by the Multi-disciplinary Team (MDT) meeting of patients 'first seen' at the Trust is entered on the national database as part of the National Lung Cancer Audit (NLCA). As a tertiary centre there are difficulties in identifying all relevant patients. A lung cancer pathway co-ordinator is tasked with identifying all patients that are first seen within the Trust. Although there is still a discrepancy about the number of patients the audit expects to be first seen by the Trust and what is believed to be the complete figure, the Trust has improved compliance and is now recruiting double the number of patients.

(c) Data submission to the Trauma Audit and Research Network (TARN) Project was lower than expected, due to difficulties in accurately identifying appropriate cases. This issue was identified in April 2011 and the Trust is now working with technical staff from TARN to remedy the situation, with full data expected to be submitted by summer 2011.

Table 4.3: Review of Trust participation in relevant national clinical audit and national confidential enquires in 2010/11

	Audit	% of cases submitted
1.	CEMACH: Perinatal mortality	100%
2.	NNAP: Neonatal intensive and special care	100%
3.	College of Emergency Medicine: Paediatric fever	100%
4.	RCPH National Childhood Epilepsy Audit: Childhood epilepsy	100%
5.	RCPH National Paediatric Diabetes Audit	100%
6.	British Thoracic Society: Emergency use of oxygen	100%
7.	British Thoracic Society: Adult community-acquired pneumonia	100%
8.	British Thoracic Society: Non-invasive ventilation	100%
9.	British Thoracic Society: Pleural procedures	100%
10.	National Cardiac Arrest Audit: Cardiac arrest	100%
11.	College of Emergency Medicine: Vital signs in majors	100%
12.	Case-mix Programme: Adult critical care	100%
13.	NHS Blood and Transplant: Potential donor audit	100%
14.	National Adult Diabetes Audit: Diabetes	100%
15.	RCOG: National Audit of Heavy menstrual bleeding (HMB)	100%
16.	National Pain Audit: Chronic pain	100%
17.	National Inflammatory Bowel Disease (IBD) Audit: Ulcerative colitis & Crohn's Disease	100%
18.	National Parkinson's Audit: Parkinson's Disease	100%
19.	British Thoracic Society/ European Audit: Chronic Obstructive Pulmonary Disease (COPD)	100%
20.	British Thoracic Society: Adult asthma	100%
21.	British Thoracic Society: Bronchiecstasis	100%
22.	National Joint Registry: Hip, knee and ankle replacement	100%
23.	National PROMs Programme: Elective surgery	42.6% (a)
24.	NHSBT UK Transplant Registry: Cardiothoracic transplantation	100%
25.	NICOR Adult Cardiac Interventions Audit: Coronary angioplasty	100%
26.	VSGBI Vascular Surgery Database: Peripheral Vascular Surgery	100%
27.	Carotid Intervention Audit: Carotid interventions	100%
28.	Adult Cardiac Surgery Audit: CABG and valvular surgery	100%
29.	National Clinical Audit of Mgt of Familiar hypercholesterolaemia (FH)	100%
30.	MINAP: Acute myocardial infarction & other ACS	100%
31.	National Heart Failure Audit: Heart failure	75%
32.	SINAP: Acute stroke	100%
33.	National Sentinel Stroke Audit: Stroke care	100%
34.	College of Emergency Medicine: Renal colic	100%
35.	National Lung Cancer Audit: Lung cancer	50% (b)
36.	National Bowel Cancer Audit Programme: Bowel cancer	100%
37.	DAHNO: Head & Neck cancer	100%
38.	National Hip Fracture Database: Hip fracture	100%
39.	TARN: Severe fracture	30% (c)
40.	National Falls & Bone Health Audit	100%
41.	National Audit of Dementia	100%
42	National Comparative Audit of Blood and Transfusion: O negative blood use	100%
43.	National Comparative Audit of Blood and Transfusion: Platelet use	100%
44.	NCEPOD Study: Surgery in children study	100%
45.	NCEPOD Study: Peri-operative care study	100%
46.	NCEPOD Study: Cardiac arrest procedures study	100%

Data source: Clinical Audit Programme and final reports
This data is governed by standard national definitions

The reports of 24 national clinical audits were reviewed by the provider in 2010/11 and University Hospital of South Manchester NHS Foundation Trust intends to take the following actions to improve the quality of health care provided:

The Clinical Effectiveness Department facilitates the participation in projects and monitoring of reports that result from national clinical audits. In response to the audit findings, UHSM has taken the following actions to improve the patient safety and quality outcomes:

National cancer audits	results and key findings are discussed at clinical governance protected-time meetings data completion in the National lung Cancer Audit was improved by identifying tertiary referrals
Myocardial Infarction National Audit Project	clinical teams were supported to improve the data quality to 100% in a single area
National Falls and Bone Health in Older People	as part of the ongoing development of the falls pathway, a new Falls Intervention Assessment Tool was introduced in 2010/11
National Stroke Audit	the Stroke Outreach Team now covers the Emergency Department and acute wards to expedite admission to the Stroke Unit
Audit Recommendations and Outcomes	devolved a process for relevant clinical directors to brief Healthcare Governance Committee as to key findings and recommendations of audit reports and any local actions required

The reports of 12 local clinical audits were reviewed by the provider in 2010/11 and University Hospital of South Manchester NHS Foundation Trust intends to take the following actions to improve the quality of health care provided:

More than 200 local clinical audit projects were carried out in 2010/11. The Trust has reviewed the reports and implemented action plan, where required, to improve the quality of services. Approximately one-third of the project reports were discussed at the relevant clinical governance protected-time meetings. Actions for improvement were implemented by the clinical directorates. Further details of the local clinical audits carried out in 2010/11 can be found in the Trust's Annual Clinical Audit Report, which is available from the Department of Clinical Effectiveness, Wythenshawe Hospital, after June 2011.

Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by University Hospital of South Manchester NHS Foundation Trust in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 19,120.

The figure of 19,120 is based on the Comprehensive Local Research Network (CLRN) records in 2010/11, and represents a 259 per cent increase on 2009/10 recruitment levels. This increasing level of participation in clinical research demonstrates UHSM's commitment to improving the quality of care it provides to patients as well as making a significant contribution to wider health improvement.

The Trust was involved in conducting 257 clinical research studies in 2010/11. It used national systems to manage the studies in proportion to risk. The average approval time for new studies through the Centralised System for Obtaining Research Permissions was 92 days in 2010/11. Over 90 per cent of the commercial studies were established and managed under national model agreements and 100 per cent of the honorary research contracts issued were through the Research Passport Scheme.

In the last three years, over 900 publications have resulted from the Trust's involvement in National Institute for Health Research (NIHR) research, helping to improve patient outcomes and experience across the NHS.

Goals Agreed with Commissioners

A proportion of University Hospital of South Manchester NHS Foundation Trust income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between University Hospital of South Manchester NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2010/11 and for the following 12 month period are available electronically at: http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

A value of £3.8m of University Hospital of South Manchester NHS Foundation Trust's income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body that they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework (CQUIN). The Trust received £3.0m in income in 2010/11 for the associated CQUIN payment.

Care Quality Commission Statement

University Hospital of South Manchester NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered to carry out regulated activities at the locations specified. University Hospital of South Manchester NHS Foundation Trust has the following conditions on registration: none.

The Care Quality Commission has not taken enforcement action against University Hospital of South Manchester NHS Foundation Trust during 2010/11.

University Hospital of South Manchester NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2010/11.

Data Quality

NHS Number and General Medical Practice Code Validity

University Hospital of South Manchester NHS Foundation Trust submitted records during 2010/11 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was: 99.6% for admitted patient care; 99.9% for outpatient care; and 98.1% for accident and emergency care.

- which included the patient's valid General Practitioner Registration Code was 100.0% for admitted patient care; 100.0% for outpatient care; and 100.0% for accident and emergency care.

Information Governance Toolkit Attainment Levels

University Hospital of South Manchester NHS Foundation Trust's Information Governance Assessment Report overall score for 2010/11 was 71% and was graded red. The Trust, however met at least Level 2 in all 22 key requirements as required by the independent regulator, Monitor.

Actions to Improve Data Quality

University Hospital of South Manchester NHS Foundation Trust will be taking the following actions to improve data quality:

- introduction of new key quality indicators such as Admission, Discharge and Transfer (ADT) monitoring, Referral-to-Treatment (RTT) data collection, clinical systems Key Performance Indicators (KPIs), admission lounge KPIs, Clinical coding performance & quality indicators;
- introduction of a robust clinical coding audit programme, monitoring and improving the quality of clinically coded data at individual coder and specialty level;
- recruitment of a 'specialised mortality coder' to work with clinicians to validate and 'sign off' every coded death;
- centralisation of the clinical coding team to incorporate obstetric coders, ensuring that all coders have access to up-to-date guidance and training opportunities;
- delivery of a data quality audit programme covering the following areas: audit of Did Not Attends (DNAs), re-admissions and clinical coding;
- establishment of data quality and audit plans for all trust-wide systems and risk assessment of each system; and
- implementation of an Information Quality Assurance Group to oversee the following: the Data Quality Scorecard (internal report), Data Quality on the Secondary Uses Service (SUS), NHS Number coverage, GP registrations etc., Payment by Results (PbR) versus SUS reconciliation, monitoring of contractual performance and quality measures, contract variations and contract challenges.

Clinical Coding Error Rate

University Hospital of South Manchester NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission. The error rates reported in an external audit carried out in January 2011 for clinical coding of diagnoses and treatment were:

Table 4.4: error rates for clinical coding of diagnoses and treatment

Primary Diagnosis:	11.0%
Secondary Diagnosis:	8.5%
Primary Procedure:	9.5%
Secondary Procedure:	11.3%

Data source: External audit carried out by a Connecting for Health approved auditor, the Audit Commission. This data is governed by standard national definitions

The results of this external audit carried out by the Audit Commission should not be extrapolated further than the actual sample audited. In terms of clinical coding accuracy, primary diagnosis, secondary diagnosis and primary procedure are all above the national benchmark when compared to the latest Audit Commission's Payment by Results Assurance Framework results from 2009/10. The accuracy of secondary procedure coding is slightly behind the benchmark. An action plan is being implemented to address the shortfalls identified. This includes additional training and awareness sessions for clinical coders.

4.3. Selected Priorities and Proposed Initiatives in 2011/12

UHSM's three priorities for 2011/12, patient safety, clinical effectiveness and *improving the* patient experience, and the initiatives chosen to deliver these priorities were established as a result of extensive consultation with patients, Governors, managers and clinical staff. UHSM has shared its proposed priorities for 2011/12 with NHS Manchester, Manchester LINk, Manchester City Council's Health and Wellbeing Overview and Scrutiny Committee and the governing council's Patient Experience Committee. The Trust has taken the feedback received into account when developing its priorities for quality improvement for 2011/12.

Priority 1	Patient safety
Priority 2	Clinical effectiveness
Priority 3	*Improving the* Patient experience

The initiatives, chosen to deliver the three priorities in 2011/12 are outlined in ***Figure 4.1***. 2010/11 performance against the 2011/12 initiatives and the associated goals for 2011/12 are included in this section of the Quality Account.

Figure 4.1: Summary of quality initiatives to be implemented in 2011/12

PATIENT SAFETY	**Reducing mortality** **Reducing rates of infection** **National 'Never Events'** **Recognising and responding to the signs of critical illness** **Preventing medication errors** **Reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE)** **Preventing harm from falls** **The World Health Organization's (WHO) Safer Surgery Checklist** **The Global Trigger Tool** **Preventing hospital-acquired pressure ulcers**
CLINICAL EFFECTIVENESS	**Advancing Quality Programme** **Nursing indicators, Clinical Rounds and Essence of Care**
Improving the PATIENT EXPERIENCE	**Gaining feedback from patients & responding to patient feedback** **Treating patients with dignity & respect**

Also included in the section which follows is performance for 2010/11 initiatives not chosen as 2011/12 initiatives. The rationale for the de-selection of these initiatives is detailed. The following are not included as initiatives in 2011/12:

- **Clinical Effectiveness** (length-of-stay and re-admissions) - not included as an initiative in 2011/12;
- **The Productive Ward Programme** - included *(in part)* in Recognising and responding to the signs of critical illness; and
- **New Tools to Improve Communication** - included *(in part)* in Recognising and responding to the signs of critical illness.

PRIORITY 1 PATIENT SAFETY

Reducing Mortality

Description of issues and rationale for prioritising

UHSM continues to work hard to reduce inpatient mortality through a number of initiatives as part of the Patient Safety & Quality Programme. This includes prevention of infection, reducing harm from falls, responding to the signs of critical illness and preventing venous thromboembolism (VTE).

The priorities for 2011/12 build on the Trust's success during 2010/11, with continued progress being made in reducing mortality and in strengthening the internal process for review of patient care. In addition, the Trust will aim to improve the quality of the clinical and administrative data, which underpins mortality, bringing greater confidence to the Board of Directors, clinicians, patients and commissioners.

Risk adjustment models, such as the Risk-adjusted Mortality Index (RAMI) undergo periodic re-calibration to account for improvements in technology, clinical techniques and improving outcomes. The effect of this re-calibration is to raise the position of the peer average by 12 points and the Trust by 10 points on the index. RAMI (2011) will be used to monitor inpatient mortality in 2011/12.

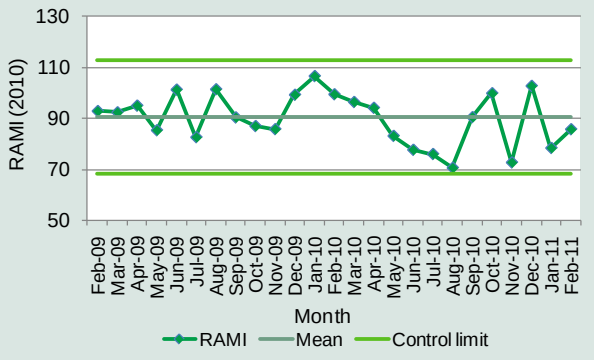
Goals *for* 2011/12

achieve a 2% reduction in the Risk-adjusted Mortality Index (RAMI 2011) compared to a baseline of 97 (March 2010 to February 2011).

2010/11 Performance

UHSM achieved a Risk-adjusted Mortality Index (RAMI 2010) of 86 during the period March 2010 to February 2011 (the latest available month), which indicates 14% less mortality than expected. It represents 199 'saved lives', which is determined by the difference between 'observed' and 'expected' mortality. This is an improvement in performance compared to 2009/10 when a RAMI (2010) of 94 was achieved, i.e. 6% less mortality than expected. The RAMI (2010) of the clinical peer group for the period March 2010 to February 2011 was 80. ***Figure 4.2*** indicates a reducing trend in RAMI (2010) over the 25-month period.

Figure 4.2: Risk-Adjusted Mortality Index (RAMI 2010), Feb-09 to Feb-11



Data source: CHKS Risk-adjusted Mortality Tool.
This data is not governed by standard national definitions.

Initiatives completed during 2010/11

Some of the initiatives implemented in 2010/11 to achieve quality goals are summarised below:

1. independent critical review of quality of care and patient management in selected cases of inpatient mortality;
2. monthly review of inpatient mortality data led by the Executive Medical Director has resulted in improvements in data quality;
3. summary mortality data reported to the Healthcare Governance Committee; and
4. clinical specialties supported to undertake local mortality and morbidity reviews.

Initiatives to be implemented in 2011/12

In 2011/12, a number of initiatives will be introduced to achieve the improvement goal:

1. ensure a uniform approach to mortality and morbidity is adopted within local teams;
2. the Patient Safety Team will work with Clinical Directors to ensure that they receive mortality information specific to their needs;
3. participate in the Dr. Foster Global Comparators 'benchmarking' project with 30 other acute trusts from the US, UK and Europe to share learning and deliver improvements in mortality; and
4. the Information Team will establish a dedicated mortality coder and implement a sign-off process whereby data is agreed by the discharging clinician.

Board Sponsor

Mr Brendan Ryan, Executive Medical Director

Implementation Lead

Mrs Kathleen Hingley, Head of Patient Safety & Quality

Project Lead

Mr David Watson, Head of Clinical Effectiveness

PRIORITY 1 PATIENT SAFETY

Reducing Rates of Infections

Description of issues and rationale for prioritising

Improving infection-prevention practices and further reducing infection rates continues to be a priority for UHSM in 2011/12. Infection prevention as *'everyone's responsibility'* is part of the UHSM culture. It is also important that the Trust provides a safe, clean and well-maintained environment. In addressing this, the Trust will work closely with its Private Finance Initiative (PFI) Partners to address any shortcomings highlighted from the quartlerly Patient Environment Action Team (PEAT) assessments.

Goals *for* 2011/12

(a) no more than 3 cases of hospital-acquired MRSA bacteraemia;
(b) no more than 64 cases of *C. difficile*; and
(c) maintain 'excellent' PEAT scores across food/ hydration, Privacy & Dignity and cleanliness.

2010/11 Performance

Improvements made in 2009/10 have been sustained resulting in the second year that UHSM has achieved its Healthcare-associated Infection (HCAI) trajectories for both MRSA bacteraemia and incidences of *Clostridium difficile*. In the last two years, the Trust has reduced hospital-acquired MRSA bacteraemia by 74% and *Clostridium difficile* by 46%.

In 2010/11, the Trust reported 5 cases of MRSA bacteraemia against a threshold of 8 cases. Similarly, there were 81 cases of *Clostridium difficile* reported compared to the threshold of 148 cases.

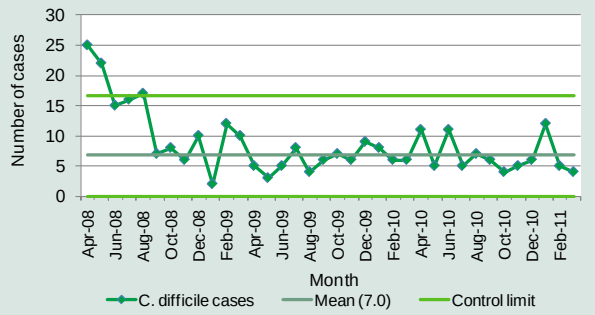
Table 4.5: incidence of MRSA bacteraemia

	08/09	09/10	10/11
Hospital-acquired	13	8	5
Community-acquired	13	10	5
Total cases	**26**	**18**	**10**
Threshold*	19	18	8

Data source: Department of Health HCAI Data Capture System. This data is governed by standard national definitions.

* Note: the threshold relates to hospital-acquired MRSA bacteraemia only

Figure 4.3: incidence of *Clostridium difficile*



Data source: Department of Health HCAI Data Capture System. This data is governed by standard national definitions.

Initiatives completed during 2010/11

Some of the initiatives implemented in 2010/11 to support achievement of the quality-improvement goals are summarised below:

1. introduction of an infection prevention e-learning package;
2. revision of root cause analysis tools for both MRSA bacteraemia and *C. difficile*;
3. introduction of MRSA screening for all relevant emergency admissions; and
4. success in attaining NHSLA Level 3 in 2011 for infection prevention standards.

Initiatives to be implemented in 2011/12

In 2011/12, a number of initiatives will be introduced to achieve the improvement goals:

1. continue to strengthen relationships and work closely with PFI Partners and external agencies;
2. continue monthly Infection Prevention Performance Meetings with representation from all clinical directorates;
3. work closely with the clinical directorates to monitor infection-prevention standards, practices and infection rates;
4. review the Infection Prevention Policy Manual;
5. complete the Infection Prevention Annual Audit Plan; and
6. review and update all infection prevention training and development packages in line with current national and local guidelines. Incorporate the changes to accommodate the newly-acquired community services.

Board Sponsor

Mrs Mandy Bailey, Chief Nurse

Implementation Lead & Project Lead

Mrs Jay Turner-Gardner, Head of Nursing, Infection Prevention and Control

PRIORITY 1 PATIENT SAFETY

Recognising and Responding to the Signs of Critical Illness

Description of issues and rationale for prioritising

Evidence from the Trust's local and national risk systems indicates that patient deterioration remains an important safety issue for UHSM. Early recognition of the deteriorating patient and prevention of avoidable cardiac arrest will again be a key feature of UHSM's Patient Safety & Quality Programme in 2011/12.

Goals *for* 2011/12

(a) a 50% improvement in adherence to the Trust's Modified Early Warning Score (MEWS) escalation policy in cases of cardiac arrest; and

(b) 10% reduction in serious incidents, particularly those occurring during weekends, evenings and night shifts where there has been a failure to recognise and act on the signs of clinical deterioration of the patient.

2010/11 Performance

Assessment of 125 cardiac arrests in 2010/11 has indicated that in a number of cases (19) there could have been better adherence to the Trust's Modified Early Warning Score (MEWS) Escalation Policy.

Initiatives completed during 2010/11

Some of the initiatives implemented in 2010/11 to support achievement of the quality-improvement goals are summarised below:

1. Modified Early Warning Score (MEWS) tool introduced to all relevant clinical areas;
2. the Outreach Team continues to provide a weekend service;
3. safety-critical policies for standards of observation and escalation were launched in early 2010 and supported by a programme of training and education during 2010/11;
4. a review of all cardiac arrests commenced in June 2010. The review of unplanned/ re-admissions to the Intensive Care Unit (ICU)/ High Dependency Unit (HDU) continued as part of the audit programme for the Outreach Team; and
5. policy under development for the management of patients with tracheostomies and laryngectomies. A draft programme of training and competencies was developed by the Critical Care Team.

Initiatives to be implemented in 2011/12

In 2011/12, a number of initiatives will be introduced to achieve the improvement goals:

1. extend the review of all cardiac arrests to include the patient's clinical team;
2. promote the appropriate use of Do Not Attempt Resuscitation (DNAR) orders;
3. implement the use of the **S**ituation, **B**ackground, **A**ssessment and **R**ecommendation (S.B.A.R) tool to support escalation for deteriorating patients;
4. create a single integrated report on recognition and response to critical illness by aligning the work of the outreach and resuscitation teams; and
5. launch the policy and training programme on relevant wards for the management and care of patients with tracheostomies and laryngectomies.

Board Sponsor

Mr Brendan Ryan, Executive Medical Director

Implementation Lead

Mrs Kathleen Hingley, Head of Patient Safety & Quality

Project Lead

Outreach Team and Resuscitation Directorate

PRIORITY 1 PATIENT SAFETY

New Tools to Improve Communication

Description of issues and rationale for prioritising

Breakdowns in verbal and written communication between healthcare staff are a major concern in the delivery of care. Communication during hand-over, referral or transfer is critically important in creating a shared understanding of the patient's condition and needs. This has been highlighted during incident investigations within the Trust.

There are several tools designed to improve communication between healthcare staff. The model adopted by UHSM is widely used throughout North America and is used in a number of trusts in the UK. It provides a structure for communication and is known as S.B.A.R which stands for **S**ituation, **B**ackground, **A**ssessment and **R**ecommendation. The S.B.A.R tool will continue to be a key component of UHSM's Patient Safety & Quality Programme in 2011/12.

2010/11 Performance

A pilot study was carried out on an acute surgical ward (A6) and an acute medical ward (F11) between May and September 2010 with the aim of implementing S.B.A.R in the nurse hand-over. The roll-out of the communication tool was aligned to the Trust's Productive Ward Programme as hand-over and communication are core features of the productive ward. Through effective clinical engagement, the quality goal of implementing S.B.A.R. on each of the Trust's wards was achieved.

Initiatives to be implemented in 2011/12

Following the initial implementation, the S.B.A.R tool will continue to be embedded on each ward area during 2011/12. Consequently, *'New Tools to Improve Communication'* will not feature as a quality indicator in the Quality Account, although it will remain a key component of the Patient Safety & Quality Programme. It already features as part of the Trust's observation policy and during the coming year it will be utilised as a method of communicating, recognising and responding to the signs of critical illness.

Board Sponsor

Mrs Mandy Bailey, Chief Nurse

Implementation Lead

Mrs Alison Kelly, Deputy Chief Nurse

Project Lead

Mrs Patricia Richardson, Patient Safety Analyst

PRIORITY 1 PATIENT SAFETY

Preventing Medication Errors

Medicines Reconciliation

Description of issues and rationale for prioritising

Prescribing errors can result in harm to patients and the aim of medicines reconciliation, conducted when patients are admitted to hospital, is to ensure that important medicines aren't stopped and that new medicines aren't prescribed, without a complete knowledge of the medicines that a patient is already taking. Ensuring that patients receive the correct medicine on admission, transfer and discharge is an essential feature of UHSM's Patient Safety & Quality Programme and involves the earliest possible intervention of pharmacists after admission.

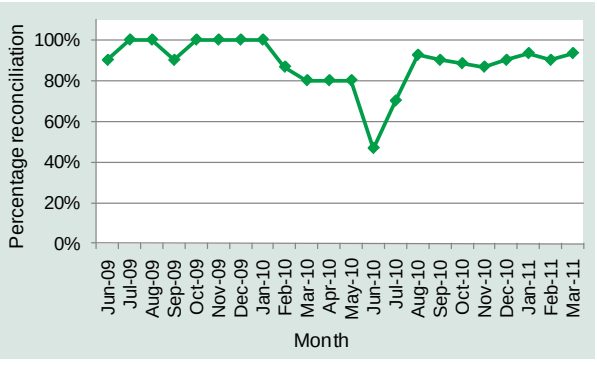
Goal *for* 2011/12

aim to consistently achieve 95% of patients having medicines reconciled within 48 hours of admission.

2010/11 Performance

Results of the monthly audit of medicines reconciliation are presented in ***Figure 4.4***. Medicines reconciliation compliance was 93% in March 2011. The average percentage compliance for reconciliation (within 48 hours) for 2010/11 was 87%. This is stratified as 85% performance for wards within Scheduled Care and 89% for wards within Unscheduled Care.

Figure 4.4: Medicines reconciliation within target*



Data source: UHSM Medicines Reconciliation Audit
This data is not governed by standard national definitions.

* Note: up until February 2010, the target was 72 hours if admitted on a Friday or Saturday

Initiatives implemented in 2010/11

In 2010/11, a number of initiatives were undertaken to support improvements in medicines reconciliation:

1. due to the changes in service delivery during the weekend, medicines reconciliation can sometimes prove difficult to achieve. Additional funding was agreed in 2011 to increase the cover by pharmacists and a weekend service to support medicines reconciliation commenced in April 2011. The additional service will help to support this important area of the Patient Safety & Quality Programme; and
2. access to GP records can help smooth the process of medicines reconciliation. Whilst this was a key initiative for 2010/11 the national programme has been placed on hold due to concerns from GPs and patient representatives concerning information privacy. UHSM is currently working with a number of GPs in the Trafford area to progress the development of a local system.

Initiatives to be implemented in 2011/12

In 2011/12, a number of initiatives will be introduced to achieve the improvement goal:

1. establish the weekend pharmacy service to support medicines reconciliation and audit the impact of this service improvement; and
2. continue to explore options to improve electronic access to patient GP records 24/7 to support and improve medicines reconciliation, with assistance from NHS Manchester/ Trafford consortia.

Board Sponsor
Mr Brendan Ryan, Executive Medical Director

Implementation Lead
Mrs Charlotte Skitterall, Chief Pharmacist

Project Lead
Mr Steve Williams, Consultant Pharmacist in Medication Safety

PRIORITY 1 PATIENT SAFETY

Preventing Medication Errors

High-risk Medicines

Description of issues and rationale for prioritising

National evidence from the National Patient Safety Agency (NPSA) has shown that medication errors continue to be a leading cause of patient harm. UHSM encourages the reporting of medication errors across the organisation to help develop solutions to high-risk medication problems and change systems/ practices to prevent repetitive harm. The Patient Safety & Quality Programme has a particular focus on high-risk medicines which include anti-coagulants, opiates, sedatives and insulin.

Goals *for* 2011/12

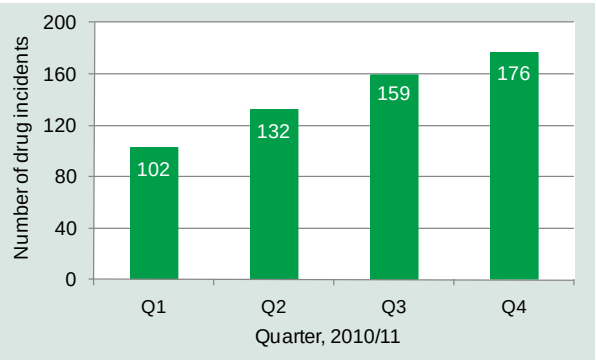
(a) perform clinical audits of high-risk medications via project groups; and

(b) sustain efforts to improve medication-error reporting and use of the Global Trigger Tool to improve data quality and identify problems.

2010/11 Performance

There has been a steady increase over the four quarters of 2010/11 in the number of drug incidents reported via the Trust's incident reporting system. This is healthy and is part of the Medication Safety Group's strategy to encourage more reporting. More information about medication safety problems means that the Trust can find appropriate solutions and thus prevent future medication harm.

Figure 4.5: Number of drug incidents reported



Data source: Hospital Incident Reporting System (HIRS)
This data is not governed by standard national definitions.

Initiatives implemented in 2010/11

Some of the initiatives implemented in 2010/11 to support achievement of the quality-improvement goals are summarised below:

1. the high-level risks associated with sedatives and opiates were reviewed and new standard operating procedures and policies introduced to try to reduce errors from occurring with these medicines;
2. the Hospital Incident Reporting System (HIRS) was monitored for drug-related errors and reporting of incidents was encouraged;
3. the Global Trigger Tool (GTT) was introduced to help identify and analyse high-risk medication errors; and
4. a new Insulin Prescription, Administration and Monitoring Chart was piloted in line with the Patient Safety First Campaign *'Think Glucose'* and the NPSA safety alert about insulin.

Initiatives to be implemented in 2011/12

In 2011/12, a number of initiatives will be introduced to achieve the improvement goals:

1. roll-out of the new Insulin Prescription, Administration and Monitoring Chart to all wards to help reduce associated errors;
2. development of a Trust-wide inpatient anti-coagulation team;
3. improve the number, range and quality of medication error reports through improved education about the benefits of reporting;
4. introduce a new prescription chart to help comply with NPSA safety alerts and improve medication safety; and
5. expand The Medication Safety Programme to include those drugs classified as high-risk in the Department of Health's 'Never Events' list (potassium-containing fluids, chemotherapy, injectable medicines, wrong-route administration of medicines intended for enteral/ oral administration and epidurals).

Board Sponsor
Mr Brendan Ryan, Executive Medical Director

Implementation Lead
Mrs Charlotte Skitterall, Chief Pharmacist

Project Lead
Mr Steve Williams, Consultant Pharmacist in Medication Safety

PRIORITY 1 PATIENT SAFETY

Reduce avoidable Death, Disability and Chronic Ill-health from Venous Thromboembolism (VTE)

Description of issues and rationale for prioritising

Venous thromboembolism (VTE) is a condition in which a blood clot (thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs; this is called deep-vein thrombosis. The thrombus may dislodge from its site of origin to travel in the blood - a phenomenon called embolism. VTE is a significant cause of death in hospital patients, and treatment of non-fatal symptomatic VTE and related long-term morbidities is associated with considerable cost to the health service.

The National Institute for Health and Clinical Excellence's (NICE) Clinical Guideline 92 requires documented VTE risk assessment for all hospital inpatients on admission and that appropriate thromboprophylaxis is prescribed.

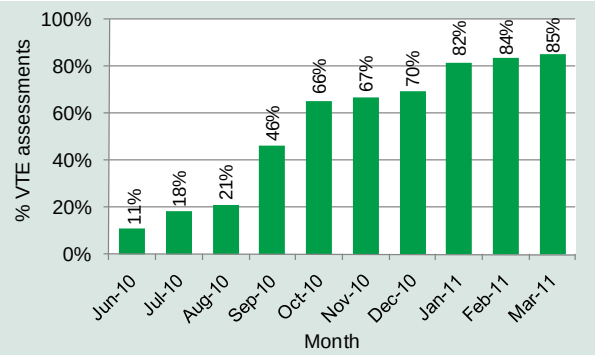
Goal *for* 2011/12

at least 90% of adult inpatients will be risk assessed for venous thromboembolism (VTE) on admission.

2010/11 Performance

A key objective in 2010/11 was to reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE) and to aim for a target of more than 90% compliance with risk assessment. At the beginning of 2010/11 the Commissioning for Quality and Innovation (CQUIN) scheme established a national target for trusts to achieve 90% compliance with risk assessment of VTE for all inpatients and day cases on admission.

Figure 4.6: VTE assessment, Jun-10 to Mar-11



Data source: UNIFY national reporting.
This data is governed by standard national definitions.

As highlighted in ***Figure 4.6***, there has been a steady improvement in performance since June 2010 when the VTE data was first reported nationally. VTE risk assessment compliance in Quarter 4 was 83.5%.

Initiatives implemented in 2010/11

Some of the initiatives implemented in 2010/11 to support achievement of the quality-improvement goals are summarised below:

1. VTE Programme reviewed and aligned to the recommendations of the NICE Clinical Guideline 92 for prevention of VTE;
2. policy for 'The Prevention and Management of VTE' approved in July 2010;
3. a dedicated programme of training in VTE prevention was delivered across the Trust;
4. a new drug chart was produced in 2010 to support the accurate recording of VTE risk assessment;
5. systems and monitoring for VTE prevention were assessed as part of the pilot of new criteria for the NHSLA Risk Management Scheme in 2011. The Trust retained Level 3, the highest level within the scheme; and
6. the Thromboprophylaxis Specialist Nurse received an award at the inaugural 2011 Lifeblood Thrombosis Prevention Awards.

Initiatives to be implemented in 2011/12

In 2011/12, a number of initiatives will be introduced to achieve the improvement goal:

1. improve the process for root cause analysis investigation of all cases of hospital-acquired VTE to ensure that the management and treatment of patients is optimal following a positive diagnosis;
2. review systems to improve the monitoring of VTE risk assessment;
3. continue to develop the programme of VTE training with an emphasis on producing a dedicated e-learning programme; and
4. develop the skills of registered nurses to undertake VTE risk assessments with the patient at pre-operative assessment.

Board Sponsor
Mr Brendan Ryan, Executive Medical Director

Implementation Lead
Mr Ian Welch, Consultant GI (gastro-intestinal) Surgeon

Project Lead
Miss Christine Bowyer, Thromboprophylaxis Specialist Nurse

PRIORITY 1 PATIENT SAFETY

Preventing Harm from Falls

Description of issues and rationale for prioritising

The National Patient Safety Agency's (NPSA) Patient Safety Observatory Report for 2007 identified that there will always be a risk of falls in hospital given the nature of the patients that are admitted, and that the injuries that may be sustained are not trivial. However, there is much that can be done to reduce the risk of falls and minimise harm, whilst at the same time properly allowing patients freedom and mobilisation during their stay in hospital.

Goals *for* 2011/12

- **(a)** more than 90% of adult patients to have a falls risk assessment on admission;
- **(b)** 85% of adult patients will have (evidence of) appropriate preventive intervention in agreed audit samples;
- **(c)** more than 80% of patients considered to need a falls risk review will receive one; and
- **(d)** the Trust will be able to demonstrate compliance with the falls intervention programme at case review for all patients who suffer or moderate or severe harms as a result of an inpatient fall.

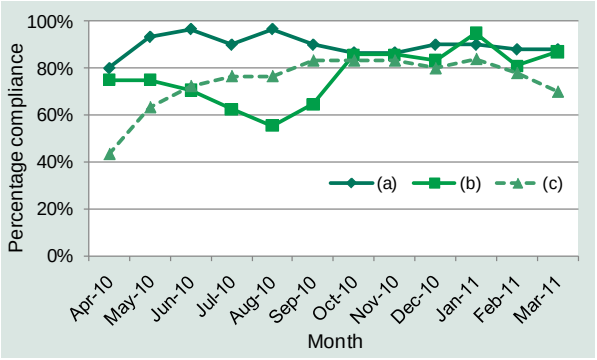
2010/11 Performance

Quality goals **(a)** risk-factor assessment and **(b)** preventive intervention were almost achieved in 2010/11 with 89.5% (90% goal) and 78.3% (80% goal) compliance respectively. Quality goal **(c)** demonstrated a lower compliance of 74.9% (80% goal).

Quality goal **(d)** focused on minimising falls resulting in moderate or severe injury. The numbers for moderate and severe injury in UHSM are similar for the last three years. Reviews of inpatient fractures have highlighted that the risk assessment process, interventions and reviews are being carried out especially in those areas where the Falls Intervention Programme is well established. Post-inpatient falls management, however, could be improved in some areas. This has already been highlighted as a national concern by the NPSA.

In 2010/11 there were 1,186 inpatient falls reported in the UHSM Hospital Incident Reporting System (HIRS). 4.22 falls per 1,000 bed days were reported in 2010/11 compared to 4.27 falls per 1,000 bed days in 2009/10. Trust performance in both years was lower than the national average of 5.6 falls per 1,000 bed days reported in 2008/09.

Figure 4.7: Falls performance



Data source: UHSM falls ward-based audits
This data is not governed by standard national definitions.

- **(a)** Falls risk-factor assessment documented
- **(b)** Falls risk-factor intervention
- **(c)** Review of falls risk-factor assessment documented

Initiatives implemented in 2010/11

Some of the initiatives implemented in 2010/11 to support achievement of the quality-improvement goals are summarised below:

1. falls training programme expanded and developed;
2. trial of new patient footwear undertaken to prevent falls;
3. introduced the Falls Intervention Audit into Scheduled Care (surgery); and
4. participated in the Royal College of Physicians' Bone Health Audit.

Initiatives to be implemented in 2011/12

In 2011/12, a number of initiatives will be introduced to achieve the improvement goals:

1. implement the requirements of the NPSA alert 2011/RRR001 - *Essential care after the inpatient fall*. This will help support improvements in the management and care of patients following a fall;
2. implement the Falls Intervention Tool across all inpatient areas; and
3. revise the programme of falls audit.

Board Sponsor

Mr Brendan Ryan, Executive Medical Director

Implementation Lead

Ms. Julia Gray, Falls Co-ordinator
Dr David Bourne, Consultant Care of the Elderly

PRIORITY 1 PATIENT SAFETY

The World Health Organization's (WHO) Surgical Safety Checklist

Description of issues and rationale for prioritising

The goal of the 'Safe Surgery Saves Lives Challenge' is to improve the safety of surgical care around the world by ensuring adherence to proven standards of care in all countries. This includes improving anaesthetic safety practices, ensuring correct-site surgery, avoiding surgical-site infections and improving communication.

The World Health Organization's (WHO) Surgical Safety Checklist has improved compliance with standards and decreased complications from surgery in eight pilot hospitals where it was evaluated.

Goals *for* 2011/12

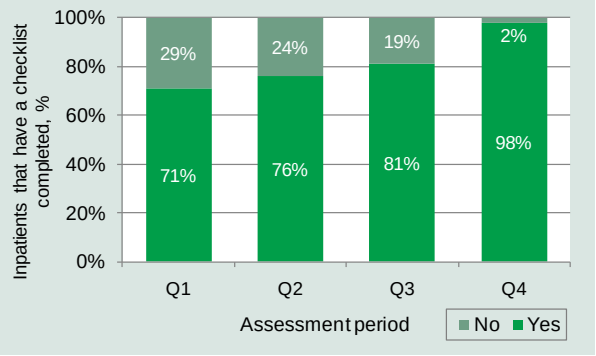
(a) 100% of UHSM patients in theatre settings to have the WHO Surgical Safety Checklist completed; and

(b) before the end of 2011 all relevant interventional areas will have adapted and introduced a version of the Surgical Safety Checklist.

2010/11 Performance

A successful pilot implementation of the Surgical Safety Checklist took place in March 2010. Combined with training and support, this has led to a roll-out of the program to include all theatre environments in UHSM. Compliance with the checklist has been monitored on a monthly basis with a retrospective audit of patients from each of the theatre environments.

Figure 4.8: WHO Checklist compliance



Data source: UHSM observational audits
This data is governed by standard national definitions.

The Trust's compliance with the World Health Organization's (WHO) Surgical Safety Checklist since its pilot in March 2010 is summarised in ***Figure 4.8***. The Trust achieved its internal target of 95% compliance in Quarter 4. The CQUIN stretch target of 100% set by NHS Manchester, however, was narrowly missed.

All exceptions to the checklist which are highlighted by the monthly audit are reviewed by the Clinical Project Lead and monitored through the Safer Surgery Group.

Radiology and Cardiology specialties have already piloted and introduced the adapted checklist for interventional areas. Other areas in the Trust will be supported to introduce the checklist before the end of June 2011.

Initiatives completed during 2010/11

Some of the initiatives implemented in 2010/11 to support achievement of the quality-improvement goals are summarised below:

1. successful roll-out of the Surgical Safety Checklist in all theatre environments;
2. implementation of an adapted Surgical Safety Checklist has commenced in non-theatre environments where interventional procedures take place;
3. Safer Surgical Policy launched;
4. all exceptions to the completion of the Surgical Safety Checklist are reviewed by the clinical lead; and
5. a new streamlined pre-operative checklist was implemented, which incorporated associated NPSA alerts and the Trust VTE risk assessment.

Initiatives to be implemented in 2011/12

In 2011/12 the following initiatives will be introduced to help achieve the quality goals:

1. maintain a monthly programme of clinical audit within theatres and relevant interventional areas; and
2. review the Trust policy, current checking procedures and controls in light of the Department of Health's 'Never Events' Report. This will include: wrong-site surgery; wrong implant/ prosthesis; and retained foreign object post-operation.

Board Sponsor

Mr Brendan Ryan, Executive Medical Director

Implementation Lead

Mrs Debbie Hickling, Associate Medical Director and Consultant Gynaecologist and Obstetrician

Mrs Caron Crumbleholme, Head of Nursing for Scheduled Care

PRIORITY 1 PATIENT SAFETY

The Global Trigger Tool (GTT)

Description of issues and rationale for prioritising

The Institute for Healthcare Improvement's (IHI) Global Trigger Tool (GTT) has been developed as a means of identifying harmful events (unintentional harm) affecting patient care. Monthly retrospective reviews of twenty healthcare records commenced in August 2009 to measure the overall level of harm at UHSM.

Goal *for* 2011/12

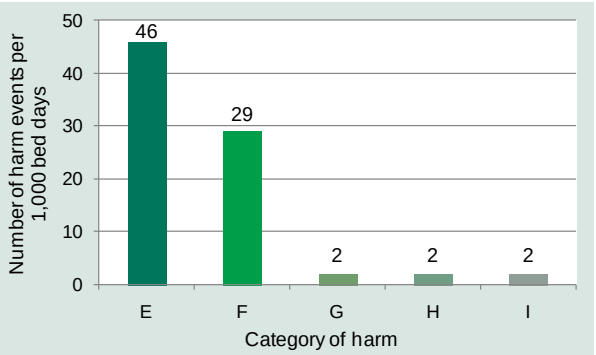
analyse two years of data collected between August 2009 and August 2011 to evaluate the effectiveness of UHSM's Patient Safety & Quality Programme and to assess whether the key interventions are helping to reduce harm.

2010/11 Performance

240 sets of patient healthcare records were reviewed and a total of 81 harmful events identified between November 2009 and October 2010. An average of 7 'harm events' were identified each month.

Harm events identified have remained predominantly in the lower categories defined as **E** - *temporary harm requiring intervention*, or **F** - *temporary harm requiring prolonged hospitalisation* - 46 and 29 harmful events. Infections account for the highest category identified, and, encouragingly, harm related to high-risk medications and VTE has been low with only 7 and 2 identified respectively. Only one pressure ulcer, acquired whilst the patient was in hospital, was identified in the twelve-month period.

Figure 4.9: Harm events by category



Data source: Global Trigger Tool Audit
This data is governed by standard national definitions.

Category of Harm

- **E** contributed to or resulted in temporary harm to the patient & required intervention;
- **F** contributed to or resulted in temporary harm to patients & required initial or prolonged hospitalisation;
- **G** contributed to or resulted in permanent patient harm;
- **H** required intervention to sustain life; and
- **I** contributed to the patient's death.

Table 4.6: Types of harmful events identified in the GTT analysis, Nov-09 to Oct-10

Description	No.	%
Infection (urine, chest, etc.)	28	34.6%
Peri-operative[2] adverse events	22	27.2%
Minor care (e.g. applying splints)	15	18.5%
Medication	7	8.6%
Falls	6	7.4%
Venous thromboembolism (VTE)	2	2.5%
Pressure ulcers	1	1.2%
Total	**81**	100.0%

Data source: Global Trigger Tool Audit
This data is governed by standard national definitions.

Initiatives to be implemented in 2011/12

In 2011/12 the following initiatives will be introduced to achieve the quality goals:

1. continue with the GTT programme;
2. analyse two years of collected data in August 2011 to assess whether key interventions are helping to reduce harm; and
3. Global Trigger Tool Team to work with the Infection Prevention Team and Safer Surgery Group to analyse emerging trends in infection prevention and surgery.

Board Sponsor

Mr Brendan Ryan, Executive Medical Director

Project Leads

Dr Selwyn Roberts, Director for Patient Safety & Quality

Mrs Helen Rogers, Patient Safety & Quality Manager

Mrs Patricia Richardson, Patient Safety Analyst

[2] The entire surgical experience, from pre-admission assessment to discharge, is known as the peri-operative period.

PRIORITY 1 PATIENT SAFETY

Preventing Hospital-acquired Pressure Ulcers

Description of issues and rationale for prioritising

Pressure ulcers can be detrimental to the recovery of a patient so it is important that this area of practice is addressed. Work has already been conducted, but the Trust acknowledges that additional work is required to further implement assessment mechanisms and ultimately reduce incidence.

Goals *for* 2011/12

(a) 95% of all patients to be risk assessed for pressure ulcers; this will be documented according to the Trust's policy;

(b) monthly monitoring of hospital-acquired pressure ulcers and feedback on learning;

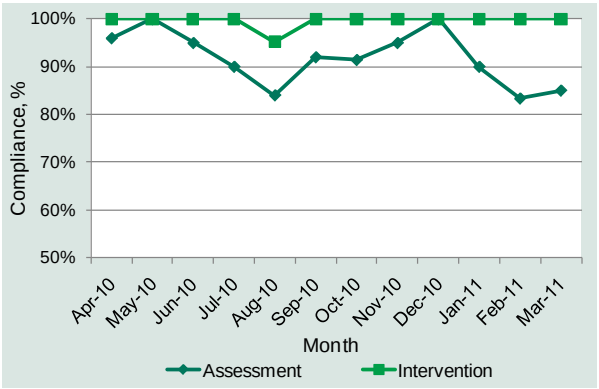
(c) reduce the number of incidences of grade 3 and 4 pressure ulcers compared to 2010/11; and

(d) conduct a baseline analysis of pressure-ulcer incidence within the relevant community services.

Current Performance

This priority continues to be one of the work streams of the Trust's Patient Safety & Quality Programme and is a fundamental element of nursing assessment and care. During 2010/11 a rolling-programme of audit was established as well as the implementation of a robust monitoring framework. During the last twelve-months, 91.6% of all patients were risk assessed for pressure ulcers and 97.8% of patients received appropriate intervention (after assessment).

Figure 4.10: Ward-based pressure ulcer audit



Data source: Ward-based audit of clinical records
This data is not governed by standard national definitions.

There were 8 grade 3 pressure ulcers and 5 grade 4 pressure ulcers (caused after admission) reported in 2010/11.

Initiatives completed during 2010/11

Some of the initiatives implemented in 2010/11 to support achievement of the quality-improvement goals are summarised below:

1. revised Trust policy launched and educational programme established;
2. the Chief Nurse reviews all investigations triggered by a hospital-acquired pressure ulcer (grades 3 & 4). The Chief Nurse Panel meetings take place with the Chief Nurse and the relevant clinical team, with relevant actions agreed; and
3. a rolling-programme of audit was established as well as the planned bi-annual prevalence audits. Clinical directorate teams are responsible for making changes in accordance with audit recommendations.

Initiatives to be implemented in 2011/12

In 2011/12 the following initiatives will be introduced to help achieve the improvement goals:

1. implement 'skin bundles', which are evidence-based measures that support best-practice in preventing pressure ulcers;
2. introduce a pressure-ulcer checklist for use by medical staff;
3. carry out spot-checks of clinical areas to assess the effectiveness of pressure-ulcer reporting;
4. conduct baseline measurements of the incidence of pressure ulcers in the relevant community services managed by the Trust; and
5. develop a multi-disciplinary approach to the monitoring and prevention of hospital-acquired pressure ulcers.

Board Sponsor
Mrs Mandy Bailey, Chief Nurse

Implementation Lead
Mrs Alison Kelly, Deputy Chief Nurse

Project Lead
Miss Louise O'Connor, Tissue Viability Specialist Nurse

PRIORITY 2 CLINICAL EFFECTIVENESS

Advancing Quality Programme

Description of issues and rationale for prioritising

Consistently offering safe and high-quality care for all UHSM patients is vitally important to the organisation and offers assurance to patients, carers and the public. UHSM participates in a regional quality initiative called 'Advancing Quality', which helps to improve the quality of the care that is received by patients in six focus areas.

Goals *for* 2011/12

- acute myocardial infarction (heart attack) 95.0%
- coronary artery bypass graft 95.0%
- hip & knee replacement 95.0%
- heart failure 75.1%
- community-acquired pneumonia 83.4%
- stroke threshold published mid-2011

2010/11 Performance

Advancing Quality performance is measured by auditing clinical records against explicit performance criteria (for example antibiotic administration for pneumonia within 6 hours of arrival at A&E). The programme initially covered five focus areas, with a sixth area (stroke care) introduced during 2010/11.

Table 4.7: Advancing Quality Programme

CQUIN target	Performance Current*	2009/10	Achieved
Heart attacks - acute myocardial infarction			
95.0%	98.8%	97%	✓
Coronary artery bypass graft			
95.0%	97.2%	85%	✓
Community-acquired pneumonia			
79.3%	84.3%	76%	✓
Heart failure			
65.3%	69.3%	60%	✓
Hip & knee replacement			
93.8%	94.1%	91%	✓
Stroke			
90.0%	81.1%	N/A	✗

Data source: NHS North West Advancing Quality Programme
This data is not governed by standard national definitions.

* Note: Advancing Quality data is collected approximately four months in arrears before it is submitted to the Advancing Quality Alliance (AQuA) for validation and publication. 2010/11 validated performance is expected to be published in late 2011. The performance presented in the Quality Account 2010/11 is therefore incomplete data. Community-acquired pneumonia, heart failure, acute myocardial infarction and joint replacement data covers the period April 2010 to January 2011. Coronary artery bypass graft data covers the period April 2010 to February 2011. Data for the stroke indicator corresponds to the reporting period October to November 2010.

High rates of compliance with the clinical-care criteria indicates reliable care and in all 5 initial focus areas there has been improvement on the previous year.

As part of the regional Commissioning for Quality and Innovation (CQUIN) scheme, targets were set for all focus areas based upon audit criteria used to measure performance during 2010/11. Partial data for 2010/11 shows that, of the six areas within the Advancing Quality Programme, five are on-track to achieve the CQUIN targets.

Initiatives completed during 2010/11

Some of the initiatives implemented in 2010/11 to support achievement of the quality-improvement goals are summarised below

1. permanent funding secured for a heart failure specialist nurse;
2. improvements in the diagnosis and commencement of treatment for pneumonia patients; and
3. external audit of UHSM's Advancing Quality data by the Audit Commission demonstrated 100% accuracy in clinical data submitted as part of the programme.

Initiatives to be implemented in 2011/12

In 2011/12 the following initiatives will be introduced to help achieve the improvement goals:

1. work with the Stroke Team to identify areas for improvement; and
2. demonstrate improvements in the key clinical indicators of length-of-stay, re-admissions and inpatient mortality.

Board Sponsor
Mr Brendan Ryan, Executive Medical Director

Implementation Lead
Mr David Watson, Head of Clinical Effectiveness

Project Lead
Consultants and Nurses working within the six focus areas

PRIORITY 2 CLINICAL EFFECTIVENESS

Nursing Indicators, Clinical Rounds and Essence of Care

Description of issues and rationale for prioritising

Nursing Ward Indicators measure the standards of care that are delivered on the Trust's wards. Some core elements are already reported in clinical directorates within Unscheduled Care, however, further work is required in 2011/12 to ensure that there is a robust nursing quality framework, which includes the Essence of Care Standards that support the delivery of high-quality nursing care.

Compliance against the revised Essence of Care Standards (these are fundamental elements of care that, following national consultation, were found to be vitally important to patients, i.e. nutrition, continence and privacy & dignity) was reviewed during 2010/11 and areas that require further work are included in Trust-wide action plans.

This work is complemented by the Senior Nurse Clinical Rounds, which are undertaken by the Chief Nurse, Deputy Chief Nurse, Head Nurses and Matrons. Carried out on a monthly basis during the last year, the rounds focused on a range of different themes such as clinical assessments; cleanliness and the environment; infection prevention as well as the Essence of Care Standards.

Goals *for* 2011/12

(a) nursing indicators to be embedded in all ward areas with agreed tolerances; and

(b) data included from The Association of UK University Hospitals (AUKUH) Acuity & Dependency Tool to establish areas of concern that require action.

2010/11 Performance

Development of nursing indicators to monitor the quality of care that is delivered to patients progressed slowly in 2010/11. Core indicators were agreed and are in use in clinical directorates within Unscheduled Care. Further work is required to introduce the indicators into directorates within Scheduled Care and Clinical Support Services.

Infection-prevention indicators are already well-established as part of an electronic performance-management framework. These indicators will also be reported to the Trust's operational boards in 2011/12.

Initiatives completed during 2010/11

Some of the initiatives implemented in 2010/11 to support achievement of the quality-improvement goals are summarised below:

1. as part of the Senior Nurse Clinical Rounds an audit timetable was developed for key audits, particularly NHSLA; and
2. Clinical Rounds at night helped to communicate key messages and clinical information to the night teams and were positively received by night staff.

Initiatives to be implemented in 2011/12

In 2011/12 the following initiatives will be introduced to help achieve the improvement goals:

1. in partnership with the Trust's Performance & Information Team, develop an electronic solution for nursing indicators to provide meaningful information to clinical areas that will help them to maintain high standards of care;
2. integrate all nursing indicators into the Trust's Data Warehouse making sure that there is appropriate alignment with the Strategic Health Authority's nursing-indicator project and the Productive Ward Programme; and
3. integrate the data obtained from the use of the AUKUH Acuity & Dependency Tool (in addition to Human Resource metrics) to provide useful insight about each ward in the Trust. A summary report will be presented to the Board of Directors.

Board Sponsor
Mrs Mandy Bailey, Chief Nurse

Implementation Lead
Mrs Alison Kelly, Deputy Chief Nurse

Project Lead
Heads of Nursing

PRIORITY 2 CLINICAL EFFECTIVENESS

Clinical Effectiveness

Description of issues and rationale for prioritising

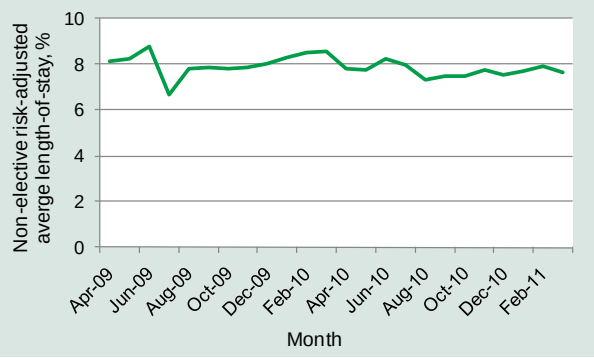
Length-of-stay in hospital and emergency re-admission are measures of the quality of patient care. Risk-adjusted average length-of-stay measures the duration of a patient's stay in hospital, adjusted for factors such as diagnosis, procedures carried out, how the patient was admitted/ discharged, as well as the age and gender of the patient. A shorter than expected stay in hospital, where it is clinically appropriate, is preferable for both the patient and the hospital.

When a patient is re-admitted to hospital within a specified timeframe following a hospital stay (usually 28 days) it may indicate that there are issues with the quality of patient care. Re-admissions can be caused by a range of complex hospital, patient & community factors.

2010/11 Performance

There was a 5.5% reduction (0.45 days) in the risk-adjusted average length-of-stay for non-elective inpatients in 2010/11 (7.75 days) compared to the previous year (8.20 days). The reduction in risk-adjusted average length-of-stay in specialties within Unscheduled Care was even greater at 8.3% (0.8 days), i.e. 9.6 days in 2009/10 compared to 8.8 days in 2010/11.

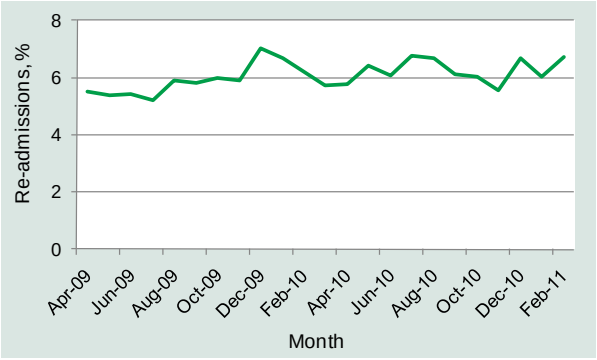
Figure 4.11: Non-elective risk-adjusted average length-of-stay



Data source: CHKS Quality & Service Improvement Tool
This data is not governed by standard national definitions

The rate of re-admissions increased slightly to 6.2% for the twelve-month period March 2010 to February 2011. This compares to a rate of 5.7% for the clinical peer. The re-admissions rate for the previous 12 months was 5.9%.

Figure 4.12: Re-admissions (within 28 days)



Data source: CHKS Quality and Patient Safety Tool.
This data is governed by standard national definitions

Initiatives completed during 2010/11

Some of the initiatives implemented in 2010/11 to support achievement of the quality-improvement goals are summarised below:

1. a patient tracker has been rolled out to all medical wards, enabling social services and discharge planning to co-ordinate the date of discharge with the date of being medically fit;
2. medical and respiratory wards have adopted the Estimated Date of Discharge (EDD) process. Patients' estimated discharge dates are displayed on the ward patient-status boards allowing coordination of efforts to allow for appropriate discharge;
3. a pilot of 'Intermediate Care at Home', which was implemented during winter, enabled patients to be discharged earlier than otherwise would have been the case.

Initiatives to be implemented in 2011/12

UHSM is committed to reducing length-of-stay and re-admissions, and whilst this indicator will no longer be presented in the Quality Account, performance monitoring will take place within individual improvement projects:

1. the Trust is attempting to identify recurrent funding to facilitate 'Early Supported Discharge';
2. UHSM is participating in the Dr. Foster Global Comparators 'benchmarking' project with 30 other acute trusts from the US, UK and Europe to share learning and deliver improvements in mortality, length-of-stay and re-admissions; and
3. length-of-stay and re-admission benefits are expected as a result of the ward-reconfiguration programme.

Board Sponsor

Mr Brendan Ryan, Executive Medical Director
Mrs Karen James, Chief Operating Officer

PRIORITY 2 CLINICAL EFFECTIVENESS

The Productive Ward Programme *('releasing time to care')*

Description of issues and rationale for prioritising

Monitoring efficiency and effectiveness on the wards is crucial if a patient's experience and the standards of care received are to be improved. The Productive Ward Programme, which aims to release more time for nurses to care for patients, has not only improved teamwork but has also improved the organisation and effectiveness of the Trust's wards.

Current Performance

The Service Improvement Team assumed responsibility for the Productive Ward Programme during the year. The 2010/11 goals required that all wards commenced the Productive Ward Programme by April 2011 and that the *'releasing time to care'* indicator was adopted as a quality outcome. During the last twelve months all hospital wards have begun the programme with initiatives developed on the pilot wards now being used across the system. UHSM has also commenced The Productive Operating Theatre Programme. Both initiatives enjoy active clinical engagement.

Initiatives completed during 2010/11

1. examples of process redesign introduced during the year are illustrated in the summary box below;

Redesign of ward processes

Patient Status at a Glance

New 'Patient Status at a Glance Boards' are in place on all the wards. Standardised symbols help to communicate essential information to ward teams in a way that is easily understood.

Handover Modules

The handover modules have been incorporated into the quality indicator *Recognising and responding to signs of critical illness*, which is described earlier in this section.

Computer learning package

A computer package, which makes information about The Productive Ward Programme accessible and easy to use for all levels of staff, is introduced across the wards.

2. commenced The Productive Operating Theatre Programme; and
3. established mechanisms for capturing efficiency and patient satisfaction outcomes.

Board Sponsor
Mrs Mandy Bailey

Implementation Lead
Mrs Trish Cavanagh

Project Lead
Miss Sarah Rys-Halska, Productive Ward Project Lead/ Ward Manager A1

PRIORITY 3 IMPROVING THE PATIENT EXPERIENCE

Gaining Feedback from Patients & Responding to Patient Feedback

Description of issues and rationale for prioritising

The patient's experience is fundamental to the services UHSM delivers and considerable efforts have been made to ensure that patient feedback is collected and acted upon. The Trust's Patient Experience Strategy *'Patient Care at our Heart, it's Everyone's Responsibility'* outlines the Trust's patient experience vision and priorities.

In the Trust's 2009/10 Quality Account, the indicators *'Gaining feedback from patients'* and *'Responding to patient feedback'* were presented separately. Following consultation and feedback from Manchester Local Involvement Network (LINk) it was agreed that the quality indicators would be merged.

Goals *for* 2011/12

(a) UHSM to be in the top 20% of trusts in the National Patient Survey results;

(b) 80% of complaints responded to within 25 working days;

(c) implement the first year of the *'Patient Care at our Heart, it's Everyone's Responsibility'* Strategy; and

(d) at least 96% of patients would recommend UHSM to others.

2010/11 Performance

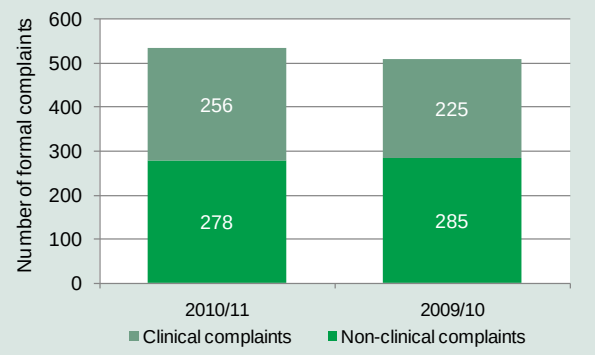
During 2010/11 the Trust obtained feedback from patients through a number of means, including complaints, concerns and comments, as well as the Patient Experience Tracker, which recorded that 96% of patients would recommend UHSM to others. Developed during the year, the Trust's Patient Experience Report is shared, on a quarterly basis, with the Governors' Patient Experience Committee and NHS Manchester.

The presentation of 'Patient Stories' to the Board of Directors' meeting each month has been well-received and has provided powerful accounts of patient experiences at the Trust.

A restructure of the corporate teams provided the opportunity to introduce a new role of Patient Experience Matron responsible for the Patient Experience Team. This new approach has brought an increased focus on the patient perspective when collecting and responding to all types of feedback.

Responding to formal complaints within 25 working days proved to be a challenge during the recent organisational restructure with 69.7% performance in 2010/11 compared to a quality goal of 80%. It is, however, encouraging to report that performance against this goal improved towards the end of the year with Quarter 4 compliance of 72.6%.

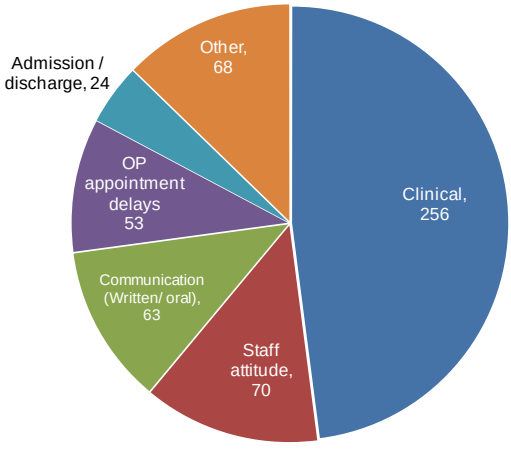
Figure 4.13: formal complaints received



Data source: UHSM complaints database, provided by the Safeguard Information System. This data is not governed by standard national definitions

As indicated in ***Figure 4.13***, the number of formal complaints received in 2010/11 increased by 4.7% compared to the previous year.

Figure 4.14: formal complaints by category



Data source: UHSM complaints database, provided by the Safeguard Information System. This data is not governed by standard national definitions

In ***Figure 4.14*** the formal complaints received in the last year are presented according to the top six categories. Clinical complaints continue to represent the largest single category with 47.9% of the total number of complaints in

2010/11; analysis of clinical complaints has not revealed any significant themes.

Improvements to the Patient Experience

Outpatients
The number of complaints about outpatient services reduced by just over 50% to 7 complaints in Quarter 4 compared to a quarterly average of 15 complaints in quarters 1-3. This improvement can, in part, be attributed to a number of interventions made to address issues raised by patient feedback. The principal aim was to provide a professional, effective service to UHSM patients, whilst enabling the Outpatient Department to become more efficient. Examples include:

- outpatient clinic templates reviewed to ensure that capacity matches demand; and
- an appointment confirmation service introduced leading to a 3% reduction in Did Not Attends (DNAs) in the last twelve months.

Inpatients
The 2010 National Inpatient Survey was completed by patients aged 16 years and over who had at least one overnight stay between June and August 2010. 410 patients responded to the survey (49% response rate).

The questions are grouped according to the following headings: *admission to hospital; the hospital and ward; doctors; nurses; your care and treatment; operations and procedures; leaving hospital and overall.* The section below provides an overview of initial results.

A detailed analysis of the 2010 National Inpatient Survey will be completed and reported to the Board of Directors in June 2011. This will be supported by a Trust-wide action plan to improve the patient experience at UHSM.

areas demonstrating improvement on the 2009 Inpatient Survey Results

- time patients waited to be admitted from Accident & Emergency;
- cleanliness of toilets and bathrooms;
- doctors and nurses washing their hands;
- opportunities for families to talk to doctors;
- involvement in discharge decisions;
- sharing mixed-sex bathroom/ shower areas; and
- overall, patients were treated with dignity and respect.

examples of areas where USHM is in the top 20% of the highest-performing trusts nationally

- patients were provided with enough privacy and dignity in Accident & Emergency;
- there was enough help from staff for patients to eat their meals;
- a discussion took place with patients about how they would feel after their operation;
- patients were involved in decisions about their care;
- hand gels were available for patients and visitors to use; and
- written information was provided about what to do after leaving hospital.

areas where further improvements are required

- some patients felt they had to wait a long time to get a bed on a ward;
- there was a lack of choice of hospital admission dates;
- questions about operations were not answered; and
- some patients were placed in a mixed-sex bay/ ward (further work has been carried out since this survey to eliminate mixed-sex accommodation and provide same-sex bathroom/ shower facilities).

Complaints handling and feedback reporting process
In the second part of the year, weekly meetings of the Risk, Patient Safety & Quality and Patent Experience teams were established to strengthen the Trust's ability to respond appropriately to issues raised in complaints, incidents and inquests. The following initiatives will continue in 2011/12:

- identify how the key themes from feedback are collected and analysed in order to improve practices and services;
- raise the profile of the Patient Experience Team internally and externally. This is particularly important given the transfer of community services to UHSM; and
- provide further support to directorates to improve complaint response times and understand themes and trends.

Patient Information

The Editorial Board reviewed and approved over 85 documents during 2010/11. Authors now attend the meetings, which has improved the effectiveness of the editorial process.

Two audits were carried out during the year to assess the extent to which essential criteria (risks, benefits and alternatives) are included in patient information. The audits provided limited assurance. Action plans are in place to ensure that all patient documentation includes, *in explicit* form, all the essential criteria.

Cancer Patient Experience Survey

During 2010/11, UHSM received the results from the National Cancer Patient Experience Survey. 418 patients responded to the survey. UHSM performed well (i.e. within the top 20% of trusts) in the following areas:

areas where USHM is in the top 20% of the highest-performing trusts nationally

- deciding the best treatment (explanations about the purpose of tests and treatments);
- support for patients with cancer;
- care received from hospital doctors;
- being given privacy when examined; and
- overall NHS care (in particular not treating patients as a 'set of symptoms').

The areas for improvement based on national comparisons are:

areas where further improvements are required

- time to first outpatient appointment;
- availability of written information;
- breaking bad news;
- advice on treatment side-effects;
- choice of different treatments;
- advice on free prescriptions; and
- information to help with care at home.

A comprehensive action plan has been developed to improve UHSM performance.

Initiatives to be implemented in 2011/12

In 2011/12 the following initiatives will be introduced to help achieve the goals:

1. carry out a combined audit of both UHSM and non-UHSM patient information, including material used by community services now provided by the Trust;
2. implement the first year of the *'Patient Care at our Heart, it's Everyone's Responsibility'* Strategy; and
3. implement an electronic bedside solution to enable every UHSM patient to provide feedback on a daily basis.

Board Sponsor

Mrs Mandy Bailey, Chief Nurse

Implementation Lead

Mrs Alison Kelly, Deputy Chief Nurse

Project Lead

Mrs Sarah Newlove, Matron, Patient Experience

PRIORITY 3 IMPROVING THE PATIENT EXPERIENCE

Treating Patients with Dignity & Respect
(Eliminating Mixed-Sex Accommodation)

Description of issues and rationale for prioritising

Maintaining patients' privacy and dignity is an important priority for UHSM and the Trust has continuously maintained positive results on this issue in the National Inpatient Survey. As described in the previous indicator, performance against the privacy, dignity and respect questions continued to be positive with UHSM scoring in the top 20% nationally. Over the last year the Trust has undertaken significant work to ensure that patients are, whenever possible, placed in accommodated with members of the same sex.

In order to maintain privacy and dignity, UHSM is committed to improving the facilities for patients, in particular bathroom and toilet facilities. The introduction of the new national guidance in 2010/11 provided the opportunity to look at working differently in some of the clinical areas; this has received positive clinical engagement. A dedicated project board has continued to meet to monitor progress against the Trust's delivery plans and in March 2010 UHSM declared compliance with the national requirements.

Stakeholders have fed back that treating patients with dignity and respect should remain a key priority in the coming year. The Trust will also consider the patients who are cared for in community services (since the transfer to UHSM of a number of community services on 1st April 2011).

Goals *for* 2011/12

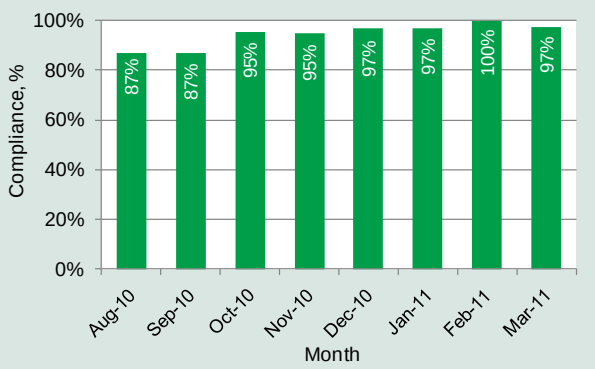
- **(a)** over 95% of respondents saying that they did not share sleeping areas with a patient of the opposite sex in the local Patient Perception Survey;
- **(b)** the Trust's revised Privacy & Dignity Policy is operational in all departments; and
- **(c)** implement an electronic reporting process for identified ward areas to monitor patient flow and the placement of patients.

2010/11 Performance

Maintaining patients' privacy, dignity and respect is a fundamental part of UHSM's Patient Experience Strategy and in response to patient feedback the Trust will continue to ensure that patients, whenever possible, are nursed in appropriate areas with members of the same sex. Considerable progress has been made over the past year to ensure that staff, patients and members of the public are fully informed about the same-sex accommodation agenda. UHSM's Patient Perception Survey results provide a good indication of success in this area; some recent results are illustrated below.

Figure 4.15: same-sex accommodation compliance (sleeping area) on admission

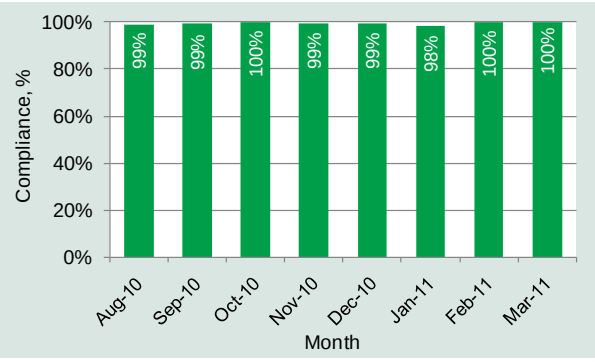
When you were first admitted to a bed on a ward did you ever share a sleeping area with patients of the opposite sex [No]?



Data source: UHSM local Patient Perception Survey
This data is governed by standard national definitions.

Figure 4.16: same-sex accommodation compliance -sleeping area

After you were moved to another ward, did you ever share a sleeping area with patients of the opposite sex [No]?



Data source: UHSM local Patient Perception Survey
This data is governed by standard national definitions.

Initiatives completed during 2010/11

Some of the initiatives implemented in 2010/11 to support achievement of the quality-improvement goals are summarised below:

1. the Board of Directors published its declaration in relation to same-sex accommodation;
2. communications strategy implemented via the Trust's Communication Team, privacy & dignity screen savers, Team Brief, and usual Trust communication mechanisms. Development of patient information leaflets and introduction of generic male and female toilet signs;
3. successful Privacy & Dignity Week, which was attended by members of staff and key stakeholders;
4. upgraded toilet and bathroom facilities on the F-side of the hospital (the oldest part of the hospital estate);
5. development of a weekly breach reporting process across all areas, which has received full clinical engagement;
6. the same-sex accommodation and privacy & dignity agenda has been integral to the delivery of estates and service improvement plans across the organisation; and
7. development of a revised Privacy & Dignity Policy to reflect national guidance.

Initiatives to be implemented in 2011/12

In 2011/12 the following initiatives will be introduced to help achieve the improvement goals:

1. continue the work carried out in 2010/11 to review the provision of patient clothing and gowns to maintain patients' dignity and respect;
2. develop daily breach reporting to highlight escalation requirements for preventing mixed-sex accommodation breaches (unless for a clinical reason); and
3. further enhance the patient flow and timely discharge facilitation from critical care areas to the wards working in partnership with the directorate/ clinical teams.

Board Sponsor
Mrs Mandy Bailey, Chief Nurse

Implementation Lead
Mrs Alison Kelly, Deputy Chief Nurse

Project Lead
Mrs Sheila Wilkinson, Patient Environment Manager

4.3.1 UHSM Performance against key National Priorities in 2010/11

UHSM was able to report compliance with the key regulatory targets throughout 2010/11. The Trust met the Emergency 4-hour waiting time for the year despite significant increases both in attendances and admissions. During the same period, UHSM achieved the referral-to-treatment targets for both non-admitted and admitted patients. The Trust also met all the national cancer targets during 2010/11.

UHSM has, once again, reduced the number of hospital-acquired MRSA bloodstream infections or 'bacteraemia' (five cases against a target of eight) and achieved a further significant reduction in cases of *Clostridium difficile*. The targets for next year (2011/12) are challenging, with no more than 3 MRSA bacteraemia and no more than 64 cases of *Clostridium difficile*. UHSM achieved all the standards included in Monitor's revised *Compliance Framework* in 2010/11 (***Table 4.8***).

Table 4.8: UHSM performance against key national priorities in 2010/11, and specifically, governance indicators published in Monitor's Revised *Compliance Framework 2010/11*

a) Acute targets - national requirements	**2010/11**	**2009/10**	**2008/09**	**Threshold***
Clostridium difficile year-on-year reduction	81	73	160	148 in 2010/11 187 in 2009/10 253 in 2008/09
MRSA - meeting the MRSA objective[(a)]	5	18 (8)	26 (13)	8 in 2010/11 18 in 2009/10 19 in 2008/09
Maximum one month wait for subsequent treatment of all cancers: surgery	99.7%	99.7%	introduced	≥ 94.0%
anti-cancer drug treatment	100.0%	100.0%	during 08/09	≥ 98.0%
Maximum two month wait from referral to treatment for all cancers:				≥ 85.0%
from urgent GP referral to treatment	88.1%	86.1%	97.0%	≥ 95% in 08/09
from consultant screening service referral	97.6%	98.0%	introduced during 08/09	≥ 90.0%
18-week referral to treatment maximum wait[(b)]:				
Non-admitted patients	98.0%	96.7%	95.8% (Q4)	≥ 95.0%
Admitted patients	92.6%	84.1%	90.7% (Q4)	≥ 90.0%
b) Acute targets - minimum standards				
Maximum one month wait from diagnosis to treatment for all cancers	99.4%	99.0%	99.6%	≥ 96.0% ≥ 98% in 08/09
Two week wait from referral to date first seen:				≥ 93.0%
all cancers	96.7%	96.7%	99.9%	≥ 98% in 08/09
for symptomatic breast patients (cancer not initially suspected)	94.9%	new target in 10/11	new target in 10/11	≥ 93.0%
Screening all elective in-patients for MRSA	165%	148%	new target in 09/10	100%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	96.7%	98.1%	97.5%	≥ 95.0% since Jun-10 ≥ 98.0% prior to Jun-10
People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	The preferred local treatment at UHSM is Primary PCI			not applicable
Access to healthcare for people with a learning disability	22/24	21/24	-	no threshold published

**threshold for achievement of standard* *≤ less than or equal to* *≥ greater than or equal to*

(a) In 2008/09 & 2010/11 the MRSA thresholds included community-acquired cases. The figure in parenthesis refers to hospital-acquired MRSA bacteraemia and is comparable with 2010/11;

(b) The 18-week referral-to-treatment standard was removed from Monitor's Revised *Compliance Framework 2010/11* in June 2010.

Annex One

Statements from External Stakeholders

In accordance with the National Health Service (Quality Account) Regulations 2010, UHSM submitted a draft copy of its Quality Account 2010/11 for document assurance to the host Primary Care Trust, NHS Manchester; Manchester Local Involvement Network (LINk) and Manchester City Council's Health and Wellbeing Overview and Scrutiny Committee. Each organisation was asked to review the draft report and provide a written statement for publication in the Annex of this Quality Report. In the case of the host Primary Care Trust this is a statutory requirement.

Written statements were received from Manchester Primary Care Trust (NHS Manchester), Manchester Local Involvement Network (LINk) and Manchester City Council's Health and Wellbeing Overview and Scrutiny Committee, within the 30-day time-scale from receipt of the draft Quality Account 2010/11. Copies of the written statements received are published unedited below.

Statement from Manchester Primary Care Trust (NHS Manchester)

NHS Manchester and South Manchester GP Commissioning Consortium welcome the opportunity to provide a statement on University Hospital of South Manchester NHS Foundation Trust's (UHSM) Quality Account 2010/11. For this purpose, we have reviewed the information available to us and can confirm the accuracy. We have been heartened by the collaborative nature of our discussions relating to the quality of care delivered to patients at UHSM.

We are particularly pleased that patients are clearly placed at the centre of the Trust's vision - 'The South Manchester Way' - which embraces dignity and mutual respect.

As commissioners, we have worked closely with UHSM over the course of 2010/11; meeting regularly to review the Trust's progress in implementing its quality improvement initiatives. We have specified quality requirements in the contract with UHSM, including the CQUIN scheme for 2010/11. These requirements are reviewed regularly, and any additional information, be it from Quality Accounts, audits, reviews, serious incidents, patient feedback or complaints, are also taken in to account.

For some indicators UHSM has not achieved the agreed threshold of improvement. The main concern however, particularly in the first three quarters, has been the timely supply of monitoring data and its quality. This has been discussed with the Trust and they are reviewing their internal monitoring and data provision processes. In this respect we are pleased to note that this document identifies areas for action to improve data quality and we look forward to seeing an improvement in performance.

Investigations into Serious Incidents and 'Never Events' are robust and detailed, however evidence of learning is less evident in this document. We will look forward to working further with UHSM to ensure that this learning is embedded across the Trust.

We were surprised to see little mention of UHSM's excellent work supporting the transfer of community services into the Trust. The drivers behind this have been to improve patient pathways and our expectations as Commissioners would be that this impacts positively on Clinical Quality. We acknowledge it will take some time for all services to be integrated.

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

We are pleased to see the sharing of objective information in this Quality Account as this does assist the public to compare and contrast the quality of services with other providers.

Statement from Manchester Local Involvement Network (LINk)

1. The Quality Account of Healthcare Providers must be sent to the LINk in the local authority area in which the provider has its registered office, inviting comments on the report from the LINk prior to its publication, with any statement (limited to 1,000 words) published as part of the Quality Account.

2. The Quality Account for the year 2010/11 has been received from UHSM, and this is the LINk's statement for inclusion.

3. Providers are asked to consider three chief aspects of quality in the Account:
    - Patient experience
    - Patient safety
    - Clinical effectiveness

4. This consideration should enable patients and public to be assured that the provider is scrutinising all their services, and concentrating on the aspects that need most attention.

5. In the case of UHSM, the LINk is **satisfied** that the Quality Account properly focuses upon the required issues above, and accords with our local knowledge of its healthcare quality:
    - outlining what it has been successful at, and where it sees improvements are required;
    - identifying its priorities for improvement in service quality for the coming year; and
    - and showing how it has involved service users, staff, and others with a legitimate interest to help them check the quality of the services, and determine priorities for improvement.

6. This satisfaction on the part of the Manchester LINk has been possible to report chiefly because of the arrangements negotiated with the Trust to meet regularly throughout the past 12 months, every couple of months or so, to talk through issues and representations brought to the meetings by the Chair and Team Leader of the LINk. The Trust has been represented at the meetings by the Executive Directors, usually the Medical Director and the Chief Nurse. It has allowed an effective exchange of views, including positive and negative events and feedback, so that problematic issues could be handled quickly and effectively. So far, this process has worked effectively in making a contribution to the identification of necessary areas for action and improvement.

Statement from Manchester City Council's Health and Wellbeing Overview and Scrutiny Committee

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

The Committee notes that Quality Accounts are aimed at members of the public. We were particularly impressed with the level of detail contained within the report, which provides the reader with enough background information and data to explain the context for each of your aims and what you have done to achieve them. To improve transparency, we would like to recommend that the University Hospital of South Manchester NHS Foundation Trust consider providing a

‘reader friendly’ simple version of future Quality Accounts, which makes it easy for the public to identify where significant improvements have been made and also where further work is required.

In terms of patient experience we sought assurance from the Trust that it was able to identify and protect vulnerable older people with specific nutritional needs. We were reassured that although you cannot breakdown patient feedback on nutrition by age, all patients undergo an individual assessment to consider their nutritional needs. Although the Trust carries out work to ensure that patient’s nutritional needs are met, we would recommend that this information is more explicit in next year’s Quality Account.

We have noted that there has been a slight increase in the number of falls resulting in moderate or more severe injury. The Trust has recognised that the management and care of patients after a fall could be improved in some areas and it will implement the National Patient Safety Agency recommendations to help support these improvements. The Council looks forward to working collaboratively with the Trust in preventing falls and improving the after-care provided to patients who have experienced a fall.

The Committee has monitored the implementation of the Transforming Community Services programme over the past year and we note that the Trust has taken over community services from April 2011. We understand that it will be a challenge for hospitals to integrate community services and to provide high-quality safe care for patients using those services. We think that this is a priority for the next year and we look forward to reviewing how the Trust measures the quality of these services in their Quality Account in 2011/12.

The Committee felt that the timescale and deadline for commenting on quality accounts is not sufficient for us to provide a full report on all of the elements that we would like. In the forthcoming year, the Committee will look at ways that we can provide a detailed response to next year’s accounts through a continuous piece of work on how commissioners and providers ensure that they provide the best quality of services for Manchester residents. We hope that University Hospital of South Manchester NHS Foundation Trust will support us in carrying out this work.

Annex Two

Statement of Directors' Responsibilities in respect of the Quality Report

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

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

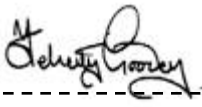
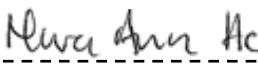
In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010/11;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2010 to May 2010;
    - papers relating to Quality reported to the Board over the period April 2010 to May 2011;
    - feedback from the commissioners dated 27/05/2011
    - feedback from governors dated 09/05/2011
    - feedback from LINks dated 31/05/2011
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 26/05/11*;
    - the latest national patient survey dated April 2011
    - the latest national staff survey dated March 2011;
    - the Head of Internal Audit's annual opinion over the trust's control environment dated 26/05/2011;
    - CQC quality and risk profiles dated September, October, November, December 2010 and February, March 2011.
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

** The Complaints Report is contained within Chapter 4 of the Annual Report and Accounts 2010/11*

By order of the Board
NB: sign and date in any colour ink except black

26th May 2011	Date		Chairman
26th May 2011	Date		Acting Chief Executive

Annex Three

Limited Scope Assurance Report from the External Auditor

Independent auditor's report to the Council of Governors of University Hospital of South Manchester NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of University Hospital of South Manchester NHS Foundation Trust to perform an independent assurance engagement in respect of the content of University Hospital of South Manchester NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the "Quality Report").

Scope and subject matter

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

Respective responsibilities of the Directors and auditors

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

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 content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

We read the other information contained in the Quality Report and considered whether it is materially inconsistent with the documents in the guidance.

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

This report, including the conclusion, has been prepared solely for the Council of Governors of University Hospital of South Manchester NHS Foundation Trust as a body, to assist the Council of Governors in reporting University Hospital of South Manchester NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. 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 University Hospital of South Manchester NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

- reading the documents.

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

Limitations

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

Conclusion

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

Julian Farmer
Engagement Lead
Audit Commission
Aspinall Close
Middlebrook
Bolton
BL6 6QQ

26th May 2011

Annex Four Summary of Quality Initiatives to be implemented in 2011/12

PATIENT SAFETY	2011/12 Quality goals	Reviewed/ monitored
Reducing mortality	• achieve a 2% reduction in the Risk-adjusted Mortality Index (RAMI 2011) compared to a baseline of 97 (March 2010 to February 2011).	• Board of Directors *(monthly)*; • Healthcare Governance Committee *(quarterly)*; • Patient Safety & Quality Board *(bi-monthly)*; • Operational Boards *(monthly)*.
Reducing rates of infection	• no more than 3 cases of hospital-acquired MRSA bacteraemia; • no more than 64 cases of *C. difficile*; • maintain 'excellent' PEAT scores across food/ hydration, Privacy & Dignity and cleanliness.	• Board of Directors *(monthly)*; • Infection Prevention Committee *(monthly)*; • Operational Board *(monthly)*.
National 'Never Events'	• to undertake a review of those 'Never Events' applicable to UHSM to ensure that policies, systems and controls are in place and robust.	• bi-annual review for the Healthcare Governance Committee; • Patient Safety & Quality Board *(bi-monthly)*; • Medication Safety Group *(monthly)*; • Safer Surgery Group *(bi-monthly)*.
Recognising and responding to the signs of critical illness	• a 50% improvement in adherence to the Trust's Modified Early Warning Score (MEWS) escalation policy in cases of cardiac arrest; and • 10% reduction in serious incidents, particularly those occurring during weekends, evenings and night shifts where there has been a failure to recognise and act on the signs of clinical deterioration of the patient.	• Board of Directors *(quarterly)*; • Patient Safety & Quality Board *(quarterly)*; • Healthcare Governance Committee *(quarterly)*.
Preventing medication errors	• aim to consistently achieve 95% of patients having medicines reconciled within 48 hours of admission; • perform clinical audits of high-risk medications via project groups; and • sustain efforts to improve medication error reporting and use of the Global Trigger Tool to improve data quality and identify problems.	• Board of Directors *(quarterly)*; • Healthcare Governance Committee *(quarterly)*; • Patient Safety & Quality Board *(quarterly)*; • Medication Safety Group *(monthly)*.
Reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE)	• at least 90% of adult inpatients will be risk assessed for venous thromboembolism (VTE) on admission.	• Board of Directors *(monthly)*; • Healthcare Governance Committee *(quarterly)*; • Patient Safety & Quality Board *(quarterly)*; • Thrombosis & Thromboprophylaxis Committee *(monthly)*; • Operational Boards *(monthly)*.

Preventing harm from falls	• more than 90% of adult inpatients to have a falls risk assessment on admission; • 85% of adult inpatients will have (evidence of) appropriate preventive intervention in agreed audit samples by Quarter 4; • more than 80% of patients considered to need a falls risk review will receive one; and • the Trust will be able to demonstrate compliance with the falls intervention programme at case review for all patients who suffer or moderate or severe harms as a result of an inpatient fall.	• Board of Directors *(quarterly)*; • Healthcare Governance Committee *(quarterly)*; • Patient Safety & Quality Board *(3 times per year)*; • Falls Group *(bi-monthly)*.
The World Health Organization's (WHO) Surgical Safety Checklist	• 100% of UHSM patients in theatre settings to have the WHO Surgical Safety Checklist completed; and • before the end of 2011 all relevant interventional areas will have adapted and introduced a version of the Surgical Safety Checklist.	• Board of Directors *(quarterly)*; • Healthcare Governance Committee *(quarterly)*; • Patient Safety & Quality Board *(quarterly)*; • Safer Surgery Group *(bi-monthly)*.
Global Trigger Tool	• analyse two years of collected data in August 2011 to evaluate the effectiveness of UHSM's Patient Safety & Quality Programme and to assess whether the key interventions are helping to reduce harm.	• Board of Directors *(bi-annual review)*; • bi-annual review for the Healthcare Governance Committee; and • Patient Safety & Quality Board *(bi-annually)*.
Preventing hospital-acquired pressure ulcers	• 95% of all patients to be risk assessed for pressure ulcers; this will be documented according to the Trust's policy; • monthly monitoring of hospital-acquired pressure ulcers and feedback on learning; • reduce the number of incidences of grade 3 and grade 4 pressure ulcers compared to 2010/11; and • conduct a baseline analysis of pressure ulcer incidence within the relevant community services.	• Board of Directors *(monthly)*; • Patient Safety & Quality Board *(every 8 weeks)*.

CLINICAL EFFECTIVENESS	**2011/12 Quality goals**	**Reviewed/ monitored**
Advancing Quality Programme	• acute myocardial infarction (heart attack) (95.0%) • coronary artery bypass graft (95.0%) • hip & knee replacement (95.0%) • heart failure (75.1%) • community-acquired pneumonia (83.4%) • stroke (threshold expected to be published in summer 2011)	• Board of Directors *(3 times per year)*; • Healthcare Governance Committee *(3 times per year)*; • Patient Safety & Quality Board *(3 times per year)*; and • Operational Boards *(quarterly)*.
Nursing indicators, Clinical Rounds and Essence of Care	• nursing indicators to be embedded in all ward areas with agreed tolerances; and • data included from the AUKUH Acuity & Dependency Tool to establish areas of concern that require action.	• Board of Directors *(quarterly)*; and • Patient Experience Committee *(bi-monthly)*.

Improving the PATIENT EXPERIENCE	2011/12 Quality goals	Reviewed/ monitored
Gaining feedback from patients & Responding to patient feedback	• UHSM to be in the top 20% of trusts in the National Patient Survey results; • 80% of complaints responded to within 25 working days; • implement the first year of the *'Patient Care at our Heart, it's Everyone's Responsibility'* Strategy; and • at least 96% of patients would recommend UHSM to others.	• Board of Directors *(monthly);* and • Patient Experience Committee *(bi-monthly)*.
Treating Patients with Dignity & Respect	• over 95% of respondent saying that they did not share sleeping areas with a patient of the opposite sex in the local Patient Perception Survey; • the Trust's revised Privacy & Dignity Policy is operational in all departments; and • implement an electronic reporting process for identified ward areas to monitor patient flow and the placement of patients.	• Board of Directors *(monthly);* • Patient Experience Committee *(bi-monthly)*; and • Privacy & Dignity Board *(monthly)*.

05 Directors' Report

UHSM is a part of the National Health Service and was established as a Foundation Trust for the provision of goods and services for the purposes of healthcare in England, which is UHSM's principal activity, on 1 November 2006.

UHSM is a complex healthcare organisation offering a wide range of specialist, district general hospital and local community based services. UHSM has major undertakings in research and education, alongside a variety of service specialisms, which attract patients from across the region and nationally. The majority of UHSM's patients come from the Public Membership area designated 'Areas 1-5' illustrated in Appendix 3. These areas are in the vicinity of South Manchester and Trafford.

UHSM contracts with a number of commissioners of healthcare services in the North West region. The commissioners, known as Primary Care Trusts, establish legally binding contracts for specified quantities and quality of service. The economic downturn, political uncertainty and forward looking focus of Monitor have warranted the Board to carefully consider possible scenarios for 2011-15 during a likely period of reduction in growth of NHS funding, or even a reduction in real funding itself.

Demand for NHS services continues to increase as innovations make more treatments possible and life expectancy increases. UHSM is experiencing an increasing demand for services, which may be incompatible with the ability of commissioners to fund it over the next parliament. The Board recognise this as a key strategic risk. At the time of writing this report, the coalition government has initiated a three month listening exercise, which may have an impact on the ambitions set out in the health and Social Care Bill.

The Board reviews the major risks to the achievement of UHSM's objectives every month, using a scoring system based on best practice techniques. Scores are calculated using a combination of weightings for the likelihood of a risk materialising and the impact should it do so. The Chief Executive takes specific leadership responsibility for chairing the Risk Management Committee and reporting to the Board monthly on those significant risks which are scored above a threshold.

As described in the introductory sections of this report, the achievement of UHSM's performance targets has been a challenge for the organisation during 2010-11, and the Board's very significant focus during the year, as it was during 2009-10, has been on planning for and implementing changes which will enable the Trust to serve its patients and carers even better.

The risks relating to the achievement of 2011-12 indicators and targets are recognised. The focus on financial constraints, increasing demand and the resultant required efficiency improvements is increasing. The integration of community services acquired as of 1 April 2011, from NHS Manchester has been planned and is being implemented. There may be additional opportunities to provide more services to patients to Trafford and the Board is eager to collaborate with partners locally to improve services for local residents there.

The significant risks which concerned the Trust during 2010-11 are explained in greater detail in this Annual Report within the Annual Governance Statement where the control systems used to reduce the potential harm to UHSM and its patients are explained. For 2011-12 the risks faced by UHSM and its patients remain very similar.

During 2010-11 UHSM implemented a new clinical leadership structure across the patient-facing directorates of the organisation. This management structure has provided a new dimension to the shaping and planning of services.

The Board recognises the importance of working with stakeholders and partners in the healthcare economy to redesign services to improve efficiency, and this is a key focus of activity for the coming year.

Whilst the outlook remains tougher than for a generation, the Board is making appropriate plans to secure the future for UHSM and to further improve the way UHSM cares for its patients and their carers. The Board reports elsewhere that in its view UHSM is considered a going concern.

PFI contact relationship

In August 1998 the Trust entered into a Concession Agreement under a Private Finance Initiative (PFI) to construct a new 400-bed Acute and Mental Health development on the Wythenshawe Hospital site.

In addition to the provision and servicing of the new PFI development, the Concession Agreement was structured to also include the delivery of all estates and facilities services to the existing residual hospital estate.

UHSM has a contract with the PFI Special Purpose Vehicle (SPV), South Manchester Healthcare Limited (SMHL), which ensures the delivery of all hard and soft estates and facilities services to the Trust “operational estate” through the management of two primary service providers. These service providers are currently Atkins Healthcare Asset Management (AHAM), who carry out planned and reactive maintenance to the estate, and Sodexo UK who provide the remainder of the soft facilities services.

During 2010 the Trust commenced a value-for-money benchmarking assessment of the services provided by Sodexo, as facilitated by the Concession Agreement every 10 years. Consequently, the Trust has negotiated with SMHL a "Hotel Services Proposal" which provides for a number of signficant revisions to the services delivered by Sodexo. This brings Sodexo service provision up-to-date in respect of meeting current industry standards but also, importantly, helps ensure that services provided better meet the requirements of front line clinical services. Integral to the delivery of these service enhancements is the realisation of a number of cost savings which will assist the Trust in the delivery of its Fit-for-Fifteen cost efficiency and productivity improvement programme. It is expected that the Hotel Services Proposal will be fully mobilised from September 2011.

Consultations

UHSM launched a consultation with staff in May 2010 on plans to make changes to the management structure in order to further enhance the clinical leadership of front line services. As a result of the consultation, changes were made to the proposals, and then implemented in autumn 2011.

UHSM is currently consulting with staff about the changes to the on-call payments following the national protection arrangement for on-call payments ending on 31st March 2011.

UHSM meets with its Joint Trade Unions and Local Negotiating Committee for Medical Staff on a regular basis to formally consult on staffing matters and is committed to the principles of partnership working and staff involvement. UHSM recognises the importance of building effective communication, consultation with its Trade Union colleagues and staff representatives.

Information on health and safety and occupational health

UHSM has in place a very clear structure in respect of all matters relating to health and safety management, which discharges the requirement to have in place competent heath and safety support, as defined and required in Regulation 7 of the Management of Health and Safety at

Work Regulations 1999. The Chief Executive is responsible for UHSM's performance in relation to Health and Safety matters and the Board takes its Health and Safety obligations very seriously. From 1st October 2010 the Chief Risk Officer assumed responsibility for the coordination and oversight of Health & Safety arrangements at UHSM on behalf of the Chief Executive.

UHSM continues to demonstrate strong compliance in respect of the health and safety. This is based upon having in place an approved Fire and Health and Safety Policy and Strategy and a scheme of delegation is in place amongst Directors for Health and Safety matters. Health and Safety responsibilities are contained within job descriptions.

UHSM has a specialist source of Health and Safety advice and Health and Safety issues are reported in Hospital Incident Reporting System and the learning shared amongst management by lower level reporting.

UHSM has received no enforcement or prohibition notices from either the Health & Safety Executive or Fire Service during 2009-10, and reduced the number of RIDDOR reportable incidents and unwanted fire signals during the year. An Internal Audit has provided an audit opinion of "Significant Assurance" for the Trust's arrangements. UHSM has undertaken two external visits of leading manufacturing industries to observe Health & Safety practices and further develop the Trust's Health & Safety arrangements. All health & safety criteria covered under the NHSLA's Risk Management Standards were independently verified and achieved Level 3 compliance at assessment in January 2011.

The Occupational Health Department establishes and maintains a safe and healthy working environment. It facilitates reasonable adaptations of work to the capabilities of workers in relation to their physical and mental health. It conducts health assessments, health/education promotions, health surveillance, environmental monitoring/workstation assessment, immunisations and vaccinations including the recent swine flu vaccinations, referrals for further treatment, rehabilitation, work related accidents, physiotherapy, counselling and management referrals.

Consultation with local groups and organisations, including the overview and scrutiny committees of local authorities covering the membership areas;

UHSM is committed to working in partnership with stakeholders within the community it serves. The Board does not assume these good relationships, but acknowledges the need to work at creating and sustaining them. The Board also recognises the importance of engagement and defines, alphabetically, those primary stakeholders pivotal to UHSM as:

Fundraisers

UHSM has on site almost a dozen charities - some new, others long established - which consistently raise funds for equipment and projects in specific areas of the hospital. It is Board policy to actively promote their cause and success within UHSM, and to meet regularly with their committees to avoid duplication of effort and purpose.

Governors

The 32 UHSM Governors are elected or appointed by the constituents they serve (public, staff, community), and it is Board policy to work closely with them to inform the decision-making process on issues which affect UHSM's safety, quality and patient experience agenda. The Board provides a comprehensive range of papers, reports, seminars and visits to ensure Governors and their committees are kept well informed. Governors are encouraged to attend Part 1 Board meetings and they receive a monthly detailed summary of business from the Chairman. Board papers for Part 1 meetings are published on the UHSM website, with some redactions of commercially sensitive content, within 3 weeks of the meeting.

Local Authorities and their elected representatives

UHSM has forged strong relationships with Manchester City Council and Trafford MBC at senior level. The UHSM strategy sets out a programme for ensuring that UHSM plays a significant role in helping the social and economic development of its local communities as well as promoting

better health and reducing health inequalities. UHSM regularly briefs the elected representatives of local communities.

Media
The Board recognises the importance of local and regional newspapers, radio and TV as a wide-ranging channel to inform all stakeholders of the work undertaken at UHSM. It is Board policy is to proactively engage with the media in an open and honest way.

Members
UHSM has over 5,000 public members, as well as a similar number of staff members. It is Board policy to ensure its membership is representative of the community it serves, to regularly communicate with them on successes around new treatments and care, and to provide them with information and updates on services. Even more importantly, the Board is committed to listening to the voices of local people and stakeholder organisations so that the plans it makes will more closely deliver services that people need and want.

MPs
UHSM keeps MPs representing all of its main catchment areas regularly briefed and consults them on any major changes to services which are planned and which may affect their constituents.

Overview and scrutiny committees of Manchester City Council and Trafford Council –
UHSM recognises the importance of liaising with both Councils, particularly as the provision by UHSM of community services from April 2011 comes at a time when local authority social service budgets are under pressure.

Patients
'Patient Care is at Our Heart' and it is Board policy to seek the views and canvass the opinions of UHSM patients, their families and carers to shape present and future services.

PCTs
UHSM works with local PCTs as well as other community partners to develop an integrated health service which meets the needs of individual patients as well as the needs of the community as a whole.

Staff
The Board believes that the involvement and engagement of staff is important in the future development of the Trust, particularly because almost 70 per cent of the people who work at UHSM live in the Trust's catchment area. The programme of cultural change 'The South Manchester Way' is pivotal to the successful transformation of the way UHSM functions, and receives Executive Director focus continually.

Volunteers
The Board is extremely grateful to the 500 people (many of whom are current or former patients) who give their time to support services and the staff at UHSM. It is Board policy to welcome and reward them by acknowledging the enormous contribution they make.

Other Community Partners
The Board notes it is important to keep local MPs, councillors, GPs, LINks and civic and cultural leaders aware of developments at UHSM, and adopts a policy of proactive engagement and inclusivity.

Untoward incidents resulting in loss of personal data
The Trust has put in place information governance arrangements to protect patient interests which meet with the requirements for a Public Authority. One serious untoward incident involving data loss has occurred during the year 2010-11. The Office of the Information Commissioner has

been informed. UHSM had 23 personal data related incidents of a lesser severity, compared to 11 in the previous year.

Further work is being undertaken to protect patient data from theft and unauthorised disclosure and to reinforce the information governance processes and procedures within the Trust. As part of this initiative, UHSM has updated mandatory staff training content, and linked satisfactory completion of mandatory staff training to incremental pay progression.

A summary of incidents for the 2010-11 year is provided below.

***Table 5.1*:** Serious Untoward Incidents involving Loss of Personal data during 2010-11

Summary of Serious Untoward Incidents Involving personal data as reported to the Information Commissioner's Office in 2010-11

Date of Incident Month	Nature of Incident	Nature of data involved	Number of People affected	Notification Steps
December 2010	Loss of unencrypted USB An action plan is in place to prevent a recurrence.	Patient identifiable	87	ICO

Table 5.2: Other Personal Data Related Incidents during 2010-11

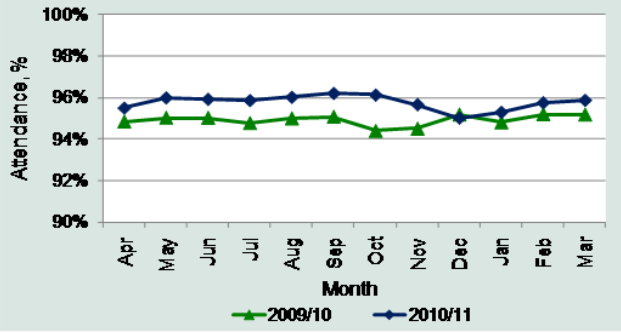
Summary of Other Personal Data Related Incidents
(not reportable to the Information Commissioner)

Category	Nature of Incident	Total
1	Loss/theft of inadequately protected electronic devices or paper documents from NHS secured premises	6
2	Loss/theft of inadequately protected electronic devices or paper documents from outside NHS secured premises	1
3	Insecure disposal of inadequately protected electronic devices or paper documents	1
4	Unauthorised disclosure	11
5	Other	4

Staff Attendance

Performance for the year was 95.7% which is an improvement on the 94.8% figure achieved last year. The figure is just above the 95.5% target and has demonstrated an upward trajectory from January 2010. This has been largely attributed to the launch of the new Managing Attendance policy in April 2010 which is an important element in supporting management in delivering the levels of attendance required to provide the services patients require. These figures are illustrated in Figure 5.1 below.

***Figure 5.1*:** Monthly attendance by UHSM staff during 2010-2011



Regulatory Ratings

Monitor is the Independent Regulator of Foundation Trusts. Monitor has devised a system of regulation described in its Compliance Framework, which is available from the Monitor web site. http://www.monitor-nhsft.gov.uk/home/our-publications?id=932

Monitor takes a proportionate, risk based approach to regulation. The assessment of risk by Foundation Trusts and by Monitor was articulated during 2010-11 in terms of risk ratings. These risk ratings were assessed under headings of financial risk and governance risk. An explanation of the ratings can be found at Appendix A4.

Monitor escalated its scrutiny of UHSM during 2009-10, as described in the annual report for that period. Monitor's concerns related initially to the failure to achieve MRSA infection targets, further failures to meet the 18 Week *referral to treatment* target, the Emergency Care 4 Hour target and governance concerns.

By early 2010, the Board had implemented considerable change and performance had improved such that Monitor informed UHSM of its intention to consider de-escalating the trust. Following a meeting in June 2010, confirmation was received in early July 2010 that UHSM would be de-escalated with immediate effect. UHSM's governance rating was initially improved to amber/green, and then one quarter later, to green.

***Table 5.3*:** UHSM's risk ratings based on annual plans and quarterly assessments during 2009-11

	Annual Plan 2009-10 rating declared by UHSM	**Annual Plan 2009-10 rating assessment determined by Monitor**	**Q1 2009-10**	**Q2 2009-10**	**Q3 2009-10**	**Q4 2009-10**
Financial Risk rating	3	3	3	3	3	3
Governance Risk rating	Amber	Amber	Red	Red	Red	Red

	Annual Plan 2010-11 rating declared by UHSM	**Annual Plan 2010-11 rating assessment determined by Monitor**	**Q1 2010-11**	**Q2 2010-11**	**Q3 2010-11**	**Q4 2010-11**
Financial Risk rating	3	3	3	3	3	3
Governance Risk rating	Green	Green	Red	Amber/ green	Green	Green

By the end of 2010-11, the UHSM Board had achieved against all of the indicators and targets for the year. This has been achieved by beginning a process of service transformation in a wide range of areas described later within this chapter.

Principal risks and uncertainties facing UHSM

UHSM has a statutory obligation to describe the principal risks facing the organisation. These are described within the annual governance statement, appearing at chapter 8.3.

Organ donation performance

During the last financial year at UHSM referral rates of patients who may be potential organ donors have vastly improved. Four families have consented to the organ donation of their deceased loved ones, resulting in liver, kidney, heart valve and tissue transplants, which have saved and enhanced many lives. In comparison, during the financial years of 2007, 2008 and 2009 there was a total of five families who consented to organ donation (2, 0 and 3 respectively). It is humbling that families find this strength and generosity at a tragic time for themselves, to think of others and allow organ donation to occur. At UHSM the wishes of individuals are recognised and respected, the organisation strives to provide the highest quality support to potential donors and their families.

The UHSM Organ Donation Committee was formed in May 2010, chaired by Non Executive Director Lorraine Clinton. It meets quarterly and its purpose is to ensure organ and tissue donation is seen as a usual and not an unusual event, to identify and resolve any obstacles to donation, and monitor / analyse performance data to support and develop further strategies with the aim of improving organ donation rates. A Tissue Donation Sub-Committee has also been set up in response to an identified need to increase the number of tissue referrals from within the hospital, and to educate and support staff regarding tissue donation issues.

5.1 Operational Performance and Service Developments

During the last twelve months the Trust has again focused significant effort on successfully reducing the incidence of hospital-acquired infection. In addition the Trust has made many improvements to pathways which have helped deliver the emergency (A&E) and elective access targets (Referral-to-Treatment and Cancer) despite the increases in demand highlighted in Table 5.1.1.

Table 5.4: Trust activity for the period 2007/08 to 2009/10

Activity	2007/08	2008/09	2009/10	2010/11
Emergency Department attendances	80,832	82,977	85,321	86,344
Inpatients and day cases	71,670	76,592	78,734	84,661
Outpatients*	312,241	355,396	370,180	378,297
Total	**464,743**	**514,965**	**534,235**	**549,302**

** includes ward attendance*

The Trust experienced a 2.2 per cent increase in demand for outpatient attendances in 2010/11 when compared to 2009/10 and a 1.2 per cent increase in Emergency Department attendances. The number of patients treated as an inpatient or a day-case during 2010/11 increased by 7.5 per cent on the number treated in 2009/10.

Summary of Service Performance 2010/11

Table 5.1.2 sets out the Trust's performance against Monitor's revised *Compliance Framework 2010/11*. UHSM achieved all the standards in each quarter of 2010/11. The performance levels are colour-coded based on the performance thresholds; achieved (green) and failed (red).

UHSM was able to report compliance with the key regulatory targets throughout 2010/11. The Trust met the Emergency 4-hour waiting time for the year despite significant increases both in attendance and admissions. During the same period, UHSM achieved the referral-to-treatment targets for both non-admitted and admitted patients. The Trust also met all the national cancer targets during 2010/11.

UHSM has, once again, reduced the number of hospital-acquired MRSA bloodstream infections or 'bacteraemia' (five cases against a target of eight) and achieved a further significant reduction in cases of *Clostridium difficile*. The targets for next year (2011/12) are challenging, with no more than, 3 MRSA bacteraemia and no more than 64 cases of *Clostridium difficile*.

Table 5.5: UHSM Performance against the governance indicators in Monitor's revised *Compliance Framework 2011/12*

a) Acute targets - national requirements	Q1	Q2	Q3	Q4	Threshold
Clostridium difficile year-on-year reduction (annual threshold 148 cases)	27	18	15	21	34 cases (Q1&2) 40 cases (Q3&4)
MRSA - meeting the MRSA objective	2	0	1	2	2 cases per quarter
Maximum one month wait for subsequent treatment of all cancers: surgery anti-cancer drug treatment	100.0% 100.0%	100.0% 100.0%	100.0% 100.0%	99.0% 100.0 %	≥ 94.0% ≥ 98.0%
Maximum two month wait from referral to treatment for all cancers:					
from urgent GP referral to treatment	87.6%	88.4%	90.2%	87.4%	≥ 85.0%
from consultant screening service referral	97.9%	97.7%	97.2%	99.0%	≥ 90.0%

b) Acute targets - minimum standards	Q1	Q2	Q3	Q4	Threshold
Maximum one month wait from diagnosis to treatment for all cancers	100.0%	99.5%	99.8%	99.0%	≥ 96.0%
Two week wait from referral to date first seen:					
all cancers	97.0%	96.6%	97.8%	96.3%	≥ 93.0%
for symptomatic breast patients (cancer not initially suspected)	94.3%	93.9%	96.4%	95.1%	≥ 93.0%
Screening all elective in-patients for MRSA	138.8%	154.5%	164.0%	215.9%	100%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	98.08%	97.07%	95.58%	95.70%	≥ 95.0%
People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	The preferred local treatment at UHSM is Primary PCI				Not applicable
Access to healthcare for people with a learning disability	87.5%	91.7%	91.7%	91.7%	No threshold published

Healthcare-Acquired Infection

As a consequence of failing the MRSA objective in 2008/09 the Trust generated a thorough review of its infection prevention processes and generated an action plan designed to significantly improve performance against the critical healthcare-acquired infection (HCAI) standards. Implementation of this action plan has continued through 2010/2011 and as a result the improvement seen last year has been sustained. This improvement has seen UHSM achieve its HCAI trajectories for both MRSA bacteraemia and incidences of *Clostridium difficile* for the second year in succession.

During 2009/10 the Trust introduced new infection prevention processes and delivered a high-profile communication campaign which led to increased awareness of the importance of infection prevention. In addition to improving outcomes the work done in 2009/10 and continued during 2010/11 has been successful in generating a culture in which infection prevention is considered 'everyone's responsibility'. This culture has withstood the many challenges faced by the Trust and the newly-formed directorates during 2010/11.The Monthly Infection Prevention Performance

Meetings chaired by the Chief Nurse have continued to provide a valuable forum for the directorates to report back and monitor local infection prevention audits and infection rates.

Some of the key successes and measures implemented during 2010/11 are listed below:

1. a new infection prevention e-learning package was introduced;
2. the Route Cause Analysis (RCA) tools for both MRSA bacteraemia & *Clostridium difficile were revised;*
3. a skill-mix review of the Infection Prevention Team was conducted resulting in new recruitment to the Team;
4. MRSA screening for relevant emergency patients was introduced;
5. a new decontamination group for utilities and ventilation was established in collaboration with the Trust's PFI partners;
6. the Trust achieved NHSLA level 3 for infection prevention standards in January 2011;
7. the Trust maintained its 'Excellent' PEAT (Patient Environment Action Team) scores in early 2011.

Emergency Access

The Trust achieved the emergency access standard in 2010/11. Several initiatives have been completed during the year to improve the management of emergency patients, including:

1. the introduction of an Urgent Care Centre adjacent to the Emergency Department (ED). This provides additional physical capacity and a more appropriate environment for the treatment of patients with minor injuries. The availability of this new facility enables the ED to focus its efforts on more seriously ill patients;
2. the introduction of a 7-day Paediatric Observation and Assessment Unit. This unit provides an alternative, more appropriate, area for the assessment of children referred by GPs;
3. the development of te Surgical Assessment Unit (SAU) to create a more appropriate environment for emergency general surgical and urological referrals has helped reduce the demands on the ED;
4. the expansion of the Integrated Assessment Team, which facilitates the discharge of patients with more complex discharge needs from the Medical Assessment Unit;
5. the Trust has established 'daily board rounds', on the core medical wards, designed to ensure that a patient's stay on an acute ward is minimised through a daily review of the medical management plan by senior clinicians;
6. the development of an electronic tracking tool, populated by the Trust and Social Services, which provides advanced notification of a patient's 'estimated date of discharge' so that social care packages can be prepared in parallel with a patient's medical recovery in order to minimise length-of-stay.

In 2011/12 the Trust will develop strategies to provide alternatives to admission (e.g. ambulatory-care pathways) and minimise length-of-stay through early supported discharge. The opportunities afforded by closer working arrangements with social services and the integration of the community health provider arm with the Trust will be fully evaluated.

Elective Access

UHSM has achieved the referral-to-treatment targets for both non-admitted and admitted patients during 2010/11. This performance has been delivered because of improved processes across the scheduled care pathway. Some of these developments and other key successes are outlined below:

1. the Admissions Lounge, which opened in November 2010, provides a facility in which patients are safely prepared for surgery and transferred to theatre in a timely manner;

2. the Productive Operating Theatre Programme was launched in November 2010. This initiative supports the Trust's aims to improve quality and safety and to put frontline staff in the driving seat for improvements. The outcomes of this work will be to:
    - increase the safety and reliability of care through reducing errors and incidents of harm in theatres;
    - improve team performance and teamwork;
    - improve the quality of the patient's experience and clinical outcomes;
    - add value and improve efficiency;
3. the Colorectal Team at UHSM has been working on the Enhanced Recovery Programme during 2010/11 and successfully launched the pathway for its patients in November 2010. The programme is concerned with improving patient outcomes and speeding up a patient's recovery after surgery. It results in benefits to both patients and staff. It is anticipated that other specialties will join the programme in the next 12 months;
4. the Trust's radiology improvement project has delivered significant service improvements in 2010/11. Considerable work has been undertaken to improve the processes associated with the reporting of radiological images thereby enabling the radiology team to provide a more efficient, responsive reporting service. The vision is to deliver a report for all examinations requiring interpretation by a radiologist on the same day that the examination is undertaken;
5. a number of ward areas completed the Productive Ward Programme in 2010/11 and can provide evidence of improvements in patient care that have resulted from this work;
6. the Trust has been successful in submitting a proposal to the Greater Manchester and Cheshire Cancer Network to lead a Network-wide project aimed at improving lung-cancer pathways. The focus of the work will be to redesign a new streamlined clinical pathway and an agreed action plan for implementation;
7. in 2010 UHSM's Maternity Services achieved UNICEF Baby Friendly Stage 2 accreditation. UHSM aims to achieve full accreditation as a Baby Friendly Hospital;
8. to ensure that UHSM benefits from collaborative learning with other healthcare organisations the Trust has joined the Advancing Quality Alliance (AQuA) which seeks to ensure the spread of best-practice amongst partner organisations. During 2011 AQuA will be launching programmes aimed at:
    - developing new approaches to the better management of long-term conditions and urgent care;
    - the promotion of shared decision-making with patients to help better manage elective demand;
    - providing support for improving productivity, including length-of-stay reductions, enhanced recovery approaches and community services initiatives;
    - the reduction in harm caused by falls, VTEs, pressure ulcers and catheter-acquired infections.

Cancer Care

UHSM achieved all the national cancer standards during 2010/11. Some of the developments in cancer care delivered at UHSM during 2010/11 are detailed below:

1. all surgical lung-cancer activity for Greater Manchester and Cheshire Cancer Network is now delivered at UHSM, following the transfer of thoracic surgery from Central Manchester Trust in 2010;
2. UHSM Clinical Nurse Specialist teams have implemented the holistic assessment of cancer patients using nationally recognised assessment tools designed to assess the practical, social, relationship, physical and spiritual needs of the patient and, therefore, significantly improve the quality of care provided to cancer patients;

3. UHSM participated in the first ever National Cancer Patient Survey in 2010. The response rate was 63% with 418 patients completing the survey. The survey did highlight some areas for improvement; however, there were a significant number of 'excellent' comments relating to the Trust's staff and services. The majority of scores were higher than 80% which matched or exceeded national average scores;
4. UHSM continues to contribute to the development of cancer services by participating in research. UHSM has significantly increased its recruitment to research trials during 2010-11 having exceeded both the target of recruitment into randomised control trials (13% against a target of 7.5%) and the overall recruitment target (30% against a target of 10%);
5. the Macmillan Cancer Information Centre will formally be awarded the Macmillan Environmental Quality Mark during 2011/12;
6. the Trust has redesigned pathways making changes to clinical practice, anaesthetic procedures, nursing support and follow-up with the aim of implementing the 23-hour model for the surgical management of breast cancer by 1 April 2011;
7. the Trust undertook eight cancer Multi-Disciplinary Team (MDT) peer reviews in 2010. All MDTs have seen an increase in their compliance against the peer-review measures from last year with the exception of the Specialist Gynaecology MDT where very high compliance has been maintained. Four MDTs (Breast, Specialist Gynaecology, Lung and Specialist UGI) have the highest percentage compliance scores when compared with their peers across the Network.

Estates Development

A number of significant developments to the Trust's estate were made during 2010. These include the following:

- **Making it Better**

During 2010/11, construction continued on the £20 million maternity unit which radically upgrades the Trust's existing maternity facilities, provides a new midwife-led birth centre, hotel-style delivery rooms with birthing pools, fully refurbished clinics and wards and an expanded special care baby unit. Phases 1 and 2 have already been successfully delivered to plan and the Trust continues to construct Phase 3 which comprises an extended and refurbished delivery suite and neonatal unit. The project is due for completion in April 2012.

Former England football captain Rio Ferdinand and his wife Rebecca officially opened the new Postnatal Unit component of the project on the newly refurbished ward C1.

The work is an element of the implementation of 'Making it Better' (MiB) which is the Greater Manchester-wide scheme designed to improve standards of care and provide care closer to home for mothers-to-be and their families.

- **Decontamination Unit**

The Trust has redesigned the way in which endoscopes are reprocessed and has constructed a new purpose-built centralised decontamination unit at a cost of £1.1m. This has brought significant improvements in the way the Trust decontaminates endoscopes and further improves patient safety.

- **Admissions Lounge**

An important aspect of the Trust's patient flow improvement project has been the construction of a purpose-built admissions lounge at a cost of £700k. The new Admissions Lounge considerably enhances the patient experience as patients are now managed in a much more integrated and efficient way prior to their surgery. The Admissions Lounge was officially opened by UHSM's Chief Executive, Julian Hartley, local MP Paul Goggins, Chairman of the League of Friends, David Wilson, and Brian Kay, who celebrated 40 years of service with the League, and other League members and Trust staff.

- **Backlog Maintenance and Infrastructure Improvements**

In 2010 the Trust completed a 2-year £4.4 million backlog maintenance and infrastructure investment programme and upgraded key fabric elements of the Trust's estate including roofs, windows, lifts, decorations, flooring, fire precautions, concrete repairs, energy-saving initiatives and essential electrical and mechanical system replacements / improvements.

- **Picture Archiving and Communication System (PACS)**

To reduce radiography reporting times for patients, during 2010 UHSM created a state-of-the-art PACS viewing suite to provide the radiographers with an environment which best meets their efficiency needs. Key features include variable lighting, comfort cooling and improved ventilation and sound proofing. This has resulted in proven service improvements, meaning faster reporting times for patients, and which are continuing to improve further.

- **Magnetic Resonance Imaging Suite (MR Scanner)**

The Trust's existing 10-year old MR scanner was replaced by an ultra-modern Siemens MAGNETOM Aera Scanner. This new MR scanner includes completely new magnet and coil technology, which allows better pictures and increased accuracy in diagnosis. The new scanner was opened by Royle Family actress and comedienne Caroline Aherne.

- **Ward Improvements**

The Trust commenced a rolling-programme of improving and refurbishing its older bathroom facilities, focused initially around the F-side wards. In total, four F-side wards were improved. This work is planned to continue throughout 2011.

5.2 Education, Research and Development

In October 2010, the UHSM Trust Board approved a five-year Academy strategy which, through its implementation, will see UHSM take its place at the forefront of healthcare education in the UK.

Over the next five years the Academy will deliver eight key strategic objectives:

1. Develop the Academy as a Unique Entity and a novel market leader in health education
2. Institute robust education governance by having standards and structures in place for education which ensure control and accountability in order to achieve continuous improvement of quality and performance
3. Enhance and develop multi professional education to enhance the learning experience of all students and employees ensuring 'one talented team'
4. Impart local, national and Global influence through the growth and enhancement of academy-established primary care, schools and developing world activities
5. Enhance our educational estates and facilities to allow the Academy to deliver state of the art, world class educational activity to its staff and external commissioners
6. Recognise the contribution of our teachers and identify and reward teaching quality
7. Capitalise on the business development opportunities that are arising within healthcare education particularly in the area of accredited course delivery, simulation and leadership development
8. Ensure, with the changes in NHS and Higher Education that UHSM complies with its stakeholder requirements.

Whilst continuing to deliver high quality educational experiences to over 600 medical, allied health professional and nursing undergraduate students and staff, this bold plan is on target and has already generated significant increased educational activity in Global Health, Primary care, health education in schools, healthcare assessments, postgraduate medicine and nursing. Highlights include:

The Health Incident Command Programme

This is a Masters programme which has been developed by two UHSM Emergency Medicine Doctors. The Academy is now administering and marketing the programme

WBEF Network

The Work-based education Facilitators Network is a regional network of 23 staff who support the development of Assistant Practitioners and others in career development. The Academy has won a competitive tender to host the network which will result in a transfer of staff and budgets to UHSM during 2011-12.

Medical Assessments

The Academy is now the host for the United Kingdom Foundation Programme Assessments, several Royal College post graduate assessments, The General Medical Council's fitness to practice assessments and the Medical School's Council Assessment Alliance.

Global Health

The Academy has hosted several global health events, including two Child and Maternal Health Conferences. Further grant funding has been secured to develop the collaboration with Gulu, Uganda, known as the 'Gulu-Man project' under which clinicians from both organisations are offered the opportunity to practise abroad and learn. 2010 saw a further 40 UHSM staff participate in the programme, delivering a significant number of new learning opportunities for staff and students at Gulu Regional Referral Hospital and Gulu University, Uganda. The Academy

has also established the Global Health Programme for the Greater Manchester Health Innovation and Education Cluster.

Research and development

In 2001/11 UHSM conducted 257 clinical research projects supported by funding from Research Councils, charities, UK Government, international funders and industry, including commercial contracts to develop new medicines, devices and procedures.

The number of UHSM patients recruited to participate in this research in 2010/11 was 19,120. This represents a 259% increase on 2009/10 recruitment levels.

Greater Manchester Comprehensive Local Research Network (CLRN) is hosted by UHSM, and in 20010/11 UHSM was the highest recruiting organisation in Greater Manchester. UHSM was also amongst the best compared to equivalent organisations for turnaround of approvals of clinical trials within Greater Manchester.

This increasing level of participation in clinical research demonstrates the UHSM's commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

PROCAS study

Professor Gareth Evans, Professor of Medical Genetics and Oncology is the lead researcher for the PROCAS study, the largest research study in the UK for the detection and prevention of breast cancer. The study involves 60,000 women. Each woman is asked to complete a short questionnaire that asks about family history and lifestyle factors. Extra assessments are also carried out with a mammogram to calculate how dense the breasts are, and some women can, if they choose, provide a saliva sample from which DNA will be extracted and analysed, to assess for genetic risk factors. Women are seen at their routine mammogram appointment, so participation in the study does not require any extra visits.

The PROCAS study aims to predict breast cancer risk for women who attend routine NHS breast screening in Greater Manchester. A woman's risk will be assessed by collecting extra information on each of the most important breast cancer risk factors – family history, lifestyle factors, breast density and genetics.

Each woman will have the opportunity to be told their individual risk, if they choose. Any woman who does want to know their risk of breast cancer, and is high risk will have the opportunity to be seen by a professional at the Nightingale Centre & Genesis Prevention Centre, where they will be advised on ways of reducing their risk, and given the opportunity to attend for more frequent screening and monitoring.
The results of this study could impact on the whole NHS Breast Screening Programme. By incorporating this process of personal risk assessment into routine screening practice, we can predict and prevent more breast cancers in the future.

The PROCAS study is the top recruiting study in the Greater Manchester Comprehensive Research Network and has contributed to UHSM's position as the top recruiting trust in the Network.

Manchester Academic Health Science Centre (MAHSC)

UHSM is one of the founder members of MAHSC, and there has been significant progress in the first two years of operation having focused on three building blocks to underpin and begin delivery of its seven strategic goals: Governance, Organisation and Management; Clinical Themes; and Enabling Infrastructure. Clinical and Enabling Sections leads have been appointed to improve the speed and breadth of translation of research to patient benefit thereby improving the health and wellbeing of our local communities and beyond. Established and effective organisation and

management across the interface between research and clinical care has delivered early benefits to management and governance of research.

Dr Simon Ray, Consultant Cardiologist at UHSM, has been appointed as Clinical Academic Section Lead for Cardiovascular for MAHSC. He will take responsibility for the clinical, enabling and education and training themes that are essential to delivery of the MAHSC strategy within the cardiovascular theme.

Professor Ashley Woodcock, Consultant in Respiratory Medicine at UHSM, has also been appointed as Clinical Academic Section Lead for Inflammation & Repair in MAHSC.

5.3 Financial Standing and Outlook

UHSM is pleased to be able to report good financial performance in 2010/11 underpinning UHSM's operational delivery of healthcare. This is evidenced by the fact that UHSM made a net surplus of £4.46m before exceptional items in 2010/11. This financial result provides a firm base for UHSM to continue to invest in improved facilities and benefit patient care. In addition, the Foundation Trust finished the year with a healthy cash position.

As part of Monitor's Compliance Framework the Foundation Trust is assessed against a Financial Risk Rating model (FRR), which is used to assess financial risk and more specifically to assess the likelihood of a financial breach of UHSM's terms of authorisation. The risk rating is on a scale of 1 to 5, with 5 being the strongest rating and 1 being the weakest. It was agreed at the start of the year by Monitor for UHSM to achieve a risk rating of 3, which has been achieved. This rating indicates that there are no concerns of a financial breach of the terms of authorisation. The following section summarises UHSM's key financial performance and how this has supported the development of the organisation.

Income and Expenditure performance (Statement of Comprehensive Income)

In 2010/11, UHSM achieved a net surplus of £4.46m before exceptional items. The achieved surplus equates to 1.3% of UHSM's turnover. This modest surplus brings a level of financial stability and provides an opportunity for a moderate level of capital investment in future years. The Foundation Trust's financial performance reflects the following key issues:

- the delivery of an £12.3m Cost Improvement Programme (CIP), met through a range of efficiency measures including clinical and corporate restructuring, nursing workforce review and procurement savings
- the opening of the second stage of the maternity capital development following the transfer of inpatient maternity and paediatric services from Trafford General Hospital in 2009/10
- investments in improving Outpatients and the Admissions Lounge to facilitate improved patient flows and experience
- continued challenge in delivering operational performance in respect of the 18 weeks elective access target, the A&E 4 hours access target and cancer targets.

However, during the course of 2010/11 operational performance with regard to earnings before interest, taxation, depreciation and amortisation (EBITDA) of £23.4m (6.7% of turnover) fell below the previous year (2009/ 10 EBITDA was £24.7m, 7.4% of turnover). Key issues to be noted in delivering this reduced level of performance include excess costs of managing a difficult winter period, with the displacement of elective activity to accommodate a significant increase in emergency activity, some of which attracted only a marginal rate tariff from commissioners.

Table 5.6 summarises the 2010/11 Statement of Comprehensive Income performance:

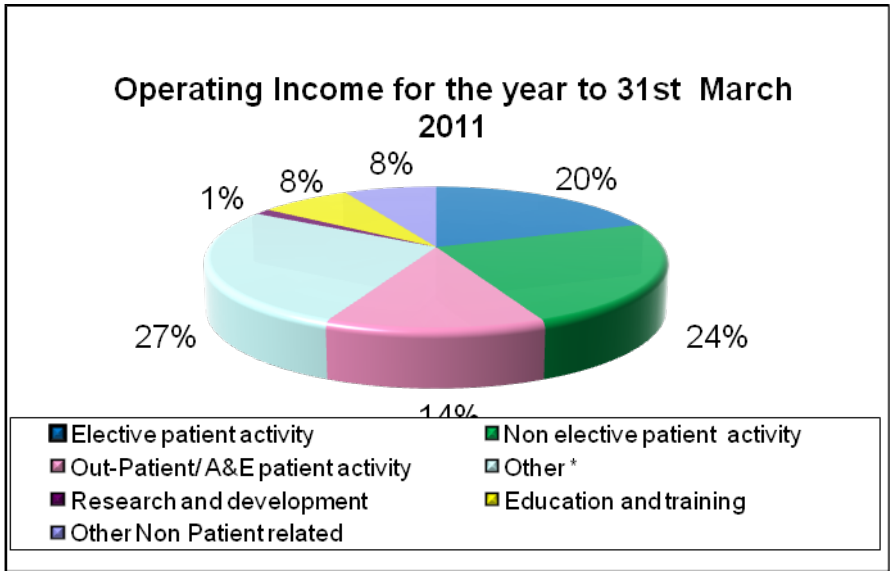
Table 5.6: 2010/11 Summarised Operational Financial Performance

	year ended March 31, 2011 £m
Income	347.75
Operating expenses	(324.39)
EBITDA	**23.36**
Depreciation	(8.97)
Net interest	(8.21)
Gain on disposal of fixed asset	0.02
Surplus before Dividend	**6.20**
Public Dividend Payment	(1.74)
Exceptional items(Impairment of Fixed Assets, costs of reorganisation)	(2.38)
Net Surplus after exceptional items	**2.08**
Add back exceptional items	2.38
Net Surplus before exceptional items	**4.46**

UHSM's income grew modestly in 2010/11 increasing by 4% on the previous year. This increase reflects a rise in the number of inpatient and day cases treated over the previous year. Of particular note is a growth in critical care income due to the provision of a highly specialist treatment for very sick patients suffering from Swine Flu during the winter period, known as Extra Corporeal Membrane Oxidation (ECMO). UHSM's expenditure increased in response to the delivery of additional activity. Pay costs increased by 5% which reflects the impact of pay awards and incremental progression offset by delivery of the Trust's first year of savings under its "Fit for Fifteen" efficiency programme of delivering high quality care at reduced cost .

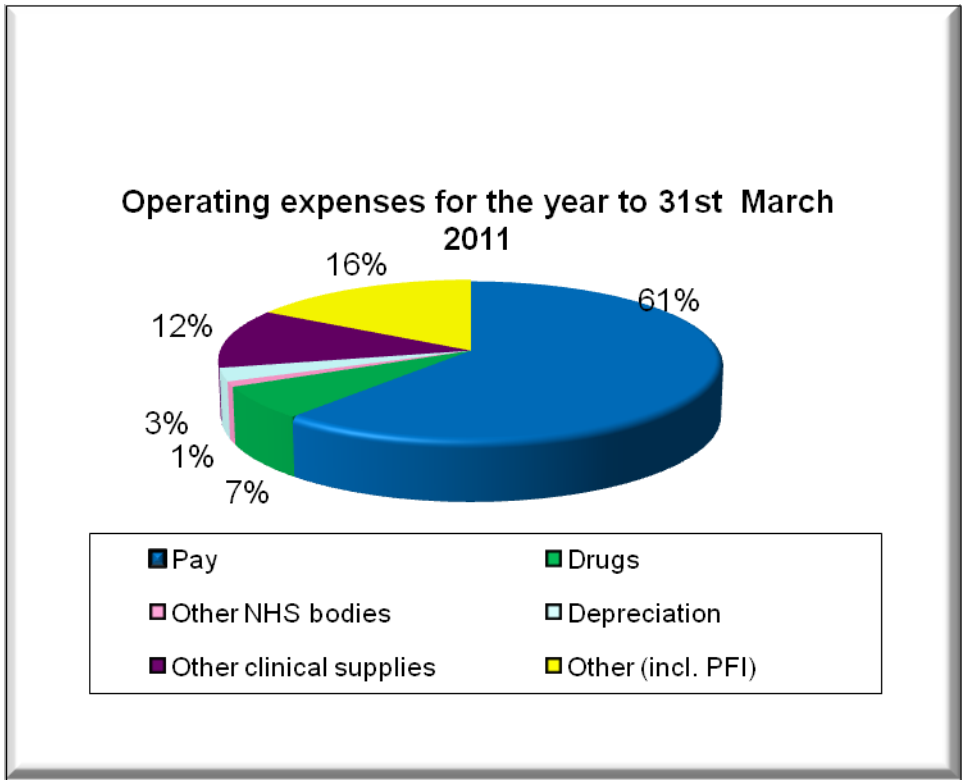
Other cost increases in 2010/11 amounted to 4.3% and were in respect of drugs, clinical negligence insurance premiums (arising from the transfer of maternity services) and cost increases in clinical consumables relating to additional activity. The following pie charts give a breakdown of the sources of income UHSM has generated and where the money has been spent.

Figure 5.2: Analysis of Trust income



As can be seen the largest proportion of UHSM's income is generated from patient related activities, the majority of this is derived from contracts with Primary Care Trusts.

Figure 5.3: Analysis of Trust Expenditure



The largest proportion of UHSM's costs are spent on staff, accounting for 61% of operating expenses with clinical supplies and services the other material proportion accounting for 12%.

Management of the Trust's assets

In delivering excellent healthcare the Trust recognises that it must manage its assets effectively including the buildings and equipment required to provide patient care.

Capital Investments

The Trust has a rolling capital programme to maintain and upgrade its assets and has plans to develop services. In 2010/11 the Trust invested £16.1m of capital expenditure to enhance and expand the asset base.

This included completion of;

- Centralisation of decontamination facilities
- phase two of our Maternity redevelopment
- replacement MRI scanner
- improvements in patient experience via enhancements to our Admissions Lounge and booking and scheduling facilities
- investment in IM&T to improve patient flow management

The following table summarises the expenditure in 2010/11;

Table 5.7: Analysis of capital expenditure

	2010/ 11
	£m
Centralised Endoscopy decontamination	1.4
Admissions Lounge/booking	1.5
Cystic Fibrosis	0.1
Maternity development	7.4
MRI scanner	0.5
Backlog maintenance	3.1
Medical equipment	2.1
Total	**16.1**

This programme of capital investment was funded from £8.0m depreciation, £7.1m from loans, and £1.0m from surpluses made in previous years.

UHSM plans to continue to invest in its assets with the final Phase 3 (£4.9m) of investment in its Maternity redevelopment planned for 2011/12. A research unit is also planned for 2011/12 funded by £2.5m government backed Public Dividend Capital (PDC) which will enable the Trust to enhance its reputation for world leading research. UHSM plans to make further capital investment in its estate and replacement equipment, including an additional operating theatre and refurbishment to Outpatient facilities. These developments will build upon previous investments in infrastructure and support the aim of improving the environment of the Foundation Trust's facilities and the patient care that is offered. However, in the context of reduced NHS funding constraints the Trust's forward capital spending plans will be at a more moderate level.

Liquid Assets

At the end of March 2011 the Trust held £44.6m in cash balances. This is an increase on last year's cash and cash equivalents reflecting improved cash management; the impact of the Trust acting as host for a number of services such as the Comprehensive Local Research Network (CLRN) and the North West Leadership Academy (NWLA); and year end contract settlements with PCTs.

Key Financial Risks

Overall UHSM's financial results are satisfactory. In delivering this financial position UHSM has had to manage the following key financial risks:

- the delivery of a challenging cost efficiency programme totalling in excess of £12m
- the cost of delivering the elective 18 week and A&E 4 hour access targets and associated increased activity volumes
- excess costs of additional bed capacity and premium staffing costs

Careful management of the Trust's finances since our authorisation as a foundation trust provides a solid base for UHSM in developing its financial plans going forward. There will continue to be financial challenges and the key financial risks as the Trust embarks on the 2011/12 financial year include:

- delivery of a £17.5m savings target which is £5m higher than the level of savings target in 2010/11
- the affordability of further increases in activity for UHSM's commissioners

- Potential contract penalties which may be applied by commissioners across a range of key performance indicators including but not restricted to non achievement of 18 week and *C. difficile* targets and
- delivery of a challenging range of new quality targets as part of the linkage between income and quality as outlined under the Commissioning for Quality and Innovation (CQUIN) national initiative and maintenance of performance across 2010/11 targets .

These risks are all being actively managed by the Board of Directors.

Forward Look

UHSM and the Board of Directors are mindful of the challenges facing the Trust in the current economic climate. Through prudent financial management and by building on the business improvement processes delivered in 2010/11 the Trust is in a good position to meet the considerable financial and performance challenges ahead of it. Our continued priority will be on improving the quality and safety of our patient services ensuring that our patient pathways and operational processes continue to be as efficient as possible.

5.4 Social Responsibility

Having delivered significant improvements in key areas of performance over the last twelve months the focus for UHSM this last year was to realise the ambition to providing patients with the best possible safety, quality and experience of any hospital in the country. In order to do this UHSM set out to bring Clinical Leadership at UHSM to centre stage to lead on the improvements needed and in order to respond to the challenges faced.

The acclaimed Darzi Report 'High Quality Care for All' was clear in its conclusion that clinical leadership needed to be stronger within the NHS. In order to respond UHSM announced its commitment to a new way of working, whereby senior clinicians, nurses and managers would work as a team to play a greater role in leading and managing UHSM and in shaping its future. Following a period of consultation, a new structure was implemented putting clinicians at the head of Directorate teams creating the environment whereby clinical leaders, in partnership with professional managers and senior nurses, are delivering improvements in patient care, quality and performance whilst being accountable for the Directorates they lead. By changing UHSM's management structure the Foundation Trust has established that future management processes and decision making will be even more effective.

The change was bold and the different emphasis challenged the existing way of working. Changes were also introduced across the corporate teams to adapt to the new structure and the new ways of working.

The first cohort of leaders within the new structure have completed the Clinical Leadership development programme developed in conjunction with the Manchester Business School and the second cohort has just commenced their participation in the programme. This is particularly important as the programme has been designed to support the development of the Clinical Leadership model.

As a result of the changing economic climate UHSM faced a significant reduction in growth funding from 2010/11. This required the Foundation Trust to be as operationally efficient as possible, in order to meet the financial challenges over the next three years whilst maintaining our ability to provide high quality safe patient care.

Work streams were established to focus on areas where it is thought that efficiencies could be made and this included such areas as Medical Workforce, Procurement, Outpatients and Diagnostics. Within the Medical Workforce project UHSM devised a Job Planning Framework and associated documentation to aid the process of Job Planning and to ensure its routine application. All Consultants have now had a job plan review using a consistent approach and documentation in order to establish a baseline set of information across the Foundation Trust. This will provide an excellent basis to build on for the forthcoming round in 2011/12. Other themes included introducing consistent rates of pay for internal locums and the completion of Extra Contractual Lists with a view to reducing such requirements.

Following the introduction of a refreshed Recruitment and Selection Policy in 2009/10 key performance indicators have been established for the recruitment process. The targets focus on the length of time it takes from 'advert to offer' (42 days) and 'offer to last recruitment check completed' (35 days). These are now reported monthly to the Board.

UHSM has seen a significant improvement in its appraisal rates following the revision to the appraisal documentation and the linkage with performance to incremental progression. The relative improvement has also been seen in the results of the Annual Staff Survey where UHSM is in the highest (best) 20% compared against all other acute trusts nationally for a range of indicators: for percentage of staff appraised in the last 12 months, percentage of staff appraised with personal development plans in the last 12 months and percentage of staff having well structured appraisals in the last 12 months. UHSM is also ranked in the highest (best) 20% for the

percentage of staff receiving health and safety training in the last 12 months; significant improvements have been seen in the attendance of Mandatory Training over the last twelve months with the target of 80% being achieved in all key areas.

Work continues to develop our employees; development Programmes have continued with the commencement of the Band 7 and Band 6 Development Programmes which have been launched throughout the year.

UHSM has been assessed against the Investors in People Standard and has been successful in being re-accredited for a further three years. UHSM has been commended on a number of areas including internal communication, the development of the South Manchester Way in supporting on-going cultural change, the appraisal process in addressing the development needs of employees and the roll out of Fit for Fifteen across the Trust. An action plan picking up on the recommendations will be drawn up with a series of actions to take forward in order to meet the IIP Gold Standard at the next assessment in 2012.

Employee Engagement and Involvement

One of the key objectives over the last twelve months has been to develop an organisational wide approach to employee engagement, strengthening and shaping the organisation's values and behaviours, communication and recognition. The South Manchester Way is UHSM's approach to deep employee engagement.

Launched in December 2009, work has continued to progress with the embedding of the South Manchester Way Values; which are 'Patient care at our heart', 'we lead, learn and inspire', 'we are one talented team', 'we strive for excellence' and 'we are honest and open'.

These values and behaviours have defined what is expected of all UHSM employees. The South Manchester Way is a set of behaviours and values which describe the way things are done at UHSM. The South Manchester Way Steering group continued to develop mechanisms for recognition and to improve communication; whilst work is continuing to develop in both these areas a further work stream of Health and Wellbeing is being developed in line with Fit for Work and the 2012 Olympics.

A national review of the well-being of NHS staff in 2009 documented the need for healthy interventions at work. In response to this important report, UHSM launched its own virtual club with a £20K donation from the staff lottery. *Fit for Life* aims to engage with the Trust's 6,000 staff and volunteers to improve their health and well-being, and in so doing improve the quality and standard of care we deliver to our patients who are at the heart of all we do. All activities are free, and to date we have launched weekly sessions in Tai Chi, Ju Jitsu and yoga and we have a cycling club that meets every Saturday. Every single colleague has been issued with a pedometer to encourage us to walk the daily 10,000 steps that our cardiologists tell us we need to achieve to keep our hearts healthy, and soon we will have zumba dancing and hola hooping sessions too.

This initiative has earned for UHSM an Inspire Mark from the organisers of the London 2012 Olympic and Paralympic Games - making it one of only three hospitals in the country to achieve this prestigious accolade. Olympic gold medallist and world champion Jonathan Edwards visited the Trust recently to present the award to Chairman Felicity Goodey and to see for himself how our success has inspired the community of Wythenshawe to organise its own Games next summer. This will be an occasion when 70,000 people will come together in a spirit of co-operation, citizenship and teamwork to improve their health and well-being, and UHSM will be at the forefront of making that happen.

Staff Survey

UHSM has again participated in the annual NHS Staff Survey. This year UHSM undertook to survey all its employees rather than the 850 random sample it has surveyed in previous years. The overall response rate of 42% was disappointing, although the results of the 2010 Staff Survey

were broadly positive. Real progress in key areas of appraisal and perceptions of effective action from employer towards violence and harassment have been evident.

Overall, out of the 38 question areas – there was either no changes or no statistically difference in response in 21 areas. There were 5 areas where UHSM increased on the rate achieved in 2009 and there were 5 areas decreased where the scores were lower than the 2009 survey. (Note that in one of these areas a lower score is better).

An action plan focussing on the bottom four ranking scores and areas where the Trust scored in the lowest 20% is to be drawn up in partnership with our Trade Union colleagues. These will become a priority in 2011/12. In summary, the Trust's rating compared to all other NHS Acute Trusts is as follows:

Response Rate:

	Trust Score 2010	Trust Score 2009	National Result 2010	Improvement/ deterioration
	41.5%	45%	54%	**Deterioration**

UHSM'S Top four ranking scores were as follows:

	Trust Score 2010	Trust Score 2009	National Average for Acute Trusts 2010	Improvement/ deterioration
Percentage of staff appraised in the last 12 months	90%	72%	78%	Improvement
Percentage of staff appraised with personal development plans in the last 12 months	79%	63%	66%	Improvement
Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months (the lower the score the better)*.	5%	-	8%	-
Percentage of staff having well structured appraisals in the last 12 months.	39%	28%	33%	Improvement

UHSM's Bottom four ranking scores were as follows:

	Trust Score 2010	Trust Score 2009	National Average for Acute Trusts 2010	Improvement/ deterioration
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	90%	95%	95%	**Deterioration**
Support from immediate managers**	3.49	3.56	3.61	**Deterioration**
Effective team working – Trust score, National average for acute trusts.**	3.61	-	3.69	-
Percentage of staff saying hand washing materials are always available	54%	57%	67%	**Deterioration**

**Since there have been changes to the format of the survey questions this year, comparisons with the 2009 survey are not possibl and a dash is shown.*

********These scores are out of a maximum of 5.*

UHSM takes seriously its corporate social responsibility and over the last 12 months has continued to work proactively with its partner organisations to recruit residents locally. Recruitment Open Days have been held over the last twelve months to attract candidates and ensure all essential vacancies are recruited to.

As a BW3 (Businesses in Wythenshawe) member, the Foundation Trust continues to engage with local schools by contributing to the Job Search Skills Events for high school students. Staff regularly visit schools on an ad-hoc basis and students attend the Trust to explore what careers are available within the NHS.

Equality and Diversity

As a public authority UHSM has a statutory general duty under the Equality Act (2010) to eliminate discrimination, promote equality of opportunity and produce relevant schemes setting out how to meet these obligations. UHSM has a Single Equality Scheme which sets out objectives with regards to Equality and Diversity. The scheme covers all aspects of diversity going beyond the statutory requirements of race, disability and gender.

The Scheme's action plan is reviewed and monitored to ensure compliance with statutory obligations and this is monitored by the Equality and Diversity Steering group led by the HR Director.

UHSM continues to honour its commitments as a *Positive about Disability* employer by ensuring that it continues to ensure good practice standards with regards to its practices in recruitment and selection and in maintaining people in work who become disabled.

In accordance with UHSM's Single Equality Scheme an annual monitoring exercise is undertaken to understand the composition of the workforce, the details of which are as follows:

		Staff 31/03/2010	%	Staff 31/03/2011	%
Age	16-20	24	0.5%	16	0.3
	21-30	887	18.2%	944	18.8
	31-40	1201	24.7%	1264	25.23
	41-50	1440	29.6%	1435	28.6
	51-60	1050	21.6%	1074	21.4
	61-70	253	5.2%	268	5.4
	70+	7	0.1%	8	0.2
Ethnicity					
	White	3993	82.1%	4168	83.2
	Mixed	44	0.9%	45	0.9
	Asian or Asian British	361	7.4%	380	7.6
	Black or Black British	122	2.5%	125	2.5
	Other / Not Stated	342	7.0%	291	5.8
Gender					
	Female	3970	81.7%	4093	81.7
	Male	892	18.3%	916	18.3

This data compares favourably with the composition of UHSM's membership, as shown below.

	Membership 31.3.10	%	Membership 31.3.11	%
Age				
0-16	17	0.34	9	0.17
17-21	75	1.49	69	1.33
22+	4925	98.17	5127	98.50
Ethnicity				
White	4761	90.75	4872	90.78
Mixed	52	0.99	54	1.01
Asian or Asian British	278	5.31	286	5.33
Black or Black British	135	2.57	136	2.53
Other	20	0.38	19	0.35
Gender				
Male	2544	46.83	2575	45.95
Female	2888	53.17	3029	54.05

Disability

2.1% of staff declare themselves to have a disability. It is thought that there is some under reporting. UHSM does not collect data on sexual orientation or religion.

Recruitment

Information is available for the recruitment of all staff (apart from junior doctors in training posts) from April 2010 to March 2011.

	Total Number	% BME	% Female	% disabled
Applicants	19068	33	68	3.7
Short listed	4567	23	77	4.7
Appointed	702	15	81	3.3

In relation to the employment of BME staff, these figures may suggest an under-representation. UHSM recently revised its Recruitment Policy and will be training managers on this in the coming year. This will include Equality and Diversity aspects of recruitment. The proportion of applicants appointed reflects UHSM membership.

The recruitment of people with a disability is in line with UHSM commitments under the Two Tick symbol, with a higher % being short listed than applicants.

Sickness

During 2010, data was kept of all staff that had received a final warning or had been dismissed under the UHSM Sickness Absence Management Policy.

Stage	Number	% BME
Short term sick - Final Warning	26	8
Short term sick - Dismissal	2	0
Total	28	7
Long term sick – redeployed	3	33
Long term sick – dismissed	12	0

Whilst the figures are small, no adverse impact on BME staff is apparent.

Discipline

Data has been collected on all cases that proceeded to a formal investigation under the Disciplinary Policy.

Stage	Number	% BME
Investigated – informal action	9	0
No case to answer	2	0
Verbal Warning	2	0
Written Warning	14	14
Final Written Warning	4	25
Dismissed	3	0
Resigned during process	2	0
Total	36	11

Whilst the figures are small, no adverse impact on BME staff is apparent.

Capability

Data has been collected of all employees who have are stage 1 and above of the Capability Procedure.

Stage	Number	% BME
Stage 2	2	0

The numbers are small and therefore it is difficult to draw any conclusions.

Grievances

Stage	Number	% BME
Not upheld	3	0

The numbers are small and therefore it is difficult to draw any conclusions.

Engaging with the local community and stakeholders

UHSM is committed to consulting with local groups and organisations covering the membership areas it serves. It recognises the importance of working with schools, particularly in light of the recent approval of junior Trust membership, and other organisations to boost engagement with the local community. The annual Open Day brings together hospital staff and volunteers in partnership with stakeholders within the community to engage with members of the public, patients and visitors.

5.5 Sustainability Report

Commentary

In accordance with the Climate Change Act 2008, as amended 2009, carbon emissions for the budgetary period including the year 2020, must be such that the annual equivalent of the carbon budget for the period is at least 34% lower than the 1990 baseline.

In addition, carbon emissions for the budgetary period including the year 2050, must be such that the annual equivalent of the carbon budget for the period is lower than the 1990 baseline by at least 80%.

UHSM recognises many reasons to increase its commitment to reduce directly generated and consequential carbon emissions which include:

- Extreme weather events are becoming more common;
- The 10 warmest years on record have occurred since 1990;
- Warming of the climate system is unequivocal: 11 of the last 12 years rank among the 12 warmest years since records began in 1850;
- Most of the observed temperature increase is very likely to be due to the observed rise in greenhouse gas concentrations; and
- The projected global temperature increase over the next 50-100 years is likely to be in the range of 2 - 4.5°C, with a best estimate of about 3°C;

The overall sustainability strategy

UHSM has long since accepted the need to reduce its own carbon emissions. In March 2008, the then Board of Directors approved an ambitious Carbon Management Implementation Plan (CMIP) which put in place a robust strategy, developed in collaboration with the Carbon Trust, to significantly reduce carbon emissions associated with UHSM's consumption of energy.

The delivery of the CMIP has been broadly successful and, since March 2008, UHSM has reduced its energy consumption from its original baseline by approximately 26% and its carbon-related emissions associated with the use of fossil fuel by some 2700 tonnes per annum.

At the July 2010 meeting of the Board of Directors, the Board acknowledged the need to implement and drive forward a wider Sustainability Strategy which adopts a similar approach to the delivery of the original CMIP to other areas of UHSM's activity that generate carbon emissions. Specifically, the following areas will be targeted:-

- Energy and Carbon Management
- Procurement and Food
- Low Carbon Travel, Transport and Access
- Water Use and Waste
- Waste Minimisation and Recycling
- Designing and Maintaining the Built Environment
- Organisational and Workforce Awareness and Development
- The Role of Partners, Stakeholders and Networks
- Governance and Assurance

Carbon and Energy Reduction

Further to the approval of the CMIP in 2008, initial energy consumption reduction targets were set at 15% by 2010 and a further 5% by 2012.

Key Performance Indicators (KPIs) were established to robustly monitor progress against an initial energy consumption base line of 2006 / 2007. Current energy consumption levels (degree day normalised) evidence an actual 26% reduction against the 2006 / 2007 base position (excluding new developments). Consequently, during 2009 / 10 the carbon emissions emitted associated with the use of fossil reduced by some 2700 tonnes. The introduction of Biomass technology within UHSM's main energy centre is capable of reducing carbon emissions by a further 21% which is reflecting in UHSM's 2011/12 fossil fuel consumption and carbon emissions.

UHSM is proud to be one of the first NHS Trusts to be awarded the Carbon Trust Standard by the Carbon Trust. We are equally proud of winning the Sustainability category of the Guardian Public Sector Awards, as well as securing and being declared the outright Overall Winner of the awards. UHSM was also overall winner at the prestigious Climate Change Week awards.

Future priorities and targets

A key priority for UHSM is to deliver its wider Sustainability Strategy. Despite the considerable progress made to date, the Foundation Trust now needs to build upon recent successes and consider in a more structured way the additional steps now needing to be taken to deliver an organisation-wide programme of sustainability and improvement.

UHSM is aiming to produce an overarching Green Sustainability Strategy, which addresses the 9 core areas identified above. In support of this, it is proposed that a specific CMIP be produced for each of the 9 core areas, these then forming the basis of the FT's Green Sustainability Strategy.

Future Direction - Effectiveness of schemes, targets and benchmarks

The development of specific CMIPs will help establish a programme to reduce consumption and carbon emissions.

In respect of energy consumption, and in accordance with the Health Technical Memorandum (HTM) 07-02 enCO2de 'Making Energy Work in Healthcare,' UHSM will benchmark using GJ/100m^3 targets detailed within the HTM.

Adaptation Reporting

UHSM has undertaken risk assessments and developed an Adaptation Plan to support its emergency preparedness and civil contingency requirements, as based on the UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Assurance Process

During 2011/12, UHSM propose to commission an audit of systems and processes currently utilised and employed to collect data used to calculate energy consumption and associated carbon emissions.

Summary of consumption performance

See Table 5.8 for consumption details.

The results include a controlled approach to the portfolio controlled by other Trusts.

Table 5.8: Summary of Sustainability Performance

Area		Non Financial data (applicable metric)	Unit	Non Financial data (applicable metric)	Unit	Non Financial data (applicable metric)	Unit	Type	tonne CO2 (K)	Financial data (£K)	Financial data (£K)	Financial data (£K)
		2008/9		2009/10		2010/11				2008/9	2009/10	2010/11
Greenhouse Gas Emissions	Electricity	20,055,833	kWhs	20,153,611	kWhs	20,248,109	kWhs	Scope 2	10.9	2,503	1,936	1,704
	Gas	35,303,333	kWhs	34,471,111	kWhs	30,185,808	kWhs	Scope 1	5.5	1,085	788	918
	Oil	605,000	kWhs	707,778	kWhs	-	kWhs	Scope 1		33	40	0
	Diesel					2,869	kWhs	Scope 1	1			33
	Biomass					6,188,267	kWhs	Scope 1	0.2			164
	Business Mileage					566,675	Miles	Scope 3	0.15			305
Waste Minimisation and Management	Absolute value for total amount of waste produced	2,145	Tonnes	1,838		1,659				551	495	455
	Methods of Disposal											
	High Temp	271	Tonnes	983	Tonnes	935	Tonnes	(a)		161	400	351
	Non Burn Treatment	1211	Tonnes	0	Tonnes	0	Tonnes	(d)		261	0	0
	Landfill	663	Tonnes	684	Tonnes	720	Tonnes	(b)		61	83	102
	WEEE	3	Tonnes	7	Tonnes	4.054	Tonnes	(b)		1	1	1
	Recycled	Not available										
Finite Resources	Water	159,105	M3	164,986	M3		M3			482	490	467

06 Board of Directors

The Board of Directors comprises six independent Non Executive Directors, including the Chairman and five Executive Directors, including the Chief Executive. The Board is of a unitary nature. Each director has a shared and equal responsibility for the corporate affairs of UHSM in strategic terms and for promoting the success of UHSM.

How the Board operates

The Board meets monthly and considers items under three broad agenda items:

- Strategy Implementation: including significant risks, current affairs and operational performance
- Strategy development: including policy formulation and decision making
- Regulatory and compliance matters

The Board takes strategic decisions and monitors the operational performance of UHSM, holding the Executive Directors to account for the Trust's achievements. The Board also meets informally regularly, to develop strategy and to consider specific issues in depth. Twice each year the Board also meets informally with the Council of Governors, as well as being invited to attend formal meetings of the Council of Governors.

The Chairman writes to the Council monthly after each Board meeting, with a summary of the decisions taken and items discussed. Up to two nominated observers of the staff side representatives (recognised trade unions) and up to two nominated observers from the Council are invited to attend the monthly 'Part 1' Board meeting. The papers for the monthly Part 1 Board meeting and the approved minutes of the previous meeting are published on the Trust's website within three weeks of the meeting (http://www.uhsm.nhs.uk/AboutUs/Pages/Board.aspx). Items of a confidential nature are discussed by the Board in private in a monthly 'Part 2' meeting. Both the staff side representatives and the Council have welcomed these initiatives.

There is a clear division of responsibilities between the Chairman and the Chief Executive. The Chairman ensures the Board has a strategy which delivers a service which meets and exceeds the expectations of its served communities and an Executive Team with the ability to execute the strategy. The Chairman facilitates the contribution of the Non Executive Directors and constructive relationships between Executive and Non Executive Directors. The Chairman also leads the Council of Governors and facilitates its effective working. The effectiveness of both the Board and the Council and the relationships between the Board and Council are the subject of annual review, led by the Chairman.

The Chief Executive is responsible for executing the Board's strategy for the Trust, and the delivery of key targets; for allocating resources, and management decision making. The differing and complementary nature of the roles of the Chairman and Chief Executive has been set out in a Memorandum approved by the Board, and signed by both parties.

All Non Executive Directors, including the Chairman, have made declarations concerning their independence. Annually, and most recently in April 2011 the board considered whether each Non Executive Director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. The Board has determined that each of the Non Executive Directors is independent. This same test of independence is stated in the Code of Governance not to apply to the Chairman except on appointment. Notwithstanding this provision, in the view of the Board, the Chairman remains independent.

The Board is satisfied that no direct conflicts of interest exist for any member of the Board and none of the Executive Directors served as a Non Executive Director of another NHS body during the year. There is a full disclosure of all Directors interests in the Register of Directors' Interests which is available upon request from the Foundation Trust Secretary, and appears within Appendix 1 of this report. All Non Executive Directors, including the Chairman, have confirmed in writing they are able to honour the necessary time commitments to undertake their various roles and responsibilities at UHSM.

The Board has approved a formal Scheme of Delegation of authority and responsibility and within this scheme there is a schedule of Matters Reserved for the Board. This scheme forms an important part of the UHSM's system of internal controls. It is set out in the UHSM Governance Manual which is available on the UHSM website:
http://www.uhsm.nhs.uk/AboutUs/Pages/Corporate.aspx

On a day to day basis the Chief Executive is responsible for the effective running of the hospital. Specific responsibilities are delegated by the Chief Executive to Executive Directors comprising the Director of Finance, who is also the Deputy Chief Executive; the Chief Operating Officer; the Medical Director; the Chief Nurse; the Director of Human Resources and three additional senior managers; the Chief Risk Officer, Director of Communications and Foundation Trust Secretary.

During 2010-11 the Chief Executive was absent for a period of more than four weeks due to being involved in a road raffic accident. The Board met to consider the resilience of the Executive Team within 3 days of the accident. The Trust's preparedness for such an eventuality was raised by the succession planning activity which had been undertaken by the Non Executive Directors in the previous month prior to the accident.

The Board put in place a series of measures to accommodate the short term absence of the Chief Executive which included appointing NoraAnn Heery as the Acting Chief Executive from 28 February 2011; designating her as the Acting Registered Manager in relation to the Care Quality Commission's registration requirements, and as the Accounting Officer in relation to Monitor's compliance regime. David Jago was appointed on 28 February 2011 as the Acting Director of Finance.

Board effectiveness, independence and evaluation

The Board recognises that a regular evaluation of its collective and individual director performance is critical to continuous development and high performance. The Board had worked with Deloitte LLP during 2009-10 to undertake a Board development programme. The Trust commissioned a fresh review of the effectiveness of the Council and the Board by an independent practitioner within the Deloitte LLP team in the summer of 2010 to gain further assurance of the progress being made. The final narrative report of the independent assessor, which was strongly affirmative of the progress being made by the Board, its committees, the directors and the Council was shared with the Council of Governors.

More information about the evaluation of the Board in 2010-11 can be found later in this Chapter under the headings *Compliance and Regulation* and *Statement of Compliance with the NHS Foundation Trust Code of Governance*.

The methodology to be used in 2011-12, as in 2010-11, will involve online responses to positive statements developed by the NHS North West Leadership Academy in its 'Board development guide'. All directors were subject to appraisal in 2010-11, using a process which included feedback provided by Board colleagues. In the case of the Chief Executive the appraisal was led by the Chairman; for the Executive Directors by the Chief Executive; for the Non Executive Directors by the Chairman and for the Chairman by the Senior Independent Director.

An online evaluation exercise undertaken by the Board to evaluate its collective performance and that of its committees showed that good progress had been made but that there remained further

opportunity to raise the collective performance of the Board. The same arrangement was used by the Council.

In accordance with the Code of Governance (provision A.3.1), UHSM Non Executive Directors are invited to consider whether they regard themselves to be independent in character and judgment, based on a number of criteria suggested by Monitor. Having made declarations effective at the end of the year under review, the Acting Chief Executive and Chair of the Audit Committee reviewed the declarations made and reported the outcome to the Audit Committee. The declaration of the Chair of the Audit Committee has been reviewed by the Chairman and Acting Chief Executive and the outcome was hereby reported to the Board. The Board then considered the status of each Non Executive Director.

The consensus of the Board was that all six of UHSM's Non Executive Directors are independent in character and judgement. This includes the Chairman, although Monitor stipulates that the test of independence does not apply to the Chairman except on appointment. All directors have made entries into the Register of Interests which is provided at Appendix 1 of chapter 09. The Board is aware of the significant other activities of the Chairman and is content that she continues to have the time to fulfil her duties at UHSM.

The Board maintains a UHSM Governance Manual available to all staff which sets out the scheme of reservation and delegation to senior individuals and committees, which provide for clarity of process and decision taking within UHSM. The Governance Manual includes terms of reference for all Board and Council committees.

Non Executive Director Resignation

Professor Chris Griffiths resigned from the Board effective 30 June 2010 due to a potential conflict of interest arising when he was appointed Acting Director of the Manchester Academic Health Science Centre ('MAHSC'), of which UHSM is a founding partner. The Board acknowledges its gratitude to Professor Griffiths for his commitment and involvement during his two years on the Board.

Non Executive Director Appointments

During the year, the Council of Governors reappointed Philip Smyth for a second term of three years as a Non Executive Director, effective 12 July 2010. Felicity Goodey was also reappointed as the Non Executive Chairman for a second term of three years effective 1 January 2011.

In each case the recommendation for appointment was moved by the Chairman of the relevant committee for making nominations for appointment. This committee comprises three Governors and two directors and has a Governor chair.

The committee met prior to making any recommendation and considered on the basis of performance evidence, including appraisal feedback and independent comment from an external assessor from Deloitte LLP, which of two possible recommendations to put to the Council. Options considered were either a recommendation for reappointment or a recommendation to make the appointment by a process of open competition.

In each case the committee put a recommendation for reappointment to the Council. Chris Laithwaite, a Public Governor was the Chair of the committee on both occasions.

The Council also made a first time appointment of a Non Executive Director to fill the vacancy created by the resignation of Professor Griffiths. The Trust Chairman led the search and selection exercise to identify suitable candidates for appointment, whom the committee then reviewed, before short listing candidates for appointment. Candidates had been identified by a process of open competition including public advertising in the British Medical Journal and through academic networks within the Manchester community.

Final interviews with a panel comprising a majority of Governors were complemented by providing the short listed candidates with opportunities to meet individually with all members of the Board and with representative members of the Council both privately and in groups. There was particular attention given to the cultural fit with the ethos on the NHS and of the Trust (that is, the South Manchester Way). This process was endorsed by Governors, Directors and by candidates alike.

As a result of this process, Professor Martin Gibson was appointed effective 15 November 2010 for a term of three years as a non executive director. Brief biographies of all directors are provided in Appendix 1.

The removal from office of a Non Executive Director is a decision reserved for the Council of Governors and requires the approval of three quarters of the of the members of the Council of Governors. At the end of the 2010-11 year there are 32 Governors on the Council. A resolution for removal would require the approval of 24 Governors to be carried. No such resolution has been proposed or moved during the year.

In accordance with Monitor's Code of Governance for NHS Foundation Trusts, the terms of office of the Non Executive Directors are set out below:

Table 6.1: Terms of office of Non Executive Directors as at 31 March 2011

Non Executive Director	Appointed	Re-appointed	Expiry of Current Term
Roger Barlow * (Audit Chair)	1.11.09	-	31.10.12
Prof Graham Boulnois	1.01.10	-	31.12.12
Lorraine Clinton	1.01.10	-	31.12.12
Felicity Goodey (Chairman)	1.1.11	-	31.12.13
Prof Martin Gibson	15.11.10	-	31.10.13
Philip Smyth**	12.7.07	12.7.10	30.6.13

* *appointed Senior Independent Director 26.1.10*
** *appointed Trust Deputy Chairman 26.1.10*

Executive Director Appointments

There were no fresh appointments made to the Executive Team during the year, other than those described elsewhere, in relation to 'acting up' arrangements on account of the temporary absence from work of the Chief Executive.

A profile of current Board members is provided at Appendix 1. In accordance with Monitor's Code of Governance for NHS Foundation Trusts, the terms of office for Board members are set out below:

Table 6.2: Terms of office of Executive Directors

Executive Director	Position	Appointed	Notice Period
Mandy Bailey	Chief Nurse	1.1.07	6 months
Julian Hartley*	Chief Executive	23.6.09	6 months
Nora Ann Heery**	Finance Director & Deputy Chief Executive	6.3.06	6 months
Karen James	Chief Operating Officer	15.6.09	6 months
Brendan Ryan	Medical Director	1.1.00	6 months
John Silverwood***	Director of Human Resources	17.11.08	3 year term
David Jago****	Acting Director of Finance	28.2.11	3 months

* Absent from work on account of being involved in a road traffic accident from 28 February 2011
** Acting Chief Executive from 28 February 2011
*** N*on-voting*
**** Acting Director of Finance from 28 February 2011 until 26 May 2011 when left UHSM to take up Director of Finance position at a neighbouring trust.

Members of the Board are invited and attend quarterly meetings of the Council of Governors. The Chairman formally meets the chairs of Council of Governors' committees each quarter and sets the agenda for the Council in consultation with them. Attendance by directors at both Board meetings and Council meetings is shown in Tables 6.3 and 6.4. The Chairman also meets governors informally on a regular basis.

Board balance, completeness and appropriateness of membership

The Board is aware of importance of considering the skills, experience and attitudes of individual directors and of the Board collectively in determining the appropriate person specification to fill any vacancy arising, and as a part in constantly raising Board performance.

As in 2009-10, the Board retained Deloitte LLP again in 2010-11 to review the effectiveness of the Board and of the Council. The outcomes of the review were shared with the Board and the Council, and reflected work that Deloitte had undertaken, including interviews with all directors and a number of Governors.

UHSM's Non Executive Directors bring a wide range of experience, from the private and public sectors. Their skills and experiences are set out in more detail in Appendix 1.

The Board has a consensus view that the changes made to the Board during 2009-10 have made a material difference to the breadth and depth of the skills and experience of the Board, which has resulted in raising the competence and effectiveness of the Board. The Board is of the view that it is well placed to develop and lead a successful organisation during 2011-12 and beyond.

Engagement with the Council of Governors

The Board recognises the value and importance of engaging with Governors in order that the Governors may properly fulfil their role as a conduit between the Board and UHSM's stakeholders. Governors increasingly understand their role as listening to the views of stakeholders and reflecting them to the Board, and vice versa,

Engagement by the Board with Governors takes many forms. The Board of Directors is responsible for the effective running of the organisation, whilst the Council of Governors holds the Board to account for the stewardship of the organisation. The Council does not delegate any its statutory decision making to its committees or individual Governors, since its conventions provide for committees to undertake advisory work only, with all Council decisions requiring ratification in a general meeting.

The engagement by the Board with the Council includes quarterly meetings of the Chairs' Advisory Committee with the Chairman and regular opportunities for small groups of Governors to meet with the Chairman in informal meetings. The Council generally invites all directors to attend its formal meetings, other than for reserved business. Governors have continued to take up the opportunity to attend Part 1 Board meetings. Feedback provided by Governors after their attendance has been very positive, with all Governors finding the experience complementing their induction and ongoing development.

The Council and the Board reviewed data from the Membership and ensured that Governors' priorities are fully reflected in the Annual Plan following work with the Governors' Annual Plan Committee and a joint 'Away Day' between Governors and the Board in March 2011. This event was was part of a bi-annual rhythm of such meetings and resulted in the identification of three top prioorities for 2011-12 which are reflected in the Annual Plan 2011-12.

The Chairman writes to all Governors providing a précis of the Part 1 Board meeting shortly after each monthly meeting, keeping Governors informed of Board activity, together with relevant news from the preceding month. On a weekly basis, the Foundation Trust Office, which is the source of support for Governors on a day to day basis, provides a summary of all relevant diary, committee and event information to Governors by email, or if preferred by post.

The Board and Council have agreed on a formalised induction for new Governors, which has been the basis of introducing the small number of new Governors to UHSM during the 2010-11 year. Existing Governors as well as Non Executive Directors have been involved in developing the content of the Induction and have used these sessions as opportunities for building effective relationships with Governors. Both second term and first term Governors have been encouraged to participate in the 2010-11 Induction Programme.

In addition to the role of listening to and reflecting back the view of the Membership to the Board and *vice versa,* the Council of Governors exercises statutory duties enshrined in law. These include the appointment of and if necessary the removal of non executive directors and determining their remuneration. The Council also appoints the External Auditor, and ratifies the appointment of the Chief Executive. The Council has the right to be presented with the Annual Report and Accounts and to be consulted on forward plans being made by the Board. These roles provide a clear context for the Board to run the hospital, the execution of which is achieved through the Chief Executive and his Executive Team.

Table 6.3 Attendance 2010/11 at Board and Council meetings

	Attendance 2010/11 at Board meetings													Attendance at 2010/11 Council meetings			
	29 Apr	**27 May**	**3 Jun**	**24 Jun**	**29 Jul**	**26 Aug**	**27 Sep**	**25 Oct**	**25 Nov**	**23 Dec**	**28 Jan**	**28 Feb**	**31 Mar**	***18 May***	***07 Sep***	***11 Nov***	***17 Feb***
Mandy Bailey	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	A	Y	A
Roger Barlow	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	A	Y	Y	Y	Y	A	Y
Graham Boulnois	Y	Y	Y	Y	Y	Y	A	Y	Y	Y	Y	Y	Y	A	Y	A	A
Lorraine Clinton	Y	A	A	Y	A	Y	Y	A	Y	Y	Y	Y	Y	A	Y	A	Y
Martin Gibson	-	-	-	-	-	-	-	-	A	Y	Y	Y	Y	-	-	-	Y
Felicity Goodey	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	A	Y	Y	Y
Chris Griffiths	Y	Y	A	Y	-	-	-	-	-	-	-	-	-	Y	-	-	-
Julian Hartley	Y	Y	Y	Y	Y	A	Y	A	Y	Y	Y	A	A	A	Y	Y	Y
Nora Ann Heery	Y	Y	Y	Y	A	A	Y	Y	Y	Y	Y	Y	Y	A	Y	Y	Y
Karen James	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
David Jago	-	-	-	-	-	-	-	-	-	-	-	Y	Y	-	-	-	-
Brendan Ryan	Y	Y	Y	A	Y	Y	Y	Y	Y	Y	Y	Y	Y	A	A	Y	A
John Silverwood*	Y	Y	A	Y	Y	Y	Y	A	Y	Y	Y	Y	Y	A	Y	A	A
Philip Smyth	Y	Y	Y	Y	Y	Y	Y	Y	A	Y	Y	Y	Y	Y	Y	Y	A

** denotes non voting member of the Board Y denotes attended; A denotes provided an apology for absence*

Committees

The UHSM Board has three statutory committees; the Audit Committee, Remuneration Committee and Nominations Committee.

A Healthcare Governance Committee and a Risk Management Committee are chaired by the Medical Director and Chief Executive respectively, and have a membership each comprising both directors and senior managers. Both committees work closely with Audit Committee but also report directly to the Board by way of exception reports and sharing of meeting minutes. The chairs of all three committees meet regularly to ensure triangulation of issues is achieved together with the avoidance of duplication.

These arrangements ensure that committees do not duplicate activity and their efforts are coordinated. Since March 2010 the Terms of Reference of the senior committees within UHSM, including those of the Board and the Council have been collated with the UHSM Governance Manual, which is available from the UHSM website.

These governance arrangements reflect a full implementation of independent advice received during in the 2009-10 year from KPMG LLP and Deloitte LLP on Board governance and effectiveness.

Audit Committee

The Audit Committee comprises three independent Non Executive Directors. It is chaired by Roger Barlow, a former senior audit partner at KPMG until 2000, for whom brief biographical details are provided in appendix 1. The other members of the committee are Lorraine Clinton and Philip Smyth. Periodically, the Audit Chairman may invite other non executive directors to attend a specific meeting or item.

The priorities for the Audit Committee are to review management systems and controls and to scrutinise on behalf of the Board all assurances that the objectives of UHSM will be met.

The Audit Committee triangulates its work with that of the Healthcare Governance Committee and the Risk Management Committee. This system is designed to ensure that the Trust has a rigorous and seamless system of scrutiny across all aspects of the Trust's activities. The Healthcare Governance Committee is chaired by the Medical Director and has two independent non executive members, both of whom are distinguished medical scientists.

The Risk Management Committee is chaired by the Chief Executive and comprises executive Directors. All three committees report directly to the Board. The three committee chairs meet several times per year to ensure work plans are fully co-ordinated. The FT Secretary and the Chief Risk Officer attend all three committees to ensure seamless working.

Senior members of staff are invited to speak to the Audit committee to enable members to enquire in more detail into what assurances are available to evidence that actions have been put in place to address specific issues which might jeopardise the system of internal control and therefore put the Trust at risk of breaching its terms of authorisation.

The Director of Finance, external and internal auditors are usually in attendance at meetings of the Audit Committee. Executive Directors and other managers are required to attend for specific items, as is the Local Counter Fraud Specialist. The committee takes a risk based approach to its work, reviewing progress against an annual plan and reflecting the Board's Assurance Framework.

In 2011, the Trust tendered the internal audit service. Members of the Ausdit Committee supported the Director of Finance in an exercise to evaluate the bids provided by public and private sector suppliers. After detailed evaluation against objective criteria, KPMG LLP were awarded the contract for internal audit and the supply of specialist local counter fraud service for

the period 2011-14. The Trust is grateful for the provision of the service by Audit North West over recent years.

The Committee continuously reviews the structure and effectiveness of the Trust's internal controls and risk management arrangements. It also monitors progress against recommendations of reports from independent sources, particularly those provided quarterly by the internal auditor. Such reports summarise progress against the internal audit plan and the outcomes from all internal audit reports, to ensure than any remedial action has been or is being taken and completed by management in areas where weaknesses have been identiofied. The committee discusses the proposed introduction of and changes to accounting policies; any requirement for restatement of the accounts, such as the introduction of reporting to International Financial Reporting Standards conventions or the proposed consolidation of charity accounts within ultimate parent Trusts; the external audit plan and progress updates with the external auditor, The Audit Commission.

During the 2010-11 year the Audit Commission has provided additional services to UHSM beyond the scope of the audit of the 2010-11 accounts. The Board maintains a policy on the engagement of the external auditor for the provision of non-audit services, which was approved by the Council of Governors, which is itself responsible for the appointment of the external auditor. The effect of the policy is that were the Exective to retain the external auditor for the supply of a non audit service with a value of more than one third of the annual audit fee, the express approval of the Council of Governors would need to be sought and obtained.

During 2010/11 the Audit Commission provided non audit services to benchmark the Foundation Trust's medical staffing costs and back office costs against other NHS trusts. This work enables the Trust to identify where potential areas of savings may exist and provides good practice to lesser performing trusts. The cost of this work during 2010/11 was £5,000 and £2,222 (plus VAT) respectively.

The fee for the statutory audit was agreed at the begining of the year at £41,300 plus VAT (2009/10: £40,360). During the year Monitor and the Department of Health mandated that additional work must be added to Foundation Trust statutory audits by the external auditor to review the Quality Account and Whole of Government Account submission. The additional fees £8,000 and £500 plus VAT respectively.

There have been no further commissions of the external auditor for non audit services other than those stated in this report and it is the policy of the Board not to commission non-audit work from the external auditor except in exceptional circumstances. The Audit Committee was engaged in discussion with The Audit Commission's Engagement Lead regarding plans for the timely rotation of the Engagement Lead, Jackie Bellard, who was replaced by Julian Farmer in summer 2010 for the 2010-11 audit. These arrangements were planned and implemented in accordance with best practice.

All of these arrangements are designed, and in the Board's view ensure, that auditor objectivity and independence is safeguarded.

Table 6.4: Attendance by Board Committee Members during 2010-11

	Audit Committee	Nominations Committee	Remuneration Committee
	Number of meetings attended out of maximum number of meetings		
Roger Barlow	7/7	1/1	4/4
Graham Boulnois*	2	1/1	2/4
Lorraine Clinton	6/7	1/1	3/4
Felicity Goodey*	1	1/1	3/4
Martin Gibson	-	1/1	1/1
Chris Griffiths	-	-	0/1
Philip Smyth	7/7	1/1	4/4

** denotes attended Audit Committee for information and learning as non-members*

Nominations Committee

The Nominations Committee comprises all independent Non Executive Directors and the Trust Chairman, who chairs the committee. The committee is responsible for reviewing the size and structure of the Board, considering succession planning and in conjunction with the Chief Executive, preparing a description of the role and capabilities required for the appointment of an Executive or Non Executive Director.

During 2010-11 the committee met just once, to consider succession planning arrangements for the retiring director of Human Resources and to fill the post becoming vacant on the resignation of the Deputy Director of Finance.

Remuneration Committee

A description of the work of the the Remuneration Committee can be found within the Remuneration Report at the end of this chapter. Attendance at meetings by its members is set out in Table 6.5 above.

Healthcare Governance Committee

The Executive Medical Director chairs the committee which has the responsibility for ensuring that an effective system of clinical governance is embedded across UHSM. The Divisional Medical Directors attend the committee which has a membership including two Non Executive Directors as detailed above.

Risk Management Committee

The Risk Management Committee is chaired by the Chief Executive. Terms of reference were reviewed during the year as a part of the refreshing of the risk and assurance processes and review of the Board's committee structure. The resultant terms of reference for the committee are clearly established to be the maximisation of patient safety through effective control systems, and to oversee the risk management activity across UHSM. Membership is restricted to the Executive Directors, and Chief Risk Officer. The Internal Auditor and a number of senior managers are regularly in attendance. Its relationship with Audit and the Healthcare Governance Committee are detailed above.

Compliance and Regulation

During 2010-11 UHSM has been considered by Monitor to be in significant breach of the Terms of the Authorisation, resulting from governance issues carried over from 2009-10. In July 2010, Monitor de-escalated UHSM from 'red' for governance to 'amber/green'. One quarter later, there was a further de-escalation to 'green'.

The Council of Governors were fully informed of the view of the Regulator. The Council provided the Board with suggestions for improved engagement. The Board and Council have worked together to introduce a much greater degree of engagement, information exchange and transparency which both parties have found to be helpful in executing their complementary roles.

The Trust has ended the year compliant with all key national targets and with a Board, Committee, Risk and Assurance structure which reflects all the advice and recommendations from external advisors and assessors during 2009-10 and 2010-11. Monitor have indicated an interest in using UHSM as a case study for other trusts to learn how the organisation can positively respond to regulatory challenge and use it as a catalyst for improved performance.

UHSM has been registered with the Care Quality Commission with no compliance restrictions during the year. Since the year end, UHSM has been asked by the Care Quality Commission to address two restricitive registration conditions in respect of new sites from which community services are delivered. In both cases, the actions required related to administration of human resources conventions, relating to two managers at community service sites acquired from NHS

Manchester effective 1 April 2011. UHSM has submitted all the requisite declarations during Q1 2011/12.

Statement of Compliance with the NHS Foundation Trust Code of Governance and other disclosure statements

Monitor's Code of Governance for NHS Foundation Trusts requires Foundation Trusts to make a full disclosure on their governance arrangements for the 2010-11 financial year. The Code can be found on the Monitor website:
http://www.monitor-nhsft.gov.uk/home/our-publications/publications-z?keyword=C

The Code requires the Directors' Report to explain how the main principles and supporting principles of the Code have been applied. The form and content are not prescribed. The information satisfying this requirement is found throughout this Annual Report and Accounts, particularly within chapters 05 (Directors report), 06 (Directors) and 07 (Governors).

In the second part of the compliance disclosure, UHSM is required to provide a statement either confirming compliance with each of the provisions of the Code or where appropriate, an explanation in each case why the Trust has departed from the Code.

The UHSM Board confirms that UHSM complied with all provisions of the Code for the 2010-11 year, without exception.

For the avoidance of doubt, although the Code requires Foundation Trusts to nominate a *Lead Governor* to 'have a role to play in facilitating communication between Monitor and the NHS Foundation Trust', the Council of Governors at UHSM have considered this requirement and resolved to satisfy it not by the designation of a single individual Governor, but by the collective designation of the Chairs' Advisory Committee as *Lead Governor.* In the view of the Council this way of working provides Governors with more efficient, and representative, regular two- way communications with the Chairman and Board, and with Monitor, should the need arise. This course of action has been accepted by Monitor. In the view of the UHSM Board, this arrangement, with which Monitor is content, does not constitute a non-compliance.

The Code also requires the directors to make specified information available in the annual report, or to provide certain descriptions of governance arrangements. This annual report addresses all these requirements without exception, placing much of the information and appropriate statements in relevant chapters of the report. Where any additional information or statements are required which do not fall into other chapters, is provided below.

It is the directors' responsibility to ensure that proper accounts are kept and that annual accounts are prepared in accordance with the relevant legislation and guidance issued by Monitor. The responsibilities of the auditor are set out in its report to the Council of Governors in chapter 08.

Each of the directors who was a director at the time that the report was approved has confirmed that so far as the director is aware, there is no relevant audit information of which the UHSM's auditor is unaware and the director has taken all the steps that he/she ought to have taken as a director in order to make himself / herself aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information.

No expenses have been incurred in relation to political activity or political donations either within or outside England and Wales.

UHSM has no subsidiary companies. There is one charity connected to UHSM, which is the UHSM NHS Foundation Trust Charitable Fund, charity number 1048916. In accordance with current reporting requirements, UHSM is not required to consolidate the results of that charity into those of its own.

6.1 Remuneration Report

This report provides information on those persons in senior positions having authority or responsibility for directing or controlling UHSM's major activities. This includes all Executive and Non Executive Directors only. Financial data can be found at Note 7 to the accounts.

Remuneration of Non Executive Directors

In accordance with the National Health Service Act 2006 and UHSM's Constitution, the Council of Governors determines the terms and conditions of the Chairman and the Non Executive Directors. The Council of Governors has established a Remuneration Committee to consider the remuneration levels for Non Executive Directors.

During the year under review, the members of the committee were Peter Turnbull (Chair), Chris Laithwaite, Michael Connolly and Steve Cook. Details of the constituencies which these Governors represent are provided in chapter 07.

The Committee takes into consideration any relevant guidance or direction supplied by the Department of Health or any other relevant body and may seek, where appropriate, external advice for benchmarking purposes. Comparable data from amongst the network of Foundation Trusts regionally and nationally is provided to the committee. During the year under review, the members of the committee did not retain external remuneration consultants to provide independent advice.

The committee's recommendation to the Council in May 2010 that there be no incremetal increase in Non Executive Director remuneration for the 2010-11 year was approved by the Council.

Non Executive Directors' terms and conditions are set out in letters of appointment, the main headers being a three year term of office; remuneration, time commitment, duties, declarations of interest and independence. The terms and conditions of appointment of Non Executive Directors are available on request from the Foundation Trust Office 0161 291 2357 or foundationtrustoffice@uhsm.nhs.uk

The remuneration of Non Executive Directors is not pensionable. Non Executive Directors' terms and conditions do not include holiday accrual. UHSM does not operate a performance related remuneration scheme.

Remuneration of Executive Directors

The Board has established a Remuneration Committee which comprises all independent Non Executive Directors and the Trust Chairman. During the year under review, all of the Non Executive Directors of UHSM were considered by the Board to be independent in character and judgement. Further details about the composition of the Committee and attendance at committee meetings are provided earlier within this chapter.

Philip Smyth chaired the committee. The committee is responsible for determining the terms and conditions of employment of all Executive Directors, including the Chief Executive, for assessing the performance of the Chief Executive and the Executive Directors and ensuring that their objectives are assessed at six monthly intervals.

During 2010-11 the performance of the Executive Directors was assessed by way of formal appraisals, which included reviews of individual performance against personal objectives, feedback from Board colleagues on work style and contribution to the Board as a whole, as well as progress against personal development plans.

During 2010-11 the committee also considered succession planning arrangements, which were implemented swiftly and found to be robust on the absence from work of Julian Hartley, following

a road traffic accident on 16 February 2011. Julian Hartley was absent from work for a period of three months, during which time the Deputy Chief Executive NoraAnn Heery was formally appointed as Acting Chief Executive and David Jago, Deputy Finance Director, was formally appointed as Acting Director of Finance.

The Committee takes into consideration any relevant guidance or direction supplied by the Department of Health or any other relevant body and may seek, where appropriate, external advice for benchmarking purposes. During the year under review, the members of the committee did not retain external remuneration consultants to provide independent advice. For the 2010-11 year, the committee determined that in the light of the financial downturn, and noting the restraint on pay progression within the NHS and the wider public sector generally, the Executive Directors would not receive remuneration increases. Notwithstanding this decision, the committee commended the excellent work by, and team working amongst the Executive Directors. Executive Directors received no performance related element of remuneration.

The Executive Directors are employed on contracts which do not state a specific term. The contracts are subject to six months' notice of termination by either party, and do not provide for termination payments. Pension arrangements for the Chief Executive and all Executive Directors are in accordance with the NHS Pension Scheme. The accounting policies for pensions and other relevant benefits are set out in Note 1 to the accounts. Details of the remuneration of senior employees can be found in Note 7 to the accounts.

For the purposes of this remuneration report, it is only those directors who are formally appointed as members of the Board of directors who are considered as 'senior managers' and for whom details of remuneration are provided at Note 7 to the accounts.

Nora Ann Heery
Acting Chief Executive

07 Council of Governors

UHSM's Council of Governors was formed with effect from 1 November 2006 and its membership was refreshed in 2009-10. UHSM's Council of 32 Governors consists of 20 elected Public Governors representing membership constituencies, 7 elected Staff Governors, and 5 Appointed Governors representing stakeholder interests.

As at 31 March 2011 there was one vacancy on the Council of Governors for a staff Governor – the elected Governor representing Medical & Dental Practitioners. The next highest polling candidate was invited to take office to replace Stewart Watson who retired on 31 March 2011. There were also three vacancies for Appointed Governors representing Manchester PCT, Manchester City Council and Manchester PEC to replace Brian Harrison and Cllr Eddie McCulley who sadly passed away at the end of 2010, and Mary Karasu who transferred to UHSM on 1 April 2011 as part of the TCS acquisition.

The composition of the Council of Governors is set out in Appendix 2 and a description of member constituencies is at Appendix 3.

General meetings of the Council of Governors are held in public. All elections to the Council are conducted by the Electoral Reform Services Limited on behalf of UHSM and in accordance with the Model Election Rules. During 2010-11 there was one election, for a Public Governor in Area 2 (Part of South Manchester). The election attracted 7 candidates and a turnout of 27%.

The UHSM constitution provides for the next highest polling candidate in an elected contest for appointment as an elected Governor to be offered the post if and when it falls vacant. This provision was used in two cases during the year. As a result Penny Maher and Sydney Travers have become Public Governors during the year. Emma Hurley has become a Staff Governor immediately after the year under end under the same convention.

The Council has the following three main roles established by the UHSM Constitution:

- Advisory – it communicates with the Board of Directors the wishes of members of the Trust and the wider community;
- Guardianship – it ensures that UHSM is operating in accordance with its Statement of Purpose and is compliant with its authorisation; and
- Strategic – it advises on a longer-term direction to help the Board effectively determine its policies.

The essence of these roles is elaborated on within Monitor's document '*Your Statutory Duties – A reference guide for NHS Foundation Trusts Governors'*

The Council also appoints UHSM's Chair and the Non Executive Directors, determines their terms of office, and their remuneration; it also appoints UHSM's auditor.

There have been four general meetings of the Council of Governors (on 18 May 2010, 7 September 2010, 11 November 2010 and 17 February 2011) in 2010-11. There have also been two Board / Governor 'away days' in April and October 2010.

Executive and Non Executive Directors attended these meetings to support the Council in its development and to foster a good understanding of UHSM's affairs and the Governors' views. In turn, up to two nominated Governors are invited to attend Part 1 of meetings on the Board on a monthly basis and the approved minutes of the previous meeting are published on the Trust's

website within three weeks of the meeting. In 2010-11, 11 Governors attended Part 1 Board meetings.

The Council has had reports and presentations from the Chief Executive and Executive Team regarding Trust performance and risk. It has also had a discussion on the role of Governors in membership and ratified the Membership Development Strategy.

A number of Council committees met during the course of 2010-11 and membership is shown below. Several Governors have also been involved in other work at UHSM, such as the annual PEAT assessment, preparations for the 2010 Open Day and 2011 Staff Awards.

Table 7.1: Membership of Council Committees

Committee	Membership
'Committee of the Council and the Board' (Appointment Committee)	Chris Laithwaite (Chair), Mary Karasu (until 1 April 2011), Colin Owen, Felicity Goodey, Julian Hartley
Remuneration Committee	Peter Turnbull (Chair), Steve Cook, Chris Laithwaite, Mike Connolly,
Annual Plan Advisory Committee	Alex Watson (Chair), Stewart Watson (Vice Chair until 31 March 2011), Clare Church, Gill Reddick, John Lamb, Jane Reader, Peter Turnbull, Mary Karasu (until 1 April 2011)
Community Engagement Committee	Marguerite Prenton, Honor Donnelly (until 17 February 2011), Gill Reddick, Harry Lowe (Chair) Sarah Arkwright, Sarah Newlove, Cliff Clinkard, Cllr John Lamb
Membership Development Committee	Jane Reader (Chair), Shashikant Merchant (until 15 August 2010), John Churchill, David Hird, Michael Kelly, Colin Owen (Deputy Chair), Cliff Clinkard, Wendy Mannion, Sidney Travers
Patient Experience Committee	Marguerite Prenton, Steve Cook (Chair), Syed Ali, Michael Kelly (Deputy Chair), Sharan Arkwright, Helen Kirk (Chair until 21 April 2010), Clare Church, Cllr Eddie McCulley (until 1 November 2010), John Churchill, Wendy Mannion

The Chairs of each Council Committee collectively form the Chairs' Advisory Committee which was established to support the Council and advise the Chairman on Council matters and concerns and also to advise on agenda setting for Council meetings. This committee acts in lieu of a Lead Governor for Monitor.

Governor attendance at Council meetings is shown in Table 7.2 (below). Governors are required to comply with UHSM's standards of business conduct and to declare interests that are relevant or material to the Council. All Governors declared such interests on appointment to the Council of Governors.

The Register of Interests is available for inspection by members of the public. Anyone who wishes to see the Register of Governors' Interests should contact the Foundation Trust Office at the following address: Trust HQ, Tower Block, Wythenshawe Hospital, Southmoor Road, Manchester M23 9LT.

Any member of the public wishing to make contact with a member of the Council of Governors can do so via the Foundation Trust Office by telephone on 0161 291 2357 or by email to foundationtrustoffice@uhsm.nhs.uk

Table 7.2: Governor Attendance at Council from April 2010 – March 2011

Name	Title	18.05.10 (formal)	07.09.10 (formal)	11.11.10 (formal)	17.02.11 (formal)
Marguerite Prenton	Public Governor (Area 1: part of Trafford)	Y	Y	A	Y
Jane Reader	Public Governor (Area 1: part of Trafford)	A	Y	Y	Y
Peter Turnbull	Public Governor (Area 1: part of Trafford)	Y	Y	A	Y
Shashikant Merchant (retired 15.08.10)	Public Governor (Area 2: part of South Manchester)	A	N/a	N/a	N/a
John Churchill	Public Governor (Area 2: part of South Manchester)	Y	A	Y	Y
Steve Cook	Public Governor (Area 2: part of South Manchester)	Y	X	Y	A
Honor Donnelly (removed 17.02.11)	Public Governor (Area 2: part of South Manchester)	Y	Y	Y	X
Sidney Travers (effective 15.03.11)	Public Governor (Area 2: part of South Manchester)	N/a	N/a	N/a	N/a
David Hird	Public Governor (Area 2: part of South Manchester)	Y	Y	Y	Y
Wendy Mannion (elected 16.08.10)	Public Governor (Area 2: part of South Manchester)	N/a	Y	Y	X
Syed Ali	Public Governor (Area 3: part of Central Manchester)	Y	Y	Y	Y
Michael Kelly	Public Governor (Area 3: part of Central Manchester)	Y	X	Y	Y
Harry Lowe	Public Governor (Area 3: part of Central Manchester)	Y	Y	Y	Y
Gill Reddick	Public Governor (Area 4: part of Stockport)	Y	Y	A	A
Sharan Arkwright	Public Governor (Area 4: part of Stockport)	A	A	A	A
Penny Maher (effective 18.05.10)	Public Governor (Area 4: part of Stockport)	Y	X	A	A
Helen Kirk	Public Governor (Area 5: part of Macclesfield)	A	Y	A	A
Alex Watson	Public Governor (Area 5: Rest of England and Wales)	Y	Y	Y	Y
Clare Church	Public Governor (Area 5: Rest of England and Wales)	A	A	A	A
Christopher Laithwaite	Public Governor (Area 5: Rest of England and Wales)	Y	Y	Y	Y
Rev Shneur Zalman Odze	Public Governor (Area 5: Rest of England and Wales)	Y	A	Y	Y
Chava Odze (elected 15.04.10)	Public Governor (Area 5: Rest of England and Wales)	Y	A	Y	X
Stewart Watson (retired 31.03.11)	Staff Governor (Medical Practitioners & Dental Practitioners)	Y	Y	A	Y
Michael Connolly	Staff Governor (Nursing & Midwifery)	A	Y	Y	A
Sarah Newlove	Staff Governor (Nursing & Midwifery)	A	A	Y	Y
Carol Winter	Staff Governor (Other Clinical Staff)	Y	A	Y	Y
Colin Owen	Staff Governor (Non-Clinical Staff)	Y	Y	Y	Y
Andrew Davey	Staff Governor (PFI staff)	Y	Y	Y	A
Cliff Clinkard	Staff (Volunteers)	Y	A	Y	Y

Brian Harrison (deceased 30.12.10)	Appointed Governor (Principal Commissioning PCTs: Manchester PCT)	X	Y	X	N/a
Eddie McCulley (deceased 01.11.10)	Appointed Governor (Principal Local Councils: Manchester City Council)	A	X	N/a	N/a
John Lamb	Appointed Governor (Principal Local Council: Trafford Metropolitan Borough Council)	Y	A	Y	Y
Paul O'Neill	Appointed Governor (Principal University: University of Manchester)	Y	Y	Y	Y
Mary Karasu (transferred to UHSM 01.04.11)	Appointed Governor (Primary Care Clinicians: Manchester PEC)	A	Y	Y	A

Key: Y = attended
A = apologies given
X = no apologies given
N/a = not in post

08 Financial Statements

Contents

8.1 Foreword to the accounts

In 2010/11 the University Hospital of South Manchester NHS Foundation Trust (UHSM) achieved a surplus of £4.5m before exceptional items. The achieved surplus equates to 1.28% of the Trust's turnover.

This chapter contains:

- regulatory disclosures
- other disclosures including public interest
- Accounting Officer's Statement of responsibilities
- Annual Governance Statement
- Auditor's opinion and certificate
- four primary financial statements
    - statement of comprehensive income (SoCI),
    - statement of financial position (SoFP),
    - statement of changes in taxpayers equity (SoCITE)
    - statement of cash flows (SCF)
- notes to the accounts (including remuneration of senior officers)

These accounts have been prepared under direction issued by Monitor, the independent regulator of foundation trusts and in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

The Directors of the Foundation Trust are responsible for the preparation of these accounts. The Accounting Officer for these accounts is Nora Ann Heery who is Acting Chief Executive. This acting arrangement is necessary to cover the absence of Julian Hartley, the Trust's substantive Chief Executive, during his recovery from a road traffic accident.

Regulatory Disclosures

As a Foundation Trust, UHSM operates under licence from Monitor which includes:

- A limit on the amount of private patient work that the Trust can undertake
- Limits on the levels of borrowing that are permitted under the Prudential Borrowing Regime and
- A requirement that the Trust has in place sufficient liquid resources, which may include a Working Capital Facility.

Private Patient Cap

In accordance with its Terms of Authorisation, the Trust must not exceed its predetermined private patient cap. This is set at 0.1% of the Trust's total patient-related income. The Trust stayed within its private patient cap, as shown below.

	April 1, 2010 – March 31, 2011
Private Patient Income	£0.15m
Total Patient-Related Income	£291.06m
Proportion as a percentage	0.05%

Foundation Trust Borrowing Regime

The Trust is required to comply and remain within Monitor's Prudential Borrowing Limit set out in the 'Prudential Borrowing Code'. The code sets foundation trusts a long-term borrowing limit based on key ratios and also covers major investments including PFI schemes.

The Trust has a PFI scheme and approved loans to fund its Cystics Fibrosis extension and Maternity refurbishment schemes:

Purpose of loan	Long term Borrowing Limit Agreed	Loan drawn down	Loan repaid	Loan outstanding
	£m	£m	£m	£m
PFI	68.1	68.1	2.0	66.1
Cystic Fibrosis	7.8	7.8	0.4	7.4
Maternity	20.0	15.0	0.0	15.0
Total	95.9	90.9	2.4	88.5

The compliance position is as follows:

Table 8.1: Prudential Borrowing Regime

	2010/11
Maximum prudential borrowing limit (Tier 2)	£95.9m
Long term borrowing at March 31, 2011	£88.5m

The Prudential Borrowing Code also sets foundation trusts a short-term borrowing limit for working capital facilities. UHSM has been set a £27m short-term borrowing limit for the year ended March 31, 2011, this remained unused.

The Trust has stayed within its Terms of Authorisation as required under the Prudential Borrowing Regime.

Public Interest Disclosures

As well as statutory obligations and those required by Monitor, the Trust also discloses information that may be of interest to the public. This information includes the level of management costs and the number of invoices paid to private sector bodies within agreed timescales (known as the Better Payment Practice Code).

Better Payment Practice Code

UHSM continues to recognise the importance of prompt payment to its suppliers and paid 94% by volume and 95% by value of all its undisputed invoices within thirty days of the month of receipt (the target is 95%).

Management Costs

For the twelve months to March 31, 2011, the Trust incurred £13.3m on management costs (calculated on the basis of the Department of Health guidelines). This represents 3.8% of Trust income.

Other Disclosures

Post Statement of Financial Position Events

The annual financial statements have been prepared on a going concern basis. There were no material post Statement of Financial Position events following submission of the accounts to March 31, 2011.

Going Concern

After making enquiries the Directors have a reasonable expectation that the 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.

Policies and Procedures with respect to Countering Fraud and Corruption

The Trust has established local policies and lines of reporting supporting counter fraud arrangements. The Trust has a nominated Local Counter Specialist (LCFS), who is professionally trained in this area of expertise. The LCFS combines both proactive and investigative work to deliver an effective counter fraud service for the Trust. The LCFS works to ensure a strong anti-fraud culture is engendered across the organisation.

External Audit

The Audit Commission, as external auditors, received £49k for the audit of the accounts to March 31, 2011 as set out in Note 7 to the accounts. The Trust's accounts also reflect a payment to the Audit Commission of £ 10k as an estimated cost of work being undertaken by the Audit Commission on the Trust's Quality Account and Whole of Government Accounts.

Nora Ann Heery
Acting Chief Executive

8.2 Statement of Chief Executive's responsibilities as the Accounting Officer of University Hospital of South Manchester NHS FT

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS foundation trust accounting officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the National Health Service Act 2006, Monitor has directed the University Hospital of South Manchester 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 University Hospital of South Manchester NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS foundation trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS foundation trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him 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*.

Signed……..

Nora Ann Heery, Acting Chief Executive
Date: May 26, 2011

8.3 Annual Governance Statement

Scope of responsibility

As Acting 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 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 the University Hospital of South Manchester NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the University Hospital of South Manchester NHS Foundation Trust for the year ended 31 March 2011 and up to the date of approval of the Annual Report and accounts.

Capacity to handle risk

The Board of Directors provides leadership on the overall governance agenda. The Risk Management Committee is a committee on which Directors sit, which oversees all risk management activity and ensures the correct strategy is adopted for managing risk; controls are present and effective; and action plans are robust for those risks which remain intolerant. The Risk Management Committee is chaired by myself as Acting Chief Executive and comprises of all Executive Directors, the Director of Human Resources, Foundation Trust Secretary and Chief Risk Officer. Senior managers and specialist advisors routinely attend each meeting. The Trust has kept under review and updated the Risk Management Strategy and Policy which clearly describes the process for managing risk and the roles and responsibilities of staff. While the Risk Management Committee reports directly to the Board through me, it also works closely with the Audit Committee and the Healthcare Governance Committee. These three committees triangulate their work to ensure all significant risk is properly scrutinised and managed in accordance with the Board's appetite for risk.

Training is provided to relevant staff on risk assessment, incident reporting and incident investigation. In addition, the Board has set out the minimum requirements for staff training required to control key risks. A comprehensive training needs analysis has been kept under review which sets out the training requirements for all members of staff and includes the frequency of training in each case. Risk is routinely monitored from ward to Board.

Incidents, complaints, claims and patient feedback are routinely analysed to identify lessons for learning and improve internal control. Lessons for learning are disseminated to staff using a variety of methods including newsletters, briefings and personal feedback where required. To enhance learning and improve governance, the Trust actively pursues external peer review of all serious untoward incidents.

I have ensured that all significant risks are reviewed at each formal meeting of the Board of Directors, the Risk Management Committee and the Audit Committee. All new significant risks are escalated to me as Acting Chief Executive and subject to validation by the Executive Team and Risk Management Committee. The escalation of risk is determined by the residual risk score.

The risk and control framework

The risk management process is set out in 5 key steps as follows:

1. **Risk Identification**

   Risk are identified by assessing corporate objectives, work related activities, analysingincidents, complaints, claims and taking account of events outside the Trust.

2. **Risk Assessment**

   Risk assessment involves the analysis of individual risks, including analysis of potential risk aggregation where relevant. The assessment evaluates the impact and likelihood of each risk and determines the priority based on the overall level of risk exposure.

3. **Risk Response**

   For each risk controls are ascertained or developed, documented and understood. Controls are implemented to *avoid risk*; *seek risk* (take opportunity); *modify risk*; *transfer risk* or *retain risk*. Gaps in control are mapped directly to action plans which are implemented to reduce residual risk. In determining the Organisation's risk appetite, the Board has considered tolerances for the following dimensions (i) Reputation and Credibility; (ii) Clinical, Operational and Policy Delivery; (iii) Financial; and (iv) Regulatory and Legal. The Chief Risk Officer ensures each risk is recorded on the Trust's risk register and managed in accordance with the Board's appetite for risk.

4. **Risk Reporting**

   All significant risks are reported at each formal meeting of the Board of Directors and Risk Management Committee. In addition, in the event of a significant risk arising, arrangements are in place to escalate a risk to the Chief Executive and Executive Team. The level within the Trust at which a risk must be reported is clearly set out in the Risk Management Strategy and Policy. The risk report to the Board also details what action is being taken, and by whom, to mitigate the risk and monitors its effectiveness.

5. **Risk Review**

   Those managing risks regularly review the output from the risk register to ensure it remains valid, reflects changes and supports decision making. Assurances on the operation of controls for all significant risks are kept under review by the Audit Committee. In addition, risk profiles for all directorates are kept under review as part of a rolling programme by the Risk Management Committee. The purpose of the Trust's risk review is to track how the risk profile is changing over time; evaluate the progress of actions to treat key risks; ensure controls are aligned to the risk; risk is managed in accordance with the Board's appetite; resources are reprioritised where necessary; and risk is escalated appropriately.

Quality Governance Arrangements

Strategy

Patient safety, quality and experience, alongside improving efficiency drive the Board's 'Towards 2015 Strategy' and provide the basis for annual objective setting. The potential risks to safety, quality or patient experience are identified and escalated to the Board in accordance with the process outlined in section 4.1 above.

Capabilities and Culture

The Board of Directors has ensured it has the necessary leadership, skills and knowledge to deliver on all aspects of the quality agenda. In addition, the Board has put in place a clinical leadership model which puts senior medical and nursing colleagues at the heart of decision-making and management. Our culture continues to develop - the South Manchester Way, 'the way we do things around here', places patient care at the heart of everything we do in addition to (a) being honest and

open; (b) striving for excellence; (c) leading, learning and inspiring others; (d) being one talented team.

Processes and Structure

Accountability for safety, quality, patient experience and improved efficiency are set out within the job descriptions and objectives of the Executive Team, senior leaders and staff. All policies and procedures clearly set out roles and responsibilities for all colleagues involved in the delivery of patient care. The Board actively seeks feedback from patients, members, governors and other stakeholders in the pursuit of excellence and as part of the continuous improvement cycle. Directors routinely participate in walk-rounds in clinical areas to engage with frontline teams, patients and visitors, and to evaluate the safety, quality and experience of care for patients. The Board commence each formal meeting with a patient story, reflecting on positive and negative experiences of patients using our services.

The Board of Directors monitor quality by reviewing the Quality Report on a monthly basis. Safety, quality and patient experience however are paramount in the proceedings of the UHSM's senior committees; namely Healthcare Governance Committee, Risk Management Committee and the Audit Committee.

Measurement

Information relating to safety, quality and patient experience is analysed and scrutinised by the Board on a monthly basis, and steps are taken to assure the robustness of data as part of the internal and external audit programmes. The information within the Quality Report is used to evaluate and drive accountability for performance and delivery.

Care Quality Commission Registration

Responsibility for compliance with the provisions of the Health & Social Care Act 2008 (Registration Regulations) 2010 is delegated to an Executive Director lead. For each standard, an Executive Director ensures the Foundation Trust remains at all times compliant with the Regulations and for responding to any compliance actions required by the Care Quality Commission should a condition of registration be imposed. The Chief Risk Officer oversees compliance by (i) reporting and keeping under review matters highlighted within the Care Quality Commission's Quality and Risk Profile (QRP); (ii) analysing trends from incident reporting, complaints, and patient and staff surveys; (iii) reviewing assurances on the operation of controls; (iv) receiving details of assurances provided by Internal Audit, and being notified of any Clinical Audit conclusions which provide only limited assurance on the operation of controls; and (v) challenging assurances or gaps in assurance by attending meetings of the Executive Team, Board of Directors, Risk Management Committee, Healthcare Governance Committee and Audit Committee.

The Foundation Trust is fully compliant with the CQC essential standards of quality and safety.

Following the transfer of community services from NHS Manchester to the Foundation Trust on 1st April 2011, a standard condition of registration has been applied to ensure that the regulated activity accommodation for persons requiring nursing or personal care is managed by an individual registered with the Care Quality Commission as a manager in respect of that activity at or from Buccleuth Lodge and the Dermott Murphy Centre. The Foundation Trust has made an application to the Care Quality Commission in respect of this matter which, once processed by the Care Quality Commission, is expected to satisfy this condition on the Foundation Trust's registration.

Information Governance

The Foundation Trust has undertaken a self-assessment against the Information Governance Toolkit for 2010/11 and has achieved a level 2 rating for all 22 key requirements. The risks to data security are overseen by the Foundation Trust's Information Governance Committee which delivered the following during 2010/11:

- Engaged with Information Asset Owners and Administrators;
- Populated the Information Asset Register;
- Conducted IT Systems Risk Assessments and updated the Risk Register;
- Ensured Password Management procedures are in place;
- Undertaken a data-flow exercise;
- Undertaken Information Governance Training – now accredited;
- Developed a new IT Security Policy;
- Conducted a communication exercise regarding information leaflets;
- Put in place a Psuedonymisation project and new processes to be implemented.

In Year Significant Risk

Risk management is embedded throughout the organisation. All wards and departments have detailed risk registers in place which are monitored by directorate leaders who, in turn, regularly report their risk profiles to the Risk Management Committee as part of a rolling programme. The Trust is a member of the NHSLA Clinical Negligence Scheme and has achieved the highest rating (level 3) for the second consecutive assessment period for acute services, and a planned level 2 for Maternity services. These ratings will remain in place until January 2014 and November 2013 respectively. The Trust actively promotes the reporting of incidents and near misses as part of the Trust's continuous improvement and learning arrangements.

As at 31st March 2011 the Foundation Trust had the following significant risks identified:

- **Patient Safety** (Recognising and responding to clinical deterioration)

  The Foundation Trust takes patient safety very seriously. Following a clinical audit, which raised a concern about the level of compliance with the frequency of observations and the timeliness of responses, the risk was escalated to the Board of Directors in accordance with the Risk Management Process. Action has been taken to improve the standard, frequency and recording of observations; this resulting in a fall in the number of cardiac arrest calls at the Foundation Trust compared to 2009/10. Action is ongoing to embed the early warning scoring system and escalation arrangements. Outcomes will be assessed by monitoring the number of cardiac arrest calls, untoward incidents and reviewing assurances provided by clinical audit.

- **Service performance** (18 Week RTT, A&E, 62-day Cancer targets)

  Uncertainty regarding the potential failure of demand management schemes within primary care settings and the receipt of late referrals represented a risk to the achievement of the A&E 4 hour; 18 weeks admitted, and 62-day cancer targets during 2010/11. These risks were mitigated by dynamic waiting list management; structural reforms to scheduled and unscheduled care pathways within the Trust; engagement with other providers including the cancer network to address late referrals; ongoing data validation and improvements to data quality; and robust performance reviews with clinical teams. Outcomes were kept under constant review by monitoring progress with national targets.

- **Infection Prevention** (MRSA and Decontamination)

  The Trust achieved the MRSA target during 2010/11. To mitigate the risk of breaching the Foundation Trust's infection prevention targets, we continued to deliver a wide ranging programme of work which emphasises to all staff that remaining compliant with the requirements of the Code of Practice for Healthcare Associated Infections is everyone's responsibility. Ongoing mitigation included (i) continuing to raise awareness and leading by example; (ii) regular audits of compliance to ensure all infection prevention and control policies and procedures continue to be implemented, including in particular hand hygiene,

environmental and decontamination standards; and (iii) training on all aspects of infection prevention continue to be delivered and have been extended to include electronic learning opportunities. Outcomes were assessed by reviewing progress with the MRSA target, and auditing compliance with national standards/regulations.

The Foundation Trust has improved the decontamination of flexible endoscopes by commissioning a centralised decontamination facility which came into operation in April 2011.

Outcomes were assessed by reviewing progress with the MRSA target, and auditing compliance with national standards/regulations.

- **Activity demand volatility and reduced income streams**

  In response to the possible stabilisation or fall in NHS income, and potential failure of PCT demand management schemes we identified a risk in respect of PCT affordability and this risk was adequately mitigated in 2010/11. A satisfactory outcome was achieved with a level-3 Financial Risk Rating which, under Monitor's Compliance Framework, indicates sound financial performance.

Principal Risk and Uncertainties Facing the Organisation

In accordance with the risk management process the Trust keeps under constant review all potential significant risk exposures. The Trust's annual plan and 3 year strategy have been assessed to identify future risk exposure. These risks are reported within the Trust's Annual Plan which is reviewed by the Board of Directors and submitted to Monitor.

Quality, Diversity and Human Rights

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

Pensions

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.

Carbon Reduction

UHSM is proud to be one of the first NHS Trusts to be awarded the Carbon Trust Standard by the Carbon Trust. We are equally proud of winning the Sustainability category of the Guardian Public Sector Awards, as well as securing and being declared the outright Overall Winner of the awards. The Trust was also overall winner at the prestigious Climate Change Week awards. Energy consumption has been reduced by 26% at UHSM over the previous 3 years (from its original baseline and excluding new buildings) due to the introduction and delivery of the Trust's Carbon Management Implementation Plan. Specific energy saving initiatives have included:

- More efficient lighting, heat exchangers and building controls
- The installation of a 4MW biomass boiler – a first for a North West hospital which will reduce annual CO2 emission by 3,459 tonnes
- A second, smaller 200 kilowatt biomass boiler, which has been operating in our state of the art Cardiac Centre for three years, and makes the centre self sufficient in terms of its heating needs.
- The installation of ground source heating pumps in our newly-completed Cystic Fibrosis Unit which are proving extremely energy efficient.

- Car share and cycle to work schemes, which operate among staff to reduce carbon foot print to and from UHSM.
- Consequently, the Trust believes it is Britain's '*Greenest'* hospital and this has been independently endorsed by DEFRA.

UHSM is proud to be the first NHS Trust to win the Carbon Trust Award. Energy consumption has been dramatically reduced due to a series of innovative methods. The Trust has a strategy to be acknowledged as Britain's '*Greenest'* hospital. The Foundation Trust has undertaken risk assessments and developed an Adaptation Plan to support its emergency preparedness and civil contingency requirements, as based on the 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

As Acting Accounting Officer, I am responsible for ensuring that the organisation has arrangements in place for securing value for money in the use of its resources. To do this I have implemented systems to:

- Set, review and implement strategic and operational objectives;
- Engage with patients, staff, members and other stakeholders to ensure key messages about services are received and acted upon;
- Monitor and improve organisational performance; and
- Deliver cost improvements.

The Trust submits annually to Monitor a three year service strategy incorporating a supporting financial plan approved by the Board of Directors. This informs the detailed operational plans and budgets which are also approved by the Board. The views obtained from the Council of Governors are taken into account by the Board prior to approval.

The Board agrees annually a set of corporate objectives which are set out in the Annual Plan. This provides the basis for performance reviews at directorate level. Operational performance is kept under constant review by the Executive Team and Board of Directors. In order to keep under review the delivery of the corporate objectives, the Board has a monthly Quality Report covering patient safety, quality, access and experience metrics in addition to a monthly finance performance report. I have overseen the development of the Trust's Quality Report in readiness for publication during 2011.

Assurances on specific issues relating to economy, efficiency, effectiveness, patient safety and quality are commissioned and reviewed by the Audit Committee and, where appropriate, the Healthcare Governance Committee as part of an agreed audit plan. The implementation of recommendations made by Internal Audit is overseen by the Audit Committee.

Effective performance management has been demonstrated through, for example:

- The Financial Risk Rating, issued by Monitor, the Independent Regulator of NHS Foundation Trusts, has continued to be at planned level;
- The achievement of NHSLA level 3 for Trust-wide services in January 2011, and planned level 2 for Maternity service in November 2010;
- Maintained registration with the Care Quality Commission without compliance conditions; and
- Improvements against national priorities during 2010/11.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

UHSM has developed strong clinical leadership for the development of the Quality Report during 2010/11 and this has been provided by the Executive Medical Director in close collaboration with the Chief Nurse and the Chief Operating Officer. Performance and outcomes highlighted within the Quality Report are reviewed and acted on by the Healthcare Governance Committee (HGC), which is committee on which directors sit. The HGC is chaired by the Executive Medical Director with membership comprising of two other executive and two non-executive directors; the Director of Human Resources; and the Chief Risk Officer. There is a specific Quality Account Board, chaired by the Executive Medical Director with the Chief Nurse as a member, responsible for developing and monitoring indicators used within the Annual Quality Report and overseeing data quality. In order to maintain the completeness, accuracy, relevance, validity, reliability and timeliness of data, other members of this Board include the Deputy Chief Nurse, the Associate Medical Director, the Head of Patient Safety & Quality and the Director of Performance.

There are a range of committees and groups established under the leadership of the Healthcare Governance Committee to take forward and evaluate safety, quality and patient experience. Specific groups with strong clinical engagement are in place to focus on key initiatives, examples include (i) medication safety; (ii) safer surgery; (iii) thromboembolic prophylaxis; (iv) falls prevention; (v) patient experience; and (vi) mortality.

Each committee or group has a chair and membership comprised from a wide range of staff with a variety of clinical skills and backgrounds, including consultants, nurses, pharmacists, therapists and midwives. Support is also provided to these specific project groups through the Information, Performance and Communication Teams with regard to the production and presentation of performance data and the promotion of key safety initiatives.

Each element of the Patient Safety, Quality and Patient Experience programme is supported by a range of policies, procedures and safe systems to promote staff engagement and ensure the implementation of key safety initiatives. Examples of this include hand hygiene audits, safer surgery checklists and VTE risk assessment tools.

During 2011/12, there has been further development of the quality and safety metrics in the Board of Directors monthly Quality Report. Each monthly report received by the Board contains information in relation to incidents and complaints trends and root cause analysis investigations, including any serious untoward incidents. On a monthly or quarterly basis, depending on the indicator, the Board regularly receives and reviews quality account metrics in relation to the Patient Safety, Quality and Patient Experience programme.

The Commissioning for Quality and Innovation Contract has provided the Trust with a process for external scrutiny of many elements of the data contained within the Patient Safety, Quality and Patient Experience programme during 2010/11. This information has been reviewed on a quarterly basis by NHS Manchester, the Trust's main Commissioner.

There has also been external audit of data quality on the submitted data relating to the Advancing Quality component of the Quality Report undertaken by the Audit Commission during 2010/11, and, as on a previous occasion, UHSM has been assessed as achieving 100% data quality.

The Trust has a contract with Comparative Health Knowledge System (CHKS) to provide quality and safety benchmarked data, including mortality, which is a routine component of the monthly Quality Report to the Board of Directors.

Review of effectiveness

As Acting 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 assurances from the executive directors 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 attached to this Annual Report and other performance information available to me. My review is also informed by comments made by 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, Healthcare Governance and Risk Management Committees and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors

The Board has set out the governance arrangements including the committee structure within the Governance Manual. The Board has an established Audit Committee, Healthcare Governance Committee and Risk Management Committee the Chairs of which report to the Board at the first available Board meeting after each committee meeting. Urgent matters are escalated by the committee chair to the Board as deemed appropriate.

Audit Committee

The priority for the Audit Committee is to monitor the integrity of the Trust's financial statements and to review the Trust's financial and non-financial controls and management systems. The Committee's work has focussed on the register of risks, controls and related assurances underpinning the delivery of the Board's objectives. The Committee meets at least four times per year and comprises three Non-Executive Directors. Executive Directors, Chief Risk Officer, Foundation Trust Secretary, Chief Internal Auditor and External Audit are in routine attendance. The Chair of the Risk Management and Healthcare Governance Committees routinely report to the Audit Committee. The Chair of Audit Committee ensures that the Committee undertakes detailed reviews of significant risks and all disclosure statements that flow from the Trust's assurance processes as part of a programme of internal and external audit. In particular, these cover financial statements; the Annual Governance Statement (formerly known as the Statement on Internal Control); compliance with applicable standards and regulations; and assurances underpinning declarations to regulators such as Monitor and the Care Quality Commission.

Healthcare Governance Committee

The priority for the Healthcare Governance Committee is to be responsible for ensuring that an effective system of quality governance is embedded throughout the Trust. The Committee's work is focussed on the requirements of the Quality Report and compliance with relevant clinical controls, standards and regulations in order to ensure patient safety, high-quality and high-levels of patient satisfaction. The Committee is chaired by the Executive Medical Director and comprises the Chief Nurse, Chief Operating Officer, two non-executive directors, Director of Human Resources, and the Chief Risk Officer. Clinical leaders, Associate Medical Directors, Deputy Chief Nurse, Foundation Trust Secretary, and Head of Clinical Governance are in routine attendance. The Committee receives, reviews and provides assurances on the operation of controls to deliver the Quality Report, patient safety, clinical effectiveness, and relevant standards from the Care Quality Commission and National Health Service Litigation Authority (NHSLA). In addition, the Committee routinely considers lessons for learning arising out of failures or investigations into NHS trusts or relevant healthcare industry entities.

Risk Management Committee

The priority for the Risk Management Committee is to champion and promote highly-effective risk management practices and ensure that the risk management process and culture are embedded throughout the Trust. The Committee is responsible for ensuring the effective management of all significant risk and will provide assurance on the operation of controls and compliance with relevant NHSLA standards to the Audit Committee. In addition, the Committee oversees the development and implementation of the Risk Management Strategy and Policy and related policies and procedures. The Committee is chaired by myself, as Acting Chief Executive, and comprises Executive Directors, the Director of Human Resources and the Chief Risk Officer with the Foundation Trust Secretary, Internal Audit and relevant operational leaders in routine attendance.

Clinical Audit

Clinical Audit is an integral part of the NHS Foundation Trust's internal control framework. An annual programme of clinical audit is developed involving all clinical directorates. Clinical audit priorities are aligned to the Trust's clinical risk profile, compliance requirements under the provisions of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, and national clinical audit priorities or service reviews. Clinical audit is overseen by the Healthcare Governance Committee.

Internal Audit

With respect to the internal audits concluded during 2010/11, there were three assignments for which Internal Audit reported the level of assurance as limited for the year ended 31st March 2011. These audits provide limited assurance as a result of weaknesses in the design and/or operation of controls. Management action plans are designed and implemented to address these weaknesses and progress against these is reviewed by the Audit Committee. The number of audits providing limited assurance decreased from 2009/10 (seven audits provided limited assurance) and was fewer than in 2008/09 (four provided limited assurance).

Concluding Remarks

As Acting Accounting Officer with responsibility for maintaining a sound system of internal control at the University Hospital of South Manchester NHS Foundation Trust, I confirm that no significant issues of internal control arose during the financial year ended 31st March 2011 and up to the date of approval of the annual report and accounts.

Signed…….

Nora Ann Heery
Acting Chief Executive Date: 26th May 2011

8.4 Independent external auditor's report

I have audited the financial statements of University Hospital of South Manchester NHS Foundation Trust for the year ended 31 March 2011 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies.

I have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes on page 139 and 140
- the table of pension benefits of senior managers and related narrative notes on page 140.

This report is made solely to the Council of Governors of University Hospital of South Manchester NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My audit work has been undertaken so that I might state to the Council of Governors those matters I am required to state to it in an auditor's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for this report or for the opinions I have formed.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

My responsibility is to audit the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. I read all the information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the state of affairs of University Hospital of South Manchester NHS Foundation Trust's affairs as at 31 March 2011 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the Annual Governance Statement on which I report to you if, in my opinion the Annual Governance Statement does not reflect compliance with Monitor's requirements.

Certificate

I certify that I have completed the audit of the accounts of University Hospital of South Manchester NHS Foundation Trust in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Julian Farmer
Officer of the Audit Commission
Aspinall Close
Middlebrook
Bolton
BL3 6QQ

Date 26 May 2011

8.5 Financial Statements

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED

March 31, 2011

	NOTE	**2010/11 £000**	2009/10 £000
Income from patient care activities	3	**291,062**	277,795
Other operating income	4	**57,031**	55,897
Operating expenses (excluding impairments of property and restructuring costs)	7	**(333,536)**	(318,142)
Exceptional item - impairments of property	7,13	**(375)**	(34,407)
Exceptional item - restructuring costs	7	**(2,009)**	**-**
OPERATING SURPLUS/ (DEFICIT)		**12,173**	**(18,857)**
Finance costs:			
Finance income	11	**157**	78
Finance expense - financial liabilities	12	**(8,368)**	(7,877)
Finance expense - unwinding of discount on provisions	26	**(149)**	(103)
Surplus/ (Deficit) for the financial year		**3,813**	(26,759)
Public dividend capital dividends payable	31	**(1,735)**	(2,842)
RETAINED SURPLUS/ (DEFICIT) FOR THE YEAR		**2,078**	(29,601)
Other comprehensive income			
Share of comprehensive income from associates and joint ventures		**-**	-
Revaluation (losses)/ gains and impairment losses on property, plant and equipment	15	**(12,882)**	(9,199)
Increase in donated asset reserve due to receipt of donated assets	15	**59**	40
Reduction in donated asset reserve in respect of depreciation, impairment and/or disposal of donated assets		**(476)**	(511)
Additions/(reductions) on other reserves		**-**	-
Other recognised gains/(losses)		**-**	-
Actuarial gains/(losses) on defined benefit pension schemes			
TOTAL comprehensive (expense) /income for the year		**(11,221)**	(39,271)
RETAINED SURPLUS/ (DEFICIT) FOR THE YEAR		**2,078**	(29,601)
exclude exceptional losses - impairments of property	7,13	**375**	34,407
exclude exceptional losses - restructuring costs	7	**2,009**	-
Surplus for the year before exceptional items		**4,462**	4,806

The notes on pages 127 to 135 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT
March 31, 2011

	Note	**March 31, 2011**	March 31, 2010
		£000	£000
Non-current assets			
Intangible assets	14	**641**	1,088
Property, plant and equipment	15	**181,028**	186,693
Trade and other receivables	20	**2,066**	2,096
Total non-current assets		**183,735**	189,877
Current assets			
Inventories	17	**5,611**	5,272
Trade and other receivables	19	**13,824**	14,071
Cash and cash equivalents	20	**44,650**	30,435
		64,085	49,778
Non-current assets held for sale		**-**	-
Total current assets		**64,085**	49,778
Total assets		**247,820**	239,655
Current liabilities			
Trade and other payables	21	**(43,311)**	(36,113)
Borrowings	22	**(3,549)**	(2,438)
Provisions	26	**(5,605)**	(3,738)
Other liabilities	23	**(13,718)**	(9,880)
Net current assets/(liabilities)		**(2,098)**	(2,391)
Total assets less current liabilities		**181,637**	187,486
Non-current liabilities			
Trade and other payables	21	**-**	-
Borrowings	22	**(84,968)**	(81,460)
Provisions	26	**(4,882)**	(5,159)
Other liabilities	23	**(3,932)**	(1,791)
Total assets employed		**87,855**	99,076
Financed by taxpayers' equity:			
Public dividend capital	SOCITE	**117,472**	117,472
Revaluation reserve	SOCITE	**30,112**	43,365
Donated asset reserve	SOCITE	**5,872**	6,090
Retained earnings	SOCITE	**(65,601)**	(67,851)
Total Taxpayers' Equity		**87,855**	99,076

The financial statements on pages 122 to 126 were approved by the Board on Directors on May 26, 2011 and signed on its behalf by:

May 26, 2011

Signed: ……(Acting Chief Executive) Date: ……

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC) £000	Income & Expenditure Reserve £000	Revaluation reserve £000	Donated asset reserve £000	Total £000
Balance at April 1, 2010					
As previously stated	117,472	(67,851)	43,365	6,090	**99,076**
Prior Period Adjustment	-	-	-	-	**-**
Restated balance	117,472	(67,851)	43,365	6,090	**99,076**
Changes in taxpayers' equity for 2010/11					
Total Comprehensive Income for the year:					
Retained (deficit) / surplus for the year	-	2,078	-	-	**2,078**
Share of comprehensive income from associates and joint ventures	-	-	-	-	**-**
Impairment gains/(losses) on property, plant and equipment	-	-	(13,103)	199	**(12,904)**
Revaluation gains/(losses) on property, plant and equipment	-	-	22	-	**22**
Increase in the donated asset reserve due to receipt of donated assets	-	-	-	59	**59**
Reduction in the donated asset reserve in respect of depreciation, impairment and/or disposal of donated assets	-	-	-	(476)	**(476)**
Additions/(reduction) in other reserves					**-**
Other recognised gains and losses	-	-	-	-	**-**
Actuarial gains/(losses) on defined benefit pension schemes	-	-	-	-	**-**
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	-	172	(172)	-	**-**
New PDC received	-	-	-	-	**-**
PDC repaid in year	-	-	-	-	**-**
Other transfers between reserves	-	-	-	-	**-**
Balance at March 31, 2011	117,472	(65,601)	30,112	5,872	**87,855**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC) £000	Income & Expenditure Reserve £000	Revaluation reserve £000	Donated asset reserve £000	Total £000
Balance at April 1, 2009					
As previously stated	115,019	(38,441)	50,676	8,640	**135,894**
Prior Period Adjustment	-	-	-	-	**-**
Restated balance	115,019	(38,441)	50,676	8,640	**135,894**
Changes in taxpayers' equity for 2009/10					
Total Comprehensive Income for the year:					
Retained (deficit) / surplus for the year	-	(29,601)	-	-	**(29,601)**
Share of comprehensive income from associates and joint ventures	-	-	-	-	**-**
Impairment gains/(losses) on property, plant and equipment	-	-	(7,120)	(2,079)	**(9,199)**
Revaluation gains/(losses) on property, plant and equipment	-	-	-	-	**-**
Increase in the donated asset reserve due to receipt of donated assets	-	-	-	40	**40**
Reduction in the donated asset reserve in respect of depreciation, impairment and/or disposal of donated assets	-	-	-	(511)	**(511)**
Additions/(reduction) in other reserves	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	**-**
Actuarial gains/(losses) on defined benefit pension schemes	-	-	-	-	**-**
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		191	(191)		**-**
New PDC received	2,453	-	-	-	**2,453**
PDC repaid in year	-	-	-	-	**-**
Other transfers between reserves	-	-	-	-	**-**
Balance at March 31, 2010	117,472	(67,851)	43,365	6,090	**99,076**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED

March 31, 2011

	NOTE	**2010/11 £000**	2009/10 £000
Cash flows from operating activities			
Operating surplus/(deficit) from continuing operations		**12,173**	(18,857)
Non-cash income and expense:			
Depreciation and amortisation	7	**8,968**	9,253
Impairments	7	**397**	34,407
Reversals of impairments		**-**	-
Transfer from the donated asset reserve	4	**(476)**	(511)
Amortisation of government grants		**(13)**	-
Amortisation of PFI credit		**-**	-
(Increase)/Decrease in Trade and Other Receivables		**904**	(3,159)
(Increase)/Decrease in Other Assets		**-**	-
(Increase)/Decrease in Inventories		**(339)**	(159)
Increase/(Decrease) in Trade and Other Payables		**4,826**	1,747
Increase/(Decrease) in Other Liabilities		**5,992**	3,709
Increase/(Decrease) in Provisions		**1,441**	(1,755)
Tax (paid) / received		**4,250**	275
Movements in operating cash flow of discontinued operations		**-**	-
Other movements in operating cash flows		**-**	(14)
Net cash generated from / (used in) operating activities		**38,123**	24,936
Cash flows from investing activities			
Interest received	11	**157**	78
Purchase of financial assets		**-**	-
Sales of financial assets		**-**	-
Purchase of intangible assets	14	**-**	(2)
Sales of intangible assets		**-**	-
Purchase of Property, Plant and Equipment	15	**(18,040)**	(22,681)
Sales of Property, Plant and Equipment		**-**	18
Cash flows attributable to investing activities of discontinued operations		**-**	-
Net cash generated from / (used in) investing activities		**(17,883)**	(22,587)
Net cash inflow/(outflow) before financing		**20,240**	2,349
Cash flows from financing activities			
Public dividend capital received		**-**	2,453
Public dividend capital repaid		**-**	-
Loans received		**7,057**	11,440
Loans repaid		**(420)**	(210)
Capital element of finance lease rental payments		**-**	-
Capital element of Private Finance Initiative Obligations		**(2,018)**	(2,130)
Interest paid		**(635)**	(231)
Interest element of finance lease		**-**	-
Interest element of Private Finance Initiative obligations		**(7,647)**	(7,544)
PDC Dividend paid		**(2,362)**	(2,970)
Net cash generated from / (used in) financing activities		**(6,025)**	808
Net increase/(decrease) in cash and cash equivalents		**14,215**	3,157
Cash (and) cash equivalents (and bank overdrafts) at the April 1		**30,435**	27,278
Cash (and) cash equivalents (and bank overdrafts) at the March 31	20	**44,650**	30,435

8.6 Notes to the Accounts

1. ACCOUNTING POLICIES

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS foundation trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2010/11 NHS foundation trust Annual Reporting Manual (FT ARM) issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1 Consolidation

The Trust has no subsidiaries, joint ventures, associates or joint operations requiring consolidation.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme. Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised as tangible assets where:

- they are held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- they are expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.
- individually they have a cost of at least £5,000; or
- they form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, 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
- they form part of the initial setting-up cost of a new building or refurbishment of a 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 e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs 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.

All land and buildings are revalued using professional valuations every five years. A three yearly interim valuation is also carried out. Valuations are carried out by the District Valuer, who is external to the Trust, and in accordance with the Royal Institute of Chartered Surveyors (RICS) *Appraisal and Valuation Manual*.

The valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. An interim valuation of all land and buildings was undertaken in 2009 using a valuation date of 1st April 2009. The purpose of this interim valuation was to restate the assessment of depreciated replacement cost using a modern equivalent asset basis (MEA).The valuation was carried out by the District Valuer, who is external to the Trust, and in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

Land and buildings were also revalued at March 31, 2011; this valuation of land and buildings was undertaken by the District Valuer and has been accounted for on March 31, 2011.

The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.
Assets in the course of construction are valued at cost and are valued by professional valuers as part of the five or three-yearly valuation or when they are brought into use.
Equipment assets are valued at depreciated historical cost basis.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Freehold land is considered to have an infinite life and is not depreciated.

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 and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the FT ARM, impairments that 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.
An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve where the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;

- the sale must be highly probable i.e.:
    - management are committed to a plan to sell the asset;
    - an active programme has begun to find a buyer and complete the sale;
    - the asset is being actively marketed at a reasonable price;
    - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the Statement of Comprehensive Income is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. The underlying assets are recognised as Property, Plant and Equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme.

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

1.6 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.
Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. 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 e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.7 Government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Grants from the Department of Health, including those for achieving three star status, are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

1.9 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as 'Fair Value through Income and Expenditure', Loans and receivables or 'Available-for-sale financial assets'.

Financial liabilities are classified as 'Fair value through Income and Expenditure' or as 'Other Financial liabilities'.

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the Statement of Comprehensive Income. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in non-current assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'Finance Costs' in the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the 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 Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly or through the use of a bad debt provision.

1.10 Leases

Finance leases

The Trust assesses the terms of each individual lease agreement to determine whether substantially all the risks and rewards of ownership are borne by the Trust.

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.11 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for

early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 26 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 28 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 28, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- 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 entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.13 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services, excluding cash balances held in GBS accounts held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.14 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.15 Corporation Tax

The Trust is a Health Service body within the meaning of the Income and Corporation Tax Act (ICTA) 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to display the exemption in relation to the specified activities of a foundation trust (ICT Act 1988). Accordingly, the Trust is potentially within the scope of Corporation Tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits therefrom exceed £50,000pa. There is no tax liability arising in respect of the current financial year.

1.16 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Resulting exchange gains or losses are recognised in income or expense in the period in which they arise.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM.*

1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

2. Operating segments

The Foundation Trust operates in only one segment, healthcare.

3. Income from patient care

3.1 Income from patient care activities - by source

	note	2010/11 £000	2009/10 £000
Foundation trusts		**37**	**216**
NHS trusts		**-**	**-**
Strategic health authorities	a)	**1,325**	**5,925**
Primary care trusts		**274,664**	**262,567**
Local authorities		**42**	**37**
Department of Health - grants		**-**	**-**
Department of Health - other		**-**	**-**
NHS other	a)	**13,553**	**7,664**
Non-NHS: Private patients		**149**	**185**
Non-NHS: Overseas patients (non-reciprocal)		**119**	**129**
NHS Injury costs recovery scheme	b)	**1,173**	**1,072**
Non-NHS other		**-**	**-**
		291,062	**277,795**

a) Income received from specialist commissioners has been recategorised in 2010/11 and is now included within "NHS other". In 2009/10 this income was included within income from Strategic health authorities.

b) Injury cost recovery income is subject to a provision for impairment of receivables of 8.2% to reflect expected rates of collection.

3.2 Income from patient care activities - by point of delivery

		2010/11 £000	2009/10 £000
Elective income		**68,032**	62,672
Non-elective income		**82,583**	79,883
Out-patient income		**39,429**	42,791
A&E income		**7,747**	7,388
Other clinical activity income	a)	**91,716**	83,625
Private patient income		**150**	185
Other non-protected clinical income		**1,405**	1,251
		291,062	277,795

a) 'Other clinical activity income' increased in 2010/11 as a result of the full year effect of the National Aspergillosis Centre, the expansion of an organ retrieval service and the extension of the CQUIN quality payments scheme.

3.3 Income from patient care activities - mandatory and non-mandatory

	2010/11 £000	2009/10 £000
Income from mandatory patient care activities	**289,507**	276,359
Income from non-mandatory patient care activities	**1,555**	1,436
	291,062	277,795

3.4 Private patient income

The NHS Act 2006 requires that the proportion of private patient income to the total patient related income of the Foundation Trust should not exceed it proportion whilst the body was an NHS Trust in 2002/03 (the 'base year').

	Base Year 2002/03 £000	2010/11 £000	2009/10 £000
Private patient income	169	**150**	185
Total patient related income	161,764	**291,062**	277,795
Proportion (as a percentage) not to exceed the base year cap	0.10%	**0.05%**	0.07%

4. Other Operating Income

	NOTE	2010/11 £000	2009/10 £000
Research and development		**4,520**	3,370
Education and training		**26,203**	25,141
Charitable and other contributions to expenditure		**-**	-
Transfer from donated asset reserve in respect of depreciation on donated assets		**476**	511
Non-patient care services to other bodies		**14,708**	13,735
Other	5	**11,124**	13,126
Profit on disposal of tangible fixed assets		**-**	14
Total		**57,031**	55,897

5. Other Operating Income : Other Income

		2010/11 £000	2009/10 £000
Car parking		**1,720**	1,543
Estates recharges		**378**	373
Staff recharges		**1,740**	1,954
IT recharges		**18**	-
Pharmacy sales		**936**	1,113
Staff accommodation rentals		**48**	61
Crèche services		**351**	257
Clinical tests		**1,142**	1,127
Clinical excellence awards		**2,259**	2,064
Property rentals		**324**	562
Other	a)	**2,208**	4,072
Total		**11,124**	13,126

a) Other 'Other Income' includes funding for clinical audit, training projects and national burns database work.

6. Operating lease income

	2010/11 £000	2009/10 £000
Operating lease income		
Rents recognised as income during the period	**1,314**	1,316
Contingent rents recognised as income during the period	**-**	-
Total	**1,314**	1,316
Future minimum lease payments due		
- not later than one year	**1,576**	1,267
- later than one year and not later than five years	**6,548**	5,980
- later than five years	**14,072**	14,302
Total	**22,196**	21,549

The Trust leases property to Manchester Mental Health and Social Care NHS Trust. This income is included in note 4 above as 'non-patient care services to other bodies'.

7. Operating Expenses

	Note	2010/11 £000	2009/10 £000
Services from NHS Foundation Trusts		**1,524**	1,535
Services from NHS Trusts		**23**	24
Services from other NHS Bodies	a)	**1,954**	4,522
Purchase of healthcare from non NHS bodies	a)	**2,852**	3,363
Employee Expenses - Executive directors	b)	**898**	895
Employee Expenses - Non-executive directors		**127**	146
Employee Expenses - Staff	c)	**203,186**	193,074
Drug costs		**22,082**	20,924
Supplies and services - clinical (excluding drug costs)		**39,972**	34,614
Supplies and services - general		**24,763**	22,756
Establishment		**2,508**	3,108
Research and development	d)	**2,238**	1,686
Transport		**512**	548
Premises		**13,741**	13,805
Increase / (decrease) in bad debt provision		**(2)**	(157)
Depreciation on property, plant and equipment		**8,521**	8,799
Amortisation on intangible assets		**447**	453
Impairments of property, plant and equipment		**375**	34,407
Impairments of intangible assets		**-**	-
Reversal of impairments of property, plant and equipment		**-**	-
Reversal of impairments of intangible assets		**-**	-
Audit fees			
audit services- statutory audit	e)	**49**	47
audit services -regulatory reporting	f)	**10**	22
Other auditors remuneration			
further assurance services		**-**	-
other services		**8**	-
Clinical negligence	g)	**4,368**	3,688
Loss on disposal of investments		**-**	-
Loss on disposal of intangible fixed assets		**-**	-
Loss on disposal of land and buildings		**-**	-
Loss on disposal of other property, plant and equipment		**-**	-
Loss on disposal of assets held for sale		**-**	-
Impairments of assets held for sale		**-**	-
Legal fees		**114**	62
Consultancy costs		**651**	1,532
Training, courses and conferences		**1,565**	840
Patient travel		**61**	59
Car parking & Security		**435**	630
Redundancy/ Mutually Agreed Resignation Scheme		**2,009**	-
Early retirements		**-**	-
Hospitality		**168**	155
Publishing		**-**	-
Insurance		**748**	812
Losses, ex gratia & special payments		**12**	199
Other		**1**	1
Total operating expenses		**335,920**	352,549
Total operating expenses		**335,920**	352,549
Impairments of property, plant and equipment		**(375)**	(34,407)
Restructuring costs		**(2,009)**	-
Total operating expenses excluding impairments		**333,536**	318,142

a) The cost of services received from the Health Protection Agency have been included within "Purchase of healthcare from non-NHS bodies" in 2010/11.

b) Details provided in note 7.1.

c) Details provided in note 9.

d) The costs shown as 'Research and Development' are only non-pay items. Salary costs relating to research and

e) There is no limit on the Trust's auditors liability.

f) Costs shown as 'Audit Services- regulatory reporting' relate to external auditor's review of the Trust's Quality Report.

g) In 2010/11 the Trust's contribution to the NHS Litigation Authority's Clinical Negligence Scheme increased to reflect the higher level of births at UHSM following the transfer of maternity services from Trafford General Hospital.

7.1 Salary and pension entitlements of senior managers

Note: It is the view of the Board of Directors that the authority and responsibility for controlling major activities is retained by the statutory Board of Directors who have voting rights and is not exercised below this level.

Figures below are for the 12 months from April 1, 2010 to March 31, 2011

	A	B	C	D	E	F	
Name and title	**Salary for 12 month period (Bands of £5,000)**	**Other remuneration for period (Bands of £5,000)**	**Golden hello**	**Compensation for loss of office**	**Benefits in kind (Rounded to the nearest £100)**	**Amounts paid relating to the previous year**	
	£ 000s	**£ 000s**	**£ 000s**	**£ 000s**	**£**	**£ 000s**	
2010/11							
Executive Board Members with Voting Rights							
Bailey A. - Chief Nurse	120 to 125	-	-	-	-	-	
Hartley J. - Chief Executive	180 to 185	-	-	-	-	-	i)
Heery NA. - Director of Finance / Acting Chief Executive	135 to 140	-	-	-	-	-	ii)
Jago D - Acting Director of Finance	5 to 10	-	-	-	-	-	iii)
James K.- Chief Operating Officer	125 to 130	-	-	-	-	-	
Ryan B. - Medical Director	130 to 135	25 to 30	-	-	-	-	iv)
Non Executive Board Members							
Goodey F. - Chair	45 to 50	-	-	-	-	-	
Barlow R.- Non Executive Director	15 to 20	-	-	-	-	-	
Boulnois G.- Non Executive Director	10 to 15	-	-	-	-	-	
Clinton L.- Non Executive Director	10 to 15	-	-	-	-	-	
Gibson M - Non Executive Director	5 to 10	-	-	-	-	-	v)
Smyth P. - Non Executive Director	10 to 15	-	-	-	-	-	
Griffiths C. - Non Executive Director	0 to 5	-	-	-	-	-	vi)
2009/10							
Executive Board Members with Voting Rights							
Bailey A. - Chief Nurse	100 to 105	-	-	-	-	-	
Hartley J.- Chief Executive	180 to 185	-	-	-	-	-	
Heery NA. - Director of Finance	135 to 140	-	-	-	-	-	
James K. - Chief Operating Officer	100 to 105	-	-	-	-	-	vii)
Ryan B. - Medical Director	130 to 135	25 to 30	-	-	-	-	
Non Executive Board Members							
Goodey F. - Chair	45 to 50	-	-	-	-	-	
Barlow R.- Non Executive Director	5 to 10	-	-	-	-	-	viii)
Boulnois G.- Non Executive Director	0 to 5	-	-	-	-	-	ix)
Clinton L.- Non Executive Director	0 to 5	-	-	-	-	-	ix)
Griffiths C.- Non Executive Director	10 to 15	-	-	-	-	-	
Smyth P. - Non Executive Director	10 to 15	-	-	-	-	-	
Folkman P. - Non Executive Director	5 to 10	-	-	-	-	-	x)
Hillon B. - Non Executive Director	5 to 10	-	-	-	-	-	x)
Pattison C. - Non Executive Director	5 to 10	-	-	-	-	-	x)

i) Temporarily absent from Chief Executive post with effect from 28th February 2011 due to road traffic accident
ii) Acting up to Chief Executive commenced 28th February 2011
iii) Acting up to Director of Finance commenced 28th February 2011
iv) Other remuneration relates to clinical duties
v) Commenced with the Trust on 15th November 2010
vi) Left the Trust on 30th June 2010
vii) Commenced with the Trust on 15th June 2009.
viii) Commenced with the Trust on 1st November 2009
ix) Commenced with the Trust on 1st January 2010
x) Non Executive Directors leaving the Trust

7.2 Salary and pension entitlements of senior managers (continued)

Pension entitlements of senior managers

Note: As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.

Name and Title	Total accrued pension at age 60 at March 31, 2011 (Bands of £2,500)	Value of automatic lump sums at March 31, 2011 (Bands of £2,500)	Real increase in pension during the period (Bands of £2,500)	Real increase in automatic lump sum during the period (Bands of £2,500)	CETV at March 31, 2010 (Bands of £1,000)	CETV at March 31, 2011* (Bands of £1,000)	Real increase in CETV during the period* (Bands of £1,000)	
	£ 000s	£ 000s	£ 000s	£ 000s	£ 000s	£ 000s	£ 000s	
Bailey A. - Chief Nurse	35.0 to 37.5	105.0 to 107.5	5.0 to 7.5	15.0 to 17.5	496 to 497	508 to 509	0-1	
Hartley J.- Chief Executive	35.0 to 37.5	105.0 to 107.5	0.0 to 2.5	2.5 to 5.0	516 to 517	476 to 477	(52) to (53)	i)
Heery NA - Director of Finance/ Acting Chief Executive	42.5 to 45.0	132.5 to 135.0	0.0 to 2.5	0.0 to 2.5	785 to 786	722 to 723	(82) to (83)	
Jago D. - Acting Director of Finance	27.5 to 30.0	87.5 to 90.0	0.0 to 2.5	5.0 to 7.5	446 to 447	431 to 432	(25) to (26)	
James K.- Chief Operating Officer	42.5 to 45.0	127.5 to 130.0	0.0 to 2.5	0.0 to 2.5	754 to 755	691 to 692	(81) to (82)	
Ryan B. - Medical Director	47.5 to 50.0	147.5 to 150.0	0.0 to 2.5	5.0 to 7.5	966 to 967	941 to 942	(50) to (51)	

Source: NHS Pensions Agency

* A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

In the budget of 22nd July 2010 the Chancellor announced that the uprating (annual increase) of public sector pensions would change from the Retail Price Index (RPI) to the Consumer Prices Index (CPI). As a result the Government Actuaries Department undertook a review of all transfer factors. The new CETV factors have been used in our calculations and are lower than the previous factors we used therefore you will find that the value of the CETV's for some members has fallen since 31.03.2010.

i) The NHS Pensions Agency have revised the figures for J Hartley for 2010 from that published in the 2009/ 10 accounts.

7.3 Mutually Agreed Resignation Scheme and Redundancy Payments

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	3	12	15
£10,000 - £25,000	5	9	14
£25,001 - £50,000	3	5	8
£50,001 - £100,000	8	1	9
£100,001 - £150,000	5	1	6
£150,001 - £200,000			0
Total number of exit packages by type	**24**	**28**	**52**
Total resource cost	£1,442,327	£566,796	£2,009,123

The above table details the number of compulsory redundancies and MARS (Mutually Agreed Resignantion Scheme) agreed within the financial year 2010/11. Schemes have had approval from Monitor.

8. Arrangements containing an Operating leases

8.1 As lessee

The Trust's leases include office and laboratory accomodation together with equipment (both clinical and non-clinical).

Payments recognised as an expense	**2010/11**	2009/10
	£000	£000
Minimum lease payments	**1,114**	811
Contingent rents	**-**	-
Sub-lease payments	**-**	-
	1,114	811

Total future minimum lease payments	**2010/11**	2009/10
	£000	£000
Payable:		
Not later than one year	**961**	950
Between one and five years	**2,178**	2,122
After 5 years	**1,205**	1,131
	4,344	4,203

9. Employee expenses and numbers

9.1 Employee expenses

Includes the costs of staff and executive directors, but excludes non-executive directors.

	2010/11 Total	2010/11 Permanently Employed	2010/11 Other	2009/10 Total
	£000	**£000**	**£000**	£000
Salaries and wages	**165,965**	**148,660**	**17,305**	155,297
Social security costs	**13,464**	**12,008**	**1,456**	12,631
Pension costs - defined contribution plans				
Employers contributions to NHS Pensions	**19,271**	**17,518**	**1,753**	18,349
Pension Cost - other contributions	**-**	**-**	**-**	-
Termination benefits	**-**	**-**	**-**	-
Agency/contract staff	**7,393**	**-**	**7,393**	7,692
Employee benefits expense	**206,093**	**178,186**	**27,907**	**193,969**

9.2 Average number of people employed

	2010/11 Total	2010/11 Permanently Employed	2010/11 Other	2009/10 Total
	Number	**Number**	**Number**	Number
Medical and dental	**614**	**467**	**147**	590
Ambulance staff	**-**	**-**	**-**	-
Administration and estates	**1,026**	**930**	**96**	1,019
Healthcare assistants and other support staff	**551**	**551**	**-**	480
Nursing, midwifery and health visiting staff	**1,553**	**1,469**	**84**	1,468
Nursing, midwifery and health visiting learners	**5**	**5**	**-**	5
Scientific, therapeutic and technical staff	**719**	**663**	**56**	687
Social care staff	**-**	**-**	**-**	-
Bank and agency staff	**175**	**-**	**175**	188
Other	**-**	**-**	**-**	-
Total	**4,643**	**4,085**	**558**	4,437

The average number of people employed in 2010/11 increased as a consequence of the transfer of maternity services from Trafford General Hospital, together with other business developments.

9.3 Employee benefits

Other than the salary and pension costs detailed above, there were no material employee benefits in 2010/11 or the previous year. In addition to this there are no share options, money purchase schemes, nor long term incentive schemes in the University Hospital of South Manchester NHS Foundation Trust.

There were no director's benefits in respect of advances or credits granted by the Trust. Nor were there any kind of guarentees entered into on behalf of the directors of the Trust by the Trust.

10. Retirements due to ill-health

During the year to March 31, 2011 there were 5 retirements from the Trust agreed on the grounds of ill-health (in the previous year there were 0 retirements due to ill-health). The estimated additional pension liabilities of these ill-health retirements will be £309k (£0k in the previous year). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

11. Finance income

	2010/11 £000	2009/10 £000
Interest income:		
Interest on loans and receivables	**157**	78
Other	**-**	-
Total	**157**	78

Since incorporation the Trust has maintained a policy of only investing in UK banks with high ratings. During 2010/11 the Trust has negotiated improved interest rates on instant access accounts held with two UK banks.

12. Finance Costs- Interest expense

	2010/11 £000	2009/10 £000
Loans from the Foundation Trust Financing Facility	**721**	333
Commercial loans	**-**	-
Overdrafts	**-**	-
Finance leases	**-**	-
Other	**-**	-
Finance Costs in PFI obligations		
Main Finance Costs	**5,049**	5,206
Contingent Finance Costs	**2,598**	2,338
Total	**8,368**	7,877

13. Impairments of assets

	2010/11 £000	2009/10 £000
Impairment arising from UHSM's independent valuer's revaluation of the Trust's land and buildings at March 31, 2011 under the Modern Equivalent Assets (MEA) valuation method	**375**	34,407
Total	**375**	34,407

Where a revaluation reserve exists impairments are first charged against them and then to the Statement of Comprehensive Income. The above impairments are all charges to the Statement of Comprehensive Income.

14. Intangible assets

The only intangible assets that the Trust owns are purchased computer software applications.

	Computer software - purchased 2010/ 11	Computer software - purchased 2009/10
	£000	£000
Gross cost at April 1	**2,300**	2,298
Impairments charged to revaluation reserve	**-**	-
Reclassifications	**-**	-
Revaluation surpluses	**-**	-
Additions purchased	**-**	2
Additions donated	**-**	-
Transferred to disposal group as asset held for sale	**-**	-
Disposals other than by sale	**-**	-
Gross cost at March 31	**2,300**	**2,300**
Amortisation at April 1	**1,212**	759
Charged during the year	**447**	453
Impairments recognised in SOCI*	**-**	-
Reversal of impairments recognised in the SOCI*	**-**	-
Reclassifications	**-**	-
Revaluation surpluses	**-**	-
Transferred to disposal group as asset held for sale	**-**	-
Disposals other than by sale	**-**	-
Amortisation at March 31	**1,659**	**1,212**
Net book value		
Purchased as at April 1 restated	**-**	1,539
Donated as at April 1 restated	**1,088**	
Total at April 1 restated	**1,088**	**1,539**
Net book value		
Purchased as at March 31	**641**	-
Donated as at March 31	**-**	1,088
Total at March 31	**641**	**1,088**

* SOCI= Statement of Comprehensive Income

The intangible assets held by the Trust were initially valued at cost and are amortised over their useful economic life. The Trust is not holding a revaluation reserve for these assets.

	Minimum life Years	Maximum life Years
Intangible assets purchased		
Software	1	5

The Trust has no intangible assets acquired by government grant.

15. Non Current Tangible Assets
15.1 Property, plant and equipment

2010/11:	Land	Buildings excluding dwellings	Dwellings	Assets under construct and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at April 1, 2010	38,062	335,410	3,501	825	50,005	572	3,951	1,657	433,983
Additions purchased	-	4,335	27	8,713	2,441	-	383	177	16,076
Additions donated	-	-	-	-	49	-	10	-	59
Acquisition through business combination	-	-	-	-	-	-	-	-	-
Impairments charged to revaluation reserve*	(14,775)	1,810	61	-	-	-	-	-	(12,904)
Reclassifications	-	8,562	-	(9,101)	539	-	-	-	-
Revaluation surpluses	-	(212,194)	(3,131)	-	-	-	-	-	(215,325)
Transferred to disposal group as asset held for sale	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(1,243)	(74)	(10)	-	(1,327)
At March 31, 2011	**23,287**	**137,923**	**458**	**437**	**51,791**	**498**	**4,334**	**1,834**	**220,562**
Accumulated depreciation as at April 1, 2010	-	207,311	3,109	-	32,492	289	3,113	976	247,290
Provided during the year	-	4,508	22	-	3,463	44	346	138	8,521
Acquisition through business combination	-	-	-	-	-	-	-	-	-
Impairments recognised in operating expenses	-	375	-	-	-	-	-	-	375
Reversal of Impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluation surpluses	-	(212,194)	(3,131)	-	-	-	-	-	(215,325)
Transferred to disposal group as asset held for sale	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(1,243)	(74)	(10)	-	(1,327)
Depreciation at March 31, 2011	**-**	**-**	**-**	**-**	**34,712**	**259**	**3,449**	**1,114**	**39,534**
Net book value									
Owned at April 1, 2010	38,062	85,271	392	587	15,998	283	778	618	141,989
Finance lease at April 1, 2010	-	-	-	-	-	-	-	-	-
PFI at March 31, 2010	-	38,614	-	-	-	-	-	-	38,614
Donated at April 1, 2010	-	4,214	-	238	1,515	-	60	63	6,090
Total at April 1, 2010	**38,062**	**128,099**	**392**	**825**	**17,513**	**283**	**838**	**681**	**186,693**
Net book value									
Owned at March 31, 2011	23,287	94,232	458	199	15,825	239	840	670	135,750
Finance lease at March 31, 2011	-	-	-	-	-	-	-	-	-
PFI at March 31, 2011	-	39,406	-	-	-	-	-	-	39,406
Donated at March 31, 2011	-	4,285	-	238	1,254	-	45	50	5,872
Total at March 31, 2011	**23,287**	**137,923**	**458**	**437**	**17,079**	**239**	**885**	**720**	**181,028**

* At 31st March 2011 The Trust's valuer used an industrial valuation for land. In previous years a residential valuation has been used, this change has led to a reduction in asset valuation.

15.2 Property, plant and equipment prior year

2009/10	Land	Buildings excluding dwellings	Dwellings	Assets under construct and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at April 1, 2009	37,975	321,685	3,489	4,613	46,602	391	3,844	1,593	420,192
Additions purchased	-	6,463	100	12,795	3,578	181	107	64	23,288
Additions donated	-	-	-	26	14	-	-	-	40
Acquisition through business combination	-	-	-	-	-	-	-	-	-
Impairments charged to revaluation reserve	-	(9,198)	(88)	-	-	-	-	-	(9,286)
Reclassifications	-	16,460	-	(16,609)	149	-	-	-	-
Revaluation surpluses	87	-	-	-	-	-	-	-	87
Transferred to disposal group as asset held for sale	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(338)	-	-	-	(338)
At March 31, 2010	**38,062**	**335,410**	**3,501**	**825**	**50,005**	**572**	**3,951**	**1,657**	**433,983**
Accumulated depreciation as at April 1, 2009	-	168,131	2,696	-	29,728	263	2,758	842	204,418
Provided during the year	-	5,160	26	-	3,098	26	355	134	8,799
Acquisition through business combination	-	-	-	-	-	-	-	-	-
Impairments recognised in operating expenses	-	34,020	387	-	-	-	-	-	34,407
Reversal of Impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluation surpluses	-	-	-	-	-	-	-	-	-
Transferred to disposal group as asset held for sale	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(334)	-	-	-	(334)
Depreciation at March 31, 2010	**-**	**207,311**	**3,109**	**-**	**32,492**	**289**	**3,113**	**976**	**247,290**
Net book value									
Owned at April 1, 2009	37,975	99,786	793	4,401	15,063	128	994	675	159,815
Finance lease at April 1, 2009	-	-	-	-	-	-	-	-	-
PFI at April 1, 2009		47,319	-	-	-	-	-	-	47,319
Donated at April 1, 2009	-	6,449	-	212	1,811	-	92	76	8,640
Total at April 1, 2009	**37,975**	**153,554**	**793**	**4,613**	**16,874**	**128**	**1,086**	**751**	**168,455**
Net book value									
Owned at March 31, 2010	38,062	85,271	392	587	15,998	283	778	618	141,989
Finance lease at March 31, 2010	-	-	-	-	-	-	-	-	-
PFI at March 31, 2010	-	38,614	-	-	-	-	-	-	38,614
Donated at March 31, 2010	-	4,214	-	238	1,515	-	60	63	6,090
Total at March 31, 2010	**38,062**	**128,099**	**392**	**825**	**17,513**	**283**	**838**	**681**	**186,693**

15.3 Property, plant and equipment (cont.)

	Minimum life Years	Maximum life Years
Land	-	-
Buildings (excluding dwellings)	1	71
Dwellings	5	34
Assets under construction	1	-
Plant and machinery	1	15
Transport equipment	1	7
Information technology	1	5
Furniture and fittings	1	10

The Trust received no compensation from third parties for assets impaired, lost or given up.

15.4 Protected and unprotected tangible non-current assets

	Land	Buildings (incl. Dwellings)	Assets under construction	Equipment	Total
	£000s	£000s	£000s	£000s	£000s
Protected tangible non-current assets as at March 31, 2010	38,062	123,367			161,429
Unprotected tangible non-current assets as at March 31, 2010	-	5,124	825	19,315	25,264
	38,062	**128,491**	**825**	**19,315**	**186,693**
Protected tangible non-current assets as at March 31, 2011	23,287	133,925			157,212
Unprotected tangible non-current assets as at March 31, 2011	-	4,456	437	18,923	23,816
	23,287	**138,381**	**437**	**18,923**	**181,028**

16. Capital commitments

Contracted capital commitments at 31st March not otherwise included in these financial statements:

	March 31, 2011 £000	March 31, 2010 £000
Property, plant and equipment	**6,665**	3,684
Intangible assets	**-**	-
Total	**6,665**	**3,684**

Capital commitments at 31st March 2011 related to a new research unit and improvements to the Trust's maternity facility.

At March 31, 2011 the Trust had no non-current assets for sale, assets held in disposal groups or liabilities in disposal groups. This was the same situation as March 31, 2010.

17. Inventories

17.1. Inventories

	March 31, 2011 £000	March 31, 2010 £000
Materials	**5,611**	5,272
Work in progress	**-**	-
Finished goods	**-**	-
Inventories carried at fair value less costs to sell	**-**	-
Total	**5,611**	5,272

The Trust holds no non-current inventories.

17.2 Inventories recognised in expenses

	March 31, 2011 £000	March 31, 2010 £000
Inventories recognised as an expense in the period	**45,428**	42,874
Write-down of inventories recognised as an expense(including losses)	**19**	10
Reversal of write-downs that reduced the recognised expense	**-**	-
Total	**45,447**	42,884

Inventories recognised as an expense in the period are the total amounts that have been charged to the SOCI during the year from those significant inventories. Inventories are therefore 12% of annual expense (giving an average stock turn over of 6 weeks).

18. Investments

The Trust held no investments during either of the financial years ended March 31, 2010 or March 31, 2011.

19. Trade and other receivables

19.1 Trade and other receivables

Current	Note	March 31, 2011 £000	March 31, 2010 £000
NHS receivables		**8,745**	9,513
Other receivables with related parties		**22**	-
Provision for the impairment of receivables		**(125)**	(445)
Prepayments		**2,363**	2,099
PFI prepayments			
- capital contributions		**-**	-
- lifecycle replacements		**-**	-
Accrued income		**107**	329
Finance lease receivables		**-**	-
PDC receivables	a)	**755**	128
Other receivables		**1,957**	2,447
Total		**13,824**	14,071

Non Current	March 31, 2011 £000	March 31, 2010 £000
NHS receivables	**-**	-
Other receivables with related parties	**-**	-
Provision for the impairment of receivables	**(158)**	(158)
Prepayments	**-**	-
PFI prepayments		
- capital contributions	**-**	-
- lifecycle replacements	**-**	-
Accrued income	**2,224**	2,254
Finance lease receivables	**-**	-
PDC receivables		
Other receivables	**-**	-
Total	**2,066**	2,096

Total	March 31, 2011 £000	March 31, 2010 £000
NHS receivables	**8,745**	**9,513**
Other receivables with related parties	**22**	**-**
Provision for the impairment of receivables	**(283)**	**(603)**
Prepayments	**2,363**	**2,099**
PFI prepayments	**-**	**-**
- capital contributions	**-**	**-**
- lifecycle replacements	**-**	**-**
Accrued income	**2,331**	**2,583**
Finance lease receivables	**-**	**-**
PDC receivables	**755**	**128**
Other receivables	**1,957**	**2,447**
Total	**15,890**	16,167

a) PDC dividends are calculated on an actual basis, giving rise to a receivable where the interim payment had been overestimated.

19.2 Provision for impairment of receivables

	March 31, 2011 £000	March 31, 2010 £000
At 1st April	603	1,608
Increase in provision	(2)	-
Amounts utilised	(318)	(848)
Unused amounts reversed	-	(157)
At March 31	**283**	603

19.3. Receivables past due date, but not impaired

	March 31, 2011 £000	March 31, 2010 £000
Up to three months	**6,669**	6,495
In three to six months	**1,173**	1,010
Over six months	**800**	1,123
Balance at March 31	**8,642**	8,628

Receivables are due within 30 days of the date of invoice.

19.4. Ageing of impaired receivables

	March 31, 2011 £000	March 31, 2010 £000
Up to three months	**68**	16
In three to six months	**18**	25
Over six months	**39**	562
Balance at March 31	**125**	603

20. Cash and cash equivalents

	March 31, 2011 £000	March 31, 2010 £000
Balance at April 1	30,435	27,278
Net change in year	14,215	3,157
Balance at March 31	**44,650**	30,435
Made up of		
Commercial banks and cash in hand	209	136
Cash with the Government Banking Service	44,441	30,299
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**44,650**	30,435
Bank overdraft	-	-
Cash and cash equivalents as in statement of cash flows	**44,650**	30,435

21. Trade and other payables

	March 31, 2011 £000	March 31, 2010 £000
Current		
NHS payables	**10,681**	11,395
Amounts due to other related parties	**265**	-
Other trade payables - capital	**1,742**	3,706
Other trade payables	**6,502**	5,534
Taxes payable	**7,938**	3,688
Other payables	**4,884**	2,453
Accruals	**11,299**	9,337
Total current	**43,311**	36,113
Non Current		
Other payables	**-**	-
Total Non current	**-**	**-**
Total		
NHS payables	**10,681**	11,395
Amounts due to other related parties	**265**	-
Other trade payables - capital	**1,742**	3,706
Other trade payables	**6,502**	5,534
Taxes payable	**7,938**	3,688
Other payables	**4,884**	2,453
Accruals	**11,299**	9,337
Total	**43,311**	36,113

At March 31, 2011 the Trust had no payables to buy out the liability of early retirements. This is the same as the previous financial year.

22. Borrowings

	March 31, 2011	March 31, 2010
Current	**£000**	£000
Bank overdrafts	**-**	-
Drawdown in committed facility	**-**	-
Loans from:		
Foundation Trust Financing Facility	**421**	421
Other entities	**-**	-
Obligations under finance leases	**-**	-
PFI liabilities:		
Main liability	**3,128**	2,017
Total Current	**3,549**	2,438
Non Current		
Bank overdrafts	**-**	-
Drawdown in committed facility	**-**	-
Loans from:	**-**	-
Foundation Trust Financing Facility	**22,005**	15,369
Other entities	**-**	-
Obligations under finance leases	**-**	-
PFI liabilities:		
Main liability	**62,963**	66,091
Total Non Current	**84,968**	81,460
Total		
Bank overdrafts	**-**	**-**
Drawdown in committed facility	**-**	**-**
Loans from:		
Foundation Trust Financing Facility	**22,426**	15,790
Other entities	**-**	-
Obligations under finance leases	**-**	-
PFI liabilities:		
Main liability	**66,091**	68,108
Total	**88,517**	83,898

The Trust currently has two loans outstanding.
1. £7.4m for a Cystic Fibrosis expansion (to be repaid by 2029).
2. £15.1m for work done to date on a Maternity refurbishment scheme. The full value of this scheme is £20m and the Trust has an approved loan facility allowing further borrowing up to this level.

23. Other liabilities

	Note	**March 31, 2011**	March 31, 2010
		£000	£000
Current			
Deferred income	a), b)	**13,640**	9,789
Deferred PFI credits		**-**	-
Deferred government grant		**78**	91
Net pension scheme liability		**-**	-
Total		**13,718**	9,880
Non Current			
Deferred income	b)	**3,932**	1,723
Deferred PFI credits		**-**	-
Deferred government grant		**-**	68
Net pension scheme liability		**-**	-
Total		**3,932**	1,791
Total			
Deferred income		**17,572**	11,512
Deferred PFI credits		**-**	-
Deferred government grant		**78**	159
Net pension scheme liability		**-**	-
Total		**17,650**	11,671

a) Current Deferred Income has increased in year as the Trust received income for the Collaborative Local Research Network and Emerging Leaders schemes.

b) In 2010/11 the Trust received a further £2.0m (2009/10 £2.1m) transitional funding to support the transfer of maternity services from Trafford General Hospital. This funds additional expenditure associated with the transfer up to financial year 2016/17. The element relating to financial years 2012/13 to 2016/17 is therefore treated as a non-current deferred income liability.

24. Prudential Borrowing Limit

The Trust is given a prudential borrowing limit which it is not permitted to exceed.

The Trust is required to comply and remain within Monitor's Prudential Borrowing Limit set out in the 'Prudential Borrowing Code'. The code was amended at April 1, 2009 to allow for the changes in accounting treatment under the adoption of IFRS and with PFI schemes coming 'on-Statement of Financial Position'.

Further information on the NHS Foundation Trust Prudential Borrowing Code can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

	March 31, 2011	March 31, 2010
	£000	£000
Total long term borrowing limit set by Monitor	**95,900**	98,200
Working capital facility agreed by Monitor	**27,000**	24,000
TOTAL PRUDENTIAL BORROWING LIMIT	**122,900**	122,200
Long term borrowing at April 1	**83,898**	74,798
Net actual borrowing/(repayment) in year - long term	**4,619**	9,100
Long term borrowing at March 31	**88,517**	83,898
Working capital borrowing at April 1	**-**	-
Net actual borrowing/(repayment) in year - working capital	**-**	-
Working capital borrowing at March 31	**-**	-
Long Term Borrowing		
PFI	**66,091**	68,108
Foundation Trust Financing Facility		
-Cystic Fibrosis	**7,369**	7,790
-Maternity	**15,057**	8,000
Total	**88,517**	83,898

24.1 Finance lease obligations

Other than a PFI arrangment the Trust has no finance lease obligations.

25. Private Finance Initiative contracts

25.1 PFI schemes on-Statement of Financial Position

The Trust has a 35 year PFI contract with South Manchester Healthcare Limited which expires in 2033. The contract covers provision of two buildings at Wythenshawe hospital – the Acute Unit and the Mental Health Unit.

The Acute Unit consists of an Accident and Emergency department, a burns unit, coronary care unit, intensive care unit, six operating theatres, five medical and five surgical wards, an x-ray department, fracture clinic and renal department.

The Mental Health Unit provides adult and older people's outpatient and inpatient Mental Health services.

In addition to provision and maintenance of the two buildings, under the terms of the contract the PFI operator also provides a range of essential facilities management services across the Wythenshawe hospital site. These include cleaning, catering, portering, laundry and maintenance services.

In accordance with accounting standard IFRIC 12, the two buildings are treated as assets of the Trust and assets values are included in note 15. IFRIC 12 deems that the substance of the contract is that the Trust has a finance lease and payments comprise two elements – imputed finance lease charges and service charges. Service charges are included within operating expenditure and imputed finance lease charges are detailed in the table below.

The Trust sublets the Mental Health Unit to Manchester Health and Social Care Trust. This agreement is treated as an operating lease and the income received is included within operating income.

25.2 Total obligations for on-Statement of Financial Position (SoFP) PFI contracts due:

	March 31, 2011 £000	March 31, 2010 £000
Gross PFI liabilities	**163,203**	164,330
Of which liabilities are due:		
Not later than one year	**11,585**	9,664
Later than one year, not later than five years	**48,144**	45,601
Later than five years	**103,474**	109,065
Less finance charges allocated to future periods	**(97,112)**	(96,222)
Net PFI liabilities	**66,091**	68,108
Not later than one year	**3,128**	2,017
Later than one year, not later than five years	**16,354**	15,209
Later than five years	**46,609**	50,882
	66,091	68,108

25.3 Charges to expenditure

The Trust is committed to making the following payments for on-SoFP PFI obligations:

	March 31, 2011 Total £000	March 31, 2010 Total £000
Within one year	**31,335**	27,726
2nd to 5th years (inclusive)	**127,143**	117,848
Later than five years	**446,470**	440,808
Total	**604,948**	586,382
Present Value of Commitments		
Within one year	**31,335**	27,726
2nd to 5th years (inclusive)	**116,723**	108,139
Later than five years	**293,660**	286,275
Total	**441,718**	422,140

The PFI scheme results in an annual payment which varies from year to year, however the average cash payment falls towards the end of the contract. The final cash payment will be £27,726k which will be made in 2033.

25.4. Private Finance Initiative Costs

	March 31, 2011	March 31, 2010
	£000	£000
Service element	**19,382**	17,937
Interest costs	**5,049**	5,206
Contingent Rent	**2,598**	2,338
Lifecycle costs	**578**	466
Principal repayment	**2,017**	2,130
Total Payment	**29,624**	28,077

26. Provisions

	March 31, 2011	March 31, 2010
	£000	£000
Current		
Pensions relating to former directors	**7**	7
Pensions relating to other staff	**407**	413
Other (see below)	**5,191**	3,318
Total current	**5,605**	3,738
Non Current		
Pensions relating to former directors	**97**	99
Pensions relating to other staff	**4,649**	4,910
Other (see below)	**136**	150
Total Non current	**4,882**	5,159
Total		
Pensions relating to former directors	**104**	106
Pensions relating to other staff	**5,056**	5,323
Other (see below)	**5,327**	3,468
Total	**10,487**	8,897

	Pensions relating to former directors	**Pensions relating to other staff**	**Other Legal claims**	**Other (see below)**	**Total**
	£000	**£000**		**£000**	**£000**
As at April 1, 2010 restated	106	5,324	568	2,899	**8,897**
Arising during the year	-	-	19	3,054	**3,073**
Used during the year	(5)	(410)	-	(455)	**(870)**
Reversed unused	-	-	-	(762)	**(762)**
Unwinding of discount	3	142	-	4	**149**
At March 31, 2011	104	5,056	587	4,740	**10,487**
Expected timing of cash flows:					
- not later than 1 year	7	407	587	4,603	**5,604**
- later than 1 year and not later than 5 years	28	1,628	-	92	**1,748**
- later than 5 years	69	3,021	-	45	**3,135**
Total	104	5,056	587	4,740	**10,487**

	March 31, 2011	March 31, 2010
	£000	£000
Other provisions include		
Injury benefit	**159**	173
Public and employers insurance claims	**297**	342
Staffing issues	**1,346**	1,308
Miscellaneous contractual issues	**2,938**	1,077
	4,740	2,900

£17,146k is included in the provisions of the NHS Litigation Authority at 31/3/2011 in respect of clinical negligence liabilities of the Trust (31/03/10 £10,898k).

27. Revaluation Reserve

The Trust holds a revaluation reserve for property, plant and equipment, but not for intangible assets.

	March 31, 2011 £000	March 31, 2010 £000
Reserves at April 1	**43,365**	50,676
Prior period adjustment	-	-
Reserves at April 1	**43,365**	50,676
Impairments	**(13,103)**	(7,120)
Revaluation gains/(losses) and impairment losses on property, plant and equipment	**22**	-
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	**(172)**	(191)
Other transfers between reserves		
Reserves at March 31	**30,112**	43,365

28. Contingencies

The Trust has no contingent liabilities or contingent assets at March 31, 2011. This is the same position as at March 31, 2010.

29. Financial Instruments

29.1 Financial assets by category

The only financial assets held by the Trust are loans and recievables

	March 31, 2011 £000	March 31, 2010 £000
Trade and other receivables excluding non-financial assets	12,772	13,940
Other investments	-	-
Other financial assets	-	-
Non current assets held for sale/ disposal	-	-
Cash and cash equivalents	44,650	30,435
Total	57,422	44,375

29.2 Financial liabilities by category

The Trust has no financial liabilities held at fair value through the Statement of Comprehensive Income.

	March 31, 2011 £000	March 31, 2010 £000
Borrowings excluding finance leases and PFI obligations	22,426	15,790
Obligations under finance leases	-	-
Obligations under PFI contracts	163,203	164,330
Trade and other payables not including non-financial liabilities	35,373	32,425
Other financial liabilities	-	-
Provisions under contract	9,900	8,329
Liabilities in disposal groups excluding non-financial assets	-	-
Total	230,902	220,874

29.3 Financial risk management

Financial Reporting Standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The Trust has a continuing service provider relationship with primary care trusts and, as a result of the way these primary care trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's policy agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust is permitted to borrow to fund capital expenditure, subject to affordability as confirmed by Monitor, the Independent Regulator of Foundation Trusts. To March 31, 2011, the Trust has borrowed funds for its expansion of accommodation for its Cystic Fibrosis service together with a loan for enhancements to its Maternity Unit. These loans are with the Foundation Trust Financing Facility at a fixed level of interest. UHSM therefore has a low exposure to interest rate risk.

Credit risk

As the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at March 31, 2011 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care trusts, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

30. Events after the reporting period

On 1st April 2011, the responsibility for providing community health services in the South of Manchester transferred to the Trust from Manchester Primary Care Trust. There was no transfer of assets as part of this agreement.

31. Public Dividend Capital Dividends Paid

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

The average net relevant assets are the total assets employed by the Trust excluding donated assets and cash/ cash equivalents. The average between the opening and closing values for the period.

In 2010/11 dividends were paid on an estimated basis but then reviewed at year end and an adjustment was made based on actual performance. As a result of this adjustment the Trust has a current asset in its books relating to cash due for an overpayment.

32. The Late Payment of Commercial Debts (Interest) Act 1998

The Trust received no claims under The Late Payment of Commercial Debts (Interest) Act 1998.

33. Related party transactions

University Hospital of South Manchester NHS Foundation Trust is a public interest body authorised by Monitor - the Independent Regulator for NHS Foundation Trusts.

For the purposes of these accounts the Department of Health is deemed to be the parent of the Foundation trust. The following are considered to be related parties of an NHS foundation trust:

- Any entity which controls the NHS foundation trust, or is under common control with the NHS foundation trust (this will include all bodies within the scope of the Whole of Government Accounts).
- Any entity over which the NHS foundation trust has control (including where appropriate, the NHS charitable funds).
- Key management personnel.
- Any close family member of any individual within the categories above.
- Any entity controlled, jointly controlled, or significantly influenced by any member of key management personnel or a close family member.
- Any associate of the NHS foundation trust (within the meaning of IAS 28)
- Any joint venture in which the NHS foundation trust is a venturer (within the meaning of IAS 31).

In 2010 / 11 these transactions / balances were:

	Expenditure to Related Party	Income from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000s	£000s	£000s	£000s
Board members	-	-	-	-
Key staff members	-	-	-	-
Other related parties:				
-Department of Health	-	-	-	-
-Other NHS bodies	278,333	339,823	22,245	13,461
-Charitable Funds	-	-	-	-
Joint Ventures	-	-	-	-
Other	-	-	-	-

No security or guarantee is held against the amounts owed to UHSM by related parties, nor held by third parties where UHSM have amounts due to them.

The Trust has reviewed its accounts receivable from related parties as at March 31, 2011 for potential impairments. Where appropriate this is accounted for in note 19.

34. Third Party Assets

The Trust held £1k cash and cash equivalents at March 31, 2011 (£nil - at March 31, 2010) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

35. Losses and Special Payments

There were 189 cases of losses and special payments (2009/10: 142) totalling £220k (2009/10: £183k) accrued during 2010/11. Losses and special payments are reported on an accruals basis with the exception of provisions for future losses. No individual case included a net payment in excess of £100k.

09 Appendices

Appendix 1: Board of Directors

Directors in post at the year end

Mandy Bailey RGN, RSCN Chief Nurse Appointed January 2007
Mandy has held a variety of clinical and managerial roles in acute hospitals, most recently at Leeds Teaching Hospitals NHS Trust. She is a registered General and Children's Nurse. Mandy provides professional and clinical nursing leadership and is responsible for the delivery of the infection prevention and patient experience agendas.

Roger Barlow BA, FCA Independent Non Executive Director (Chair of Audit Committee and Senior Independent Director) Appointed November 2009
Roger is Chairman of the Marsden Building Society and Chairman of Impact Holdings (UK) plc. He is a former partner at KPMG and has held several directorships in both public and private companies. He studied Economics at Durham University and is a Chartered Accountant.

Professor Graham J. Boulnois BSc, PhD Independent Non Executive Director Appointed January 2010
Graham has board level and operational leadership roles in global businesses, and brings a combination of scientific (medical research), business (pharmaceuticals) and financial (venture capital) experience to UHSM. He was Senior Vice President (SVP) Discovery Research at Zeneca Pharmaceuticals and SVP Global Discovery Group at Aventis Pharma AG. He built one of the largest infectious disease research teams in the UK, the work of which has led to him publish more than 100 scientific publications. He has been on numerous national (e.g. The Advisory Panel on Dangerous Pathogens) and international (eg World Health Organisation Vaccines) committees.

Lorraine E. Clinton Independent Non Executive Director Appointed January 2010
Lorraine has experience of UK & European blue-chip executive board roles, combined with multi-industry, public & private non-executive director experience. She has won two national awards, and was the youngest (and first female) appointment to Pilkington's International Management Cadre. Her non-executive roles have included work for the Northern Irish Assembly Civil Service, the Agriculture & Horticulture Development Board, the North West Industry Development Board and Trafford Park Development Corporation.

Felicity Goodey CBE DL Chairman (Chair of Nomination Committee) Appointed January 2008
Felicity is a former senior BBC journalist and presenter. She combines business interests with a number of public appointments. She chairs the largest regeneration company in the country, Central Salford. She led the bid to create the UK's biggest purpose-built media hub, mediacity:uk which includes the relocation of national departments of the BBC from London to the North of England; she led the team which built and operates The Lowry, Britain's most successful arts-based millennium project, an international theatre and gallery complex. She co-founded the 'Unique' Group, a media production and corporate communication group of companies and was senior non-executive Director of NordAnglia PLC, an international education services specialist. She has lived and worked in the area for more than 30 years.

Professor Martin Gibbson BSc PhDIndependent Non Executive Director Appointed November 2010
Martin is a Consultant Physician in Diabetes & Endocrinology, and is the Director of Greater Manchester Comprehensive Local Research Network and the Clinical Lead for the Northwest

Diabetes Local Research Network. He studied a Biochemistry degree and completed a PhD in Biochemistry at the University of Liverpool before going on to study Medicine. Professor Gibson says he decided to join UHSM because of the Trust's excellent record in patient care and research.

Julian Hartley Chief Executive Appointed on 23 June 2009

Julian started his career in the NHS as a general management trainee working in the North East of England. Following his training, Julian worked in a number of NHS management posts in Middlesbrough, Durham and Newcastle working in hospital, health authority and regional level. His first Board Director appointment was at North Tees and Hartlepool NHS Trust where he was responsible for planning, operations and strategy. After two years in this post, Julian moved across the Pennines to take up his first Chief Executive post at Tameside and Glossop PCT. He led the PCT for three years during which time he took it to three star status, developed new Primary Care Centres and managed the PCTs involvement in the Shipman inquiry. Julian stayed in the North West to move to his most recent post at Blackpool Teaching Hospitals NHS Foundation Trust. Julian joined the Trust in December 2005 since which time the Trust has achieved major financial turnaround, secured Foundation Trust status and was one of the first Trusts in the country to meet the 18-week target for treating patients. Julian also chairs the North West Leadership Academy which is developing NHS leaders across the region.

Julian joined UHSM as Acting Chief Executive in April 2009 and was appointed Chief Executive on 23 June 2009. Julian was involved in a road traffic accident on 16 February 2011 and was absent from work for a period of three months, on account of his convalescence. The Board, Council and Governors and staff wish him a speedy recovery to full health during a phased return to work commencing in June 2011.

Nora Ann Heery BSc Director of Finance and Deputy Chief Executive Appointed March 2006

Nora Ann joined UHSM ad Director of Finance in April 2006. She has previously held Director of Finance posts in the NHS within acute, mental health and community health sectors. She joined the NHS as National Finance Trainee in 1983 after gaining a BSc in Economics at Queens University, Belfast. She is a member of the Institute of Public Finance and Accountancy.
As a result of existing succession planning arrangements, NoraAnn Heery was appointed by the Board as Acting Chief Executive on 28 February 2011, and as the Acting Accounting Officer too.

Karen James RGN, BSc (Hons), MSc Chief Operating Officer Appointed June 2009

Karen James joined the Trust as Chief Operating Officer in June 2009. She was previously Executive Director of Operations and Service Improvement for Aintree University Hospitals NHS Foundation Trust. Karen began her NHS career as a nurse and worked in a number of nursing and general management roles in Greater Manchester hospitals before becoming Executive Director of Operations and Performance at The Pennine Acute Hospitals NHS Trust, prior to moving to Aintree Hospitals NHS Foundation Trust.

David Jago BA (Hons) CPFA Acting Director of Finance Appointed February 2011

David Jago joined the Trust as Deputy Director of Finance in November 2008.He was previously Deputy Director of Finance at Conwy and Denbighshire NHS Trust. David began his career in the NHS as a Finance Management trainee with Mersey Regional Health Authority and following qualification as an accountant worked in a number of senior finance roles at Wirral NHS Trust .

David was appointed Acting Director of Finance on 28 February 2011 as part of the succession planning arrangements put in place in response to the absence from work of the Chief Executive.

Brendan Ryan Medical Director Appointed January 2000

Brendan has been with the Trust since 1987 and started work as a Consultant in Emergency Medicine (then A/E) in 1992. As well as continuing his work in emergency care, as the Trust's Medical Director, Brendan is the lead Director for Clinical Governance (Quality and Safety), Education (including the Healthcare Academy), and Research and Development.

John Silverwood (Non-voting) Director of Human Resources Appointed in November 2008

John was previously Group HR Director for PZ Cussons plc, and has also held senior HR roles in the textile industry and local government after starting his career in retail. He is a Fellow of the Chartered Institute of Personnel and Development.

Philip Smyth Independent Non Executive Director (Deputy Chairman and Chair of the Remuneration Committee) Appointed July 2007

Philip has extensive experience in marketing and held several General Management roles at PZ Cussons plc before joining the main Board in 1998. As a Main Board Director, he has run the Group's European business and, latterly has led Group-wide business change projects in the technical and supply chain areas. He retired from the company in 2007 and now holds a number of non executive roles in venture capital backed and privately owned companies as well as acting as a mentor for Business in the Arts.

Register of Directors' Interests

The Board regularly reviews the Register of Directors Interests. The Register is maintained by the Foundation Trust Secretary. Entries are made into the Register by directors on whom the onus is to ensure that their own entry remains up to date. The Board reviews the Register more than once per year and directors are requested to alert the Board to any potential or actual conflict of interest in relation to agenda items at the start of all formal meetings.

The Register of Directors Interests was presented to and noted by the Board in formal meetings in April 2010, December 2010 and March 2011. The interests registered by directors who served for part of the year are shown in Table 9.1.

It is a requirement of the Code that it be noted that there has been no change to material change to the time commitments of the Chairman relating to her other roles, which would affect her availability to discharge her duties at UHSM.

David Jago was appointed as Acting Director of Finance on 28 February 2011 until he left UHSM to take up a substantive role as Director of Finance at a neighbouring Trust effective 27 May 2011. A declaration of interests was made which did not declare any interests. His temporary membership of the Board of directors is therefore not reflected in Table 9.1 below.

Directors not in post at the year end

Professor Christopher Griffiths Independent Non Executive Director Appointed May 2008, resigned 30 June 2010

Christopher Griffiths, MD, FRCP, FRCPath, is Foundation Professor of Dermatology and Associate Dean for Research, Faculty of Medical and Human Sciences, University of Manchester. He trained in dermatology at St Mary's Hospital, London and the University of Michigan. He is a past President of the British Association of Dermatologists and current President of the European Dermatology forum. He is on the editorial boards of 8 scientific journals, including Associate Editor of the Journal of Investigative Dermatology; author of 380 research articles in peer-reviewed journals and 150 articles in non-peer reviewed journals and is a co-editor of the premier international textbook of dermatology - Rook's Textbook of Dermatology. His research includes immunological mechanisms of psoriasis, immunotherapy (including the new biological agents), the "brain-skin axis" and mechanisms and repair of skin ageing.

Professor Griffiths registered interests during the year under review were:
Hon. Consultant Dermatologist, Salford Royal NHS Foundation Trust (remunerated); Member of advisory Boards of: Wyeth, Merck-Serono, Centocor, Novartis, Schering-Plough, Abbott, UCB-Pharma (each remunerated); Associate Dean for Research, University of Manchester, Faculty of Medical & Human Sciences (remunerated).

Table 9.1 Register of Interests of directors in post as at 31 March 2011

NAME	FELICITY GOODEY Chairman	PHILIP SMYTH Independent Non Executive Director Deputy Chairman	PROF. MRTIN GIBSON Independent Non Executive Director	ROGER BARLOW Independent Non Executive Director, Audit Chair, Senior Independent Director	PROF. GRAHAM BOULNOIS Independent Non Executive Director	LORRAINE CLINTON Independent Non Executive Director	JULIAN HARTLEY Chief Executive	NORA ANN HEERY Director of Finance & Deputy/ Acting* Chief Executive (*from 28.2.11)	MANDY BAILEY Chief Nurse	BRENDAN RYAN Medical Director	KAREN JAMES Chief Operating Officer
EMPLOYMENT, DIRECTORSHIPS AND REMUNERATION	Chair, Salford URC; Panel member, Regional Growth Fund; Chair, Advisory Council SMART Project, First Step Trust; Director, Greater Manchester Chamber of Commerce & Industry; Council Member, Salford University; Council Member, Manchester University; Member, Leadership Council, Manchester Business School; Trustee, Friends of Rosie; Hon.Vice President, North West Riding for the Disabled; President, Cheshire Wildlife Trust	Chairman and non executive director, B3 International Ltd; contract manufacturer of personal care products. I work 3 days per month (remunerated); Non executive director, Lornamead I Ltd; privately owned personal care brand marketer. I work 2 days per month (remunerated); Advisor to Cheeky Monkey Business Solutions, project management and business change consultancy. Average involvement 1 day per month, (unremunerated).	Consultant Physician, Salford Royal NHS FT Director of the Greater Manchester Comprehensive Local Research Network Clinical Lead for the North West Diabetes local research network Evaluation Section Lead for Manchester Academic Health Sciences Centre Associate Director for Industry; Comprehensive Clinical Research Networks; (from May 2011)	Chairman and non executive director of Marsden Building Society (remunerated); Non executive Chairman of Impact Holdings (UK) plc (remunerated); Partner in Sapien Partnership (my own consultancy, currently inactive)	Partner SV Life Sciences LLP (full time). Director: Oxagen Ltd; Vantia Ltd; Affinium Inc; Delenex AG; (The above companies do not supply the NHS).	Independent Director, Dept. of Social Development, Northern Ireland Civil Service Chair, MLC Pension Fund Non-Executive Director, ENTRUST Ltd Independent Non Executive Director, and Acting Chair from 1 April 2011, Agriculture & Horticulture Development Board Member of Council, Cranfield University Executive Committee member – Women of the Year, London Trustee of HGCA Pension Fund	Chair, NHS North West Leadership Academy (remunerated); Member, National Leadership Council; Non executive director, Skills for Health (remunerated).	-	-	-	-

RELATED UNDERTAKINGS	-	-	-	-	-	-	-	-	-	-	-	-
CONTRACTS HOUSES, LAND AND BUILDINGS	-	-	-	-	-	-	-	-	-	-	-	-
SHARES AND SECURITIES	-	-	-	-	-	-	-	-	-	-	-	-
NON-FINANCIAL INTERESTS	-	Wife is Chair of Bowdon District NSPCC	Wife is Senior Lecturer in Fetal and Maternal Health in the University of Manchetser	-	-	-	-	Husband Andrew Cannell is Chief Executive of Clatterbridge Centre for Oncology NHS FT	-	-	-	-
GENERAL	-	-	Occasional Member of pharmaceutical Advisory Boards. Occasional speaker at educational events organised by pharma companies. (honoraria paid)-	-	-	-	-	-	Member of the Royal College of Nursing	-	-	-

A separate record of gifts and hospitality is maintained by the Trust, to which entries in the Register of Interests refer.

Note: A copy of the guidance issued to directors in making their entries into the Register of Interests is available on request from the Foundation Trust Secretary via the FT Office on 0161 291 2357 and by email: foundationtrustoffice@uhsm.nhs.uk

Appendix 2: Composition of the Council of Governors

The UHSM constitution requires the number of public Governors to be greater than the aggregate number of appointed and staff Governors. The Council of Governors comprises 20 Governors elected by public members, 7 Governors elected by staff members and 5 Governors appointed by stakeholder organisations.

These arrangements reflect a change recommended by the Council to Monitor. The effect of the changes, which same into force on 10 March 2010, imediately before the commencement of the year under review, was to reduce the number of stakeholder Governors from 12 to 5.

During 2010-11 the Council considered what provision might be made, if any, to ensure adequate representation of the transferring in staff from NHS Manchester as part of the Transferring Community Services initiative. The consensus was that since the incoming staff were spread amongst existing staff sub-constituencies, the incumbent Governors were appropriate in both number and accessibility to be representative of those incoming staff, who number about 400 in total. On this basis, the composition of the Council of Governors has remained unchanged during 2010-11.

Table 9.2: Public elected Governors

Elected Public Governors	No of Seats	Governor	Term of office	Term of office ends
Area 1 (part of Trafford)	3	Marguerite Prenton	3 years	31.10.12
		Jane Reader	3 years	31.10.12
		Peter Turnbull	3 years	31.10.12
Area 2 (part of South Manchester)	5	Shashikant Merchant	3 years	15.08.10
		John Churchill	3 years	31.10.12
		Steve Cook	3 years	31.10.12
		Honor Donnelly	3 years	(removed 17.02.11)
		Sidney Travers	Unexpired term of office	31.10.12
		David Hird	3 years	31.10.12
		Wendy Mannion	3 years	15.08.13
Area 3 (part of Central Manchester)	4	Syed Ali	3 years	31.10.12
		Michael Kelly	3 years	31.10.12
		Harry Lowe	3 years	31.10.12
		Gill Reddick	3 years	31.10.12
Area 4 (part of Stockport)	2	Sharan Arkwright	3 years	31.10.12
		Penny Maher	Unexpired term of office	31.10.12
Area 5 (part of Macclesfield)	1	Helen Kirk	3 years	31.10.12
Area 6 (Rest of England and Wales)	5	Alex Watson	3 years	31.10.12
		Clare Church	3 years	31.01.13
		Christopher Laithwaite	3 years	31.01.13
		Rev Shneur Zalman Odze	3 years	31.01.13
		Chava Odze	3 years	14.04.13

Table 9.3: Staff elected Governors

Elected Staff Governors	No of Seats	Governor	Term of office	Term of office ends
Class 1: Medical Practitioners & Dental Practitioners	1	Stewart Watson	3 years	31.10.12 (retired) 31.03.11)
Class 2: Nursing & Midwifery Staff	2	Mike Connolly	3 years	31.10.12
		Sarah Newlove	3 years	31.10.12
Class 3: Other Clinical Staff	1	Carol Winter (unopposed)	3 years	31.01.13
Class 4:Non-Clinical Staff	1	Colin Owen	3 years	31.10.12
Class 5: Atkins & Sodexho employees working at the Trust under PFI arrangement	1	Andrew Davey (unopposed)	3 years	31.10.12
Class 6: Volunteers working with the Trust	1	Cliff Clinkard	3 years	31.10.12

Table 9.4: Stakeholder appointed Governors

Appointed Governors		No of Seats	Governor	Date appointed
Principal Commissioning Primary Care Trusts	Manchester Primary Care Trust	1	Brian Harrison	25.06.10 (deceased 30.12.10)
Principal Local Councils	Manchester City Council	1	Councillor Edward McCulley	06.08.07 (deceased 01.11.10)
	Trafford Metropolitan Borough Council	1	Councillor John Lamb	01.11.09
Principal University	University of Manchester	1	Professor Paul O'Neill	01.11.09
Primary Care Clinicians	Manchester Professional Executive Committee	1	Mary Karasu	21.08.08 (transferred to UHSM 01.04.11)

Appendix 3: Trust Membership and Membership Constituencies

Members

UHSM has two membership constituencies:

- A *Public Constituency* divided into six defined voting areas (representing public, patients and carers living in defined areas).
- A *Staff Constituency* divided into six classes representing different area's of UHSM's workforce, including UHSM PFI partners and volunteers.

How to become a member of UHSM

Public and patients, who are interested in the affairs of the hospital, may opt to become members of UHSM. Eligibility criteria are as follows:

Public member: An individual can become a public member if he/she is aged 7 years or over and lives within the public catchment area (see map overleaf) or the rest of England and Wales.

Staff member: Employees automatically become staff members unless they choose to opt-out. In 2010-11, eight staff members have chosen to opt-out of membership. Employees of UHSM's PFI partners may become members once they have worked on site for 12 months, as may UHSM's volunteers who have worked on site for 12 months.

At March 31, 2011 UHSM membership stood at 11,684. This consisted of 5,708 public members and 5,976 staff members. Members who wish to communicate with Governors of the Trust are able to do so via the Foundation Trust Office by telephone on 0161 291 2357 or by email to foundationtrustoffice@uhsm.nhs.uk.

Membership Strategy

The Trust's Membership Strategy 2008-2011 was approved by the Council of Governors in April 2008 and the 2011-2014 strategy was approved as fit for purpose by the Board of Directors in December 2010 and ratified by the Council of Governors in February 2011.

The 2011-2014 strategy is based upon further achieving representative membership – to ensure UHSM's membership reflects, where possible, its socio-economic geography and the communities it serves. It aims to increase UHSM's public membership numbers by 2% each year over the period in accordance with directions from Monitor and the NHS Act 2006. Approx 9% new members are required each year in order to replace natural churn and improve representation. This is expected to be possible without the need to hire external membership recruitment consultants.

UHSM recognises that recruitment of members who live in the local South Manchester area, particularly from the Wythenshawe area, is a particular opportunity for UHSM. The Membership Development Committee will be concentrating on this aspect of the strategy, to boost engagement with the local community. The existing strong membership amongst Trafford residents is testament to the long term links between Trafford and UHSM.

The Trust is largely representative across the community it serves. However, the Membership Development Committee has decided to focus its efforts during the year to recruit and engage members in slightly underrepresented areas by attending community events such as festivals. It will utilise the UHSM Academy Skills Bus to ensure that members of the public from less engaged groups have the opportunity to become members and Governors. Representatives from UHSM took part in last year's Gatley Festival, using the Academy's Skills Bus to demonstrate first aid and recruit new members for the Trust.

The age of membership has been reduced from 16 years to 7 years. At the membership workshop held in November 2010 it was agreed that engagement with 'junior members' need not always require them joining the membership. Students aged 16 to 18 applying for work experience within the Trust will be expected to become members to be kept up to date with information at UHSM.

The 2011-14 membership strategy is a public document and is available on the UHSM website for members to view. UHSM values public membership and members play a crucial role in improving UHSM's services and helping to plan future developments so that UHSM delivers what the local community wants.

The Public Constituency

***Figure 9.1*:** Map of Public Constituencies

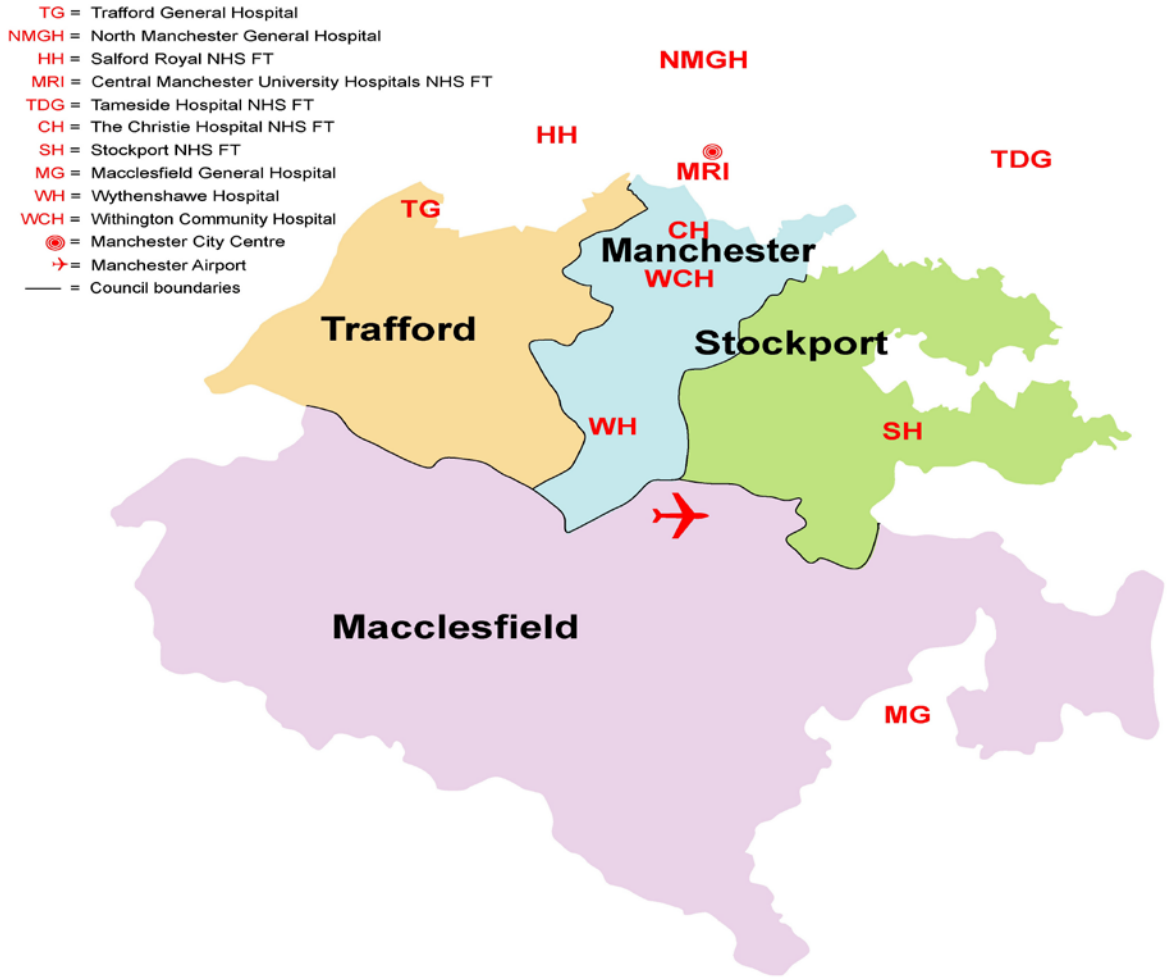


Figure 9.2: Localities assigned to membership areas

Area 1 (part of Trafford)	Area 2 (part of Manchester)	Area 3 (part of Manchester)	Area 4 (part of Stockport)	Area 5 (part of Macclesfield)
Altrincham	Baguley	Burnage	Bramhall North	Alderley Edge
Ashton upon Mersey	Brooklands	Chorlton	Bramhall South	Chelford
Bowdon	Northenden	Chorlton Park	Bredbury and Woodley	Henbury
Broadheath	Sharston	Didsbury East	Brinnington and Central	High Legh
Brooklands	Woodhouse Park	Didsbury West	Cheadle and Gatley	Knutsford Bexton
Bucklow-St-Martins		Fallowfield	Cheadle Hulme North	Knutsford Nether
Clifford		Gorton South	Cheadle Hulme South	Knutsford Norbury
Davyhulme West		Hulme	Davenport and Cale Green	Knutsford Over
Flixton		Levenshulme	Edgeley and Cheadle Heath	Mere
Hale Barns		Moss Side	Hazel Grove	Mobberley
Hale Central		Old Moat	Heald Green	Plumley
Longford		Rusholme	Heatons North	Prestbury
Priory		Whalley Range	Heatons South	Rainow
St Mary's		Withington	Marple South	Wilmslow Dean Row
Sale Moor			Reddish South	Wilmslow Fulshaw
Stretford				Wilmslow Handforth
Timperley				Wilmslow Hough
Urmston				Wilmslow Lacey Green
Village				Wilmslow Morley and Styal

Note: The sixth public sub-constituency 'Area 6' is '*The rest of England and Wales'*

Appendix 4:
Explanation of Monitor Risk Ratings during 2010-11

Table 9.5: Indicators used to derive the financial risk rating as shown in Monitor's *Compliance Framework 2010-11*

Financial criteria	Weight %	Metric to be scored	Rating categories 5	4	3	2	1
Achievement of plan	10	EBITDA* achieved (% of plan)	100	85	70	50	<50
Underlying performance	25	EBITDA* margin (%)	11	9	5	1	<1
Financial efficiency	40	20: return on assets excluding dividend (%)	6	5	3	-2	<-2
		20: I&E surplus margin net of dividend (%)	3	2	1	-2	<-2
Liquidity	25	Liquidity ratio** (days)	60	25	15	10	<10

* EBITDA: Earnings before interest, taxes, depreciation and amortisation. EBITDA (and other financial metrics) may be adjusted by Monitor for any 'one-off' non recurring revenue, costs or investment adjustments

** The liquidity ratio is defined as cash plus trade debtors (including accrued income) plus unused working capital facility (up to a maximum of 30 days) minus (trade creditors plus other creditors plus accruals) expressed as the number of days operating expenses (excluding depreciation) that could be covered

Financial risk rating is weighted average of financial criteria scores

Table 9.6: Financial risk rating shown in Monitor's *Compliance Framework 2010-11*

Rating	Description	Implications
Rating 5	Achieving weighted average of 5 across assessed components and no over-riding rules applied	Quarterly/six-monthly* monitoring
Rating 4	Achieving weighted average of 4 across assessed components and no over-riding rules applied	Quarterly monitoring
Rating 3	May be some regulatory concerns in one or more components, but significant breach of Authorisation is unlikely	Quarterly monitoring, however monthly monitoring in case of deteriorating trend or recovering from a 2 rating
		Supplementary information if required
Rating 2	Risk of significant breach of Authorisation	Monthly monitoring with supplementary information and service line information
		Remedial plan may be required
		Potential for intervention under section 52 of the Act
Rating 1	Very likely to be in significant breach of Authorisation	As with rating 2 (above) and likely intervention under section 52 of the Act

* At Monitor's discretion, after four consecutive quarters rated 5 for financial risk and green for governance risk, and at least two years after Authorisation.

Table 9.7: Governance risk rating shown in Monitor's *Compliance Framework 2010-11*

Rating	Description	Reporting requirements
Green	No material concerns • governance score less than 1.0 • self-certification complete and satisfactory	Self-certification and exception reporting
Amber-green	Limited concerns surrounding Authorisation • either emerging issues or returning to compliance Examples include: • moderate CQC concerns, or compliance registration conditions • other third party concerns with potential governance implications • self-certification concerns • service performance in one area Governance score >=1.0, <2.0	Depending on nature of risk, some additional work/ supplementary information may be required to scope the issue e.g. • clinical governance review • CQC input Once scoped, approach to address the potential issue of concern to be agreed, with specific reporting on progress • e.g. action plan to address any breach of the Authorisation For all other issues – as per **Green**
Amber-red	Breach of Authorisation, including: • service performance in a number of areas • material third party concerns (e.g. major CQC concerns) • CQC restrictive compliance conditions Governance score >=2.0, <4.0	Action plan required within agreed timeframe to address the issue(s) • Monitor will follow progress against this plan, using additional information if necessary • any subsequent regulatory action will depend on plan delivery, with failure likely to result in formal escalation For all other issues – as per **Green / Amber-green**
Red	Likely or actual significant breach of Authorisation • governance score >=4.0 or 3rd successive quarter failure against same national requirement or other 1.0 rated targets • significant governance issues emerging from CQC investigation, e.g. actual / significant risk of failure to be registered (including failure to rectify registration conditions within timescales agreed with CQC) • mandatory services breach	The NHS foundation trust may be required to attend a formal regulatory meeting to determine nature of breach Subsequent actions to depend on meeting and other evidence, including: • Monitor Board decision regarding significance of breach • detailed action plan and delivery updates required • potential for intervention under section 52 of the Act

10 List of Acronyms

A&E	Accident and Emergency
ACORN	A Classification Of Residential Neighbourhoods
ADT	Admission Discharge and Transfer
AfC	Agenda for Change
AMI	Acute Myocardial Infarction
ANTT	Aseptic Non Touch Technique
AQuA	Advancing Quality Alliance
AUKUH	Association of UK University Hospitals
BME	Black, Minority and Ethnic
BRC	Biomedical Research Centre
CABG	Coronary Artery Bypass Graft
CAMHs	Child Adolescent Mental Health Services
CATS	Clinical Assessment and Treatment Services
CD	Compact Disc
C. difficile	*Clostridium difficile*
CE	Chief Executive
CF	Cystic Fibrosis
CHKS	Comparative Health Knowledge System
CIP	Cost Improvement Plan
CLRN	Comprehensive Local Research Network
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DH	Department of Health
DNA	Did Not Attend
DNAR	Do Not Attempt Resuscitation
DVT	Deep Vein Thrombosis
EBITDA	Normalised Earnings Before Interest, Tax, Depreciation and Amortisation
EDD	Expected Date-of-Discharge
ENT	Ear Nose and Throat
EWTD	European Working Time Directive
FRR	Financial Risk Rating
FTE	Full Time Equivalent members of staff
GE	Gene-environment
GI	Gastro-Intestinal
GP	General Practitioner
GTT	Global Trigger Tool
GU	Genito-Urinary
HCAI	Healthcare-Associated Infection
HDU	High Dependency Unit
HIRS	Hospital Incident Reporting System
HR	Human Resources
HRG	Health Resource Group
HSMR	Hospital Standardised Mortality Ratio
ICATS	Independent Care Assessment and Treatment Service
ICU	Intensive Care Unit
IFRS	International Financial Reporting Systems
IHI	Institute for Healthcare Improvement
IM&T	Information Management & Technology
IIP	Investors in People
IP	Inpatient
IT	Information Technology
KPI	Key Performance Indicator
LHB	Local Health Board
LIBOR	London Interbank Offered Rate

LINk	Local Involvement Network
M	Million
MAHSC	Manchester Academic Health and Science Centre
MDT	Multi-Disciplinary Team
MESS	Mandatory Enhanced Surveillance System
MEWS	Modified Early Warning Score
MFF	Market Forces Factor
MHRA	Medicines and Healthcare Products Regulatory Agency
MiB	Making it Better
MR	Magnetic Resonance
MRSA	Methicillin Resistant Staphylococcus Aureus
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NHSLA	NHS Litigation Authority
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NLCA	National Lung Cancer Audit
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning Service
NRS	National Readership Survey
NSF	National Service Framework
OP	Outpatient
PAS	Patient Administration System
PbR	Payment by Results
PCI	Percutaneous Coronary Intervention
PCT	Primary Care Trust
PDC	Public Dividend Capital
PEAT	Patient Environment Action Team
PEC	Professional Executive Committee
PET	Patient Experience Tracker
PFI	Private Finance Initiative
PLC	Public Limited Company
PPI	Patient and Public Involvement
PROMs	Patient Reported Outcome Measures
Q	Quarter
QPID	Quality Performance Indicator Data
R&D	Research and Development
RAMI	Risk-Adjusted Mortality Index
RCA	Root Cause Analysis
RCP	Royal College of Physicians
RfPB	Research for Patient Benefit
RPI	Retail Price Index
RTT	Referral-to-Treatment
SBAR	Situation Background Assessment Recommendation
SFI	Standing Financial Instructions
SHA	Strategic Health Authority
SIC	Statement of Internal Control
SLR	Service Line Reporting
SUI	Serious Untoward Incident
SUS	Secondary Users Service
TARN	Trauma Audit and Research Network
TCS	Transferring Community Services
TRF	Translational Research Facility
TTG	Thrombosis and Thromboprophylaxis Group
UHSM	University Hospital of South Manchester NHS Foundation Trust
UK GAAP	United Kingdom Generally Accepted Accounting Principles
UNICEF	United Nation Children's Fund
VFM	Value for Money
VTE	Venous Thromboembolism
WHO	World Health Organization

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