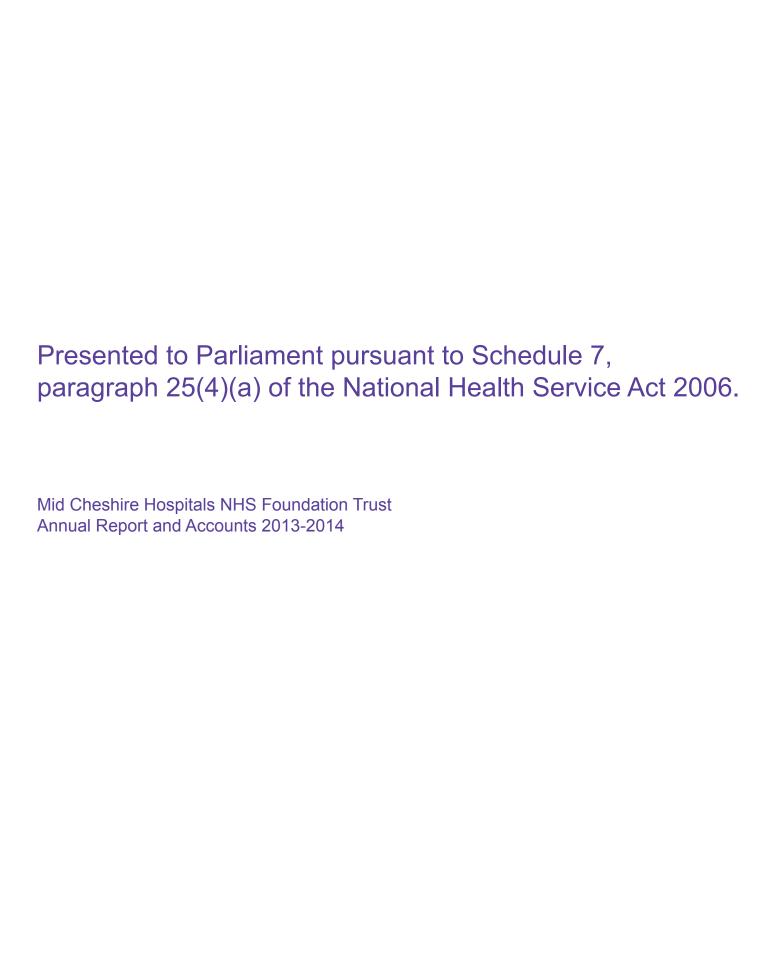
Annual Report and Accounts 2013-2014





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Chapter 1

Chief Executive's Foreword

The foreword to our Annual Report was previously written jointly by myself and the Chairman, Mr John Moran. However, after six years of committed service to our Trust, John retired on 31 March 2014. I am sure you would all wish to join me in thanking John for his unwavering loyalty to the Trust and passion for continuous service improvements for the patients and population that we serve.

This year has been incredibly challenging on a number of fronts and this report will outline some of these in detail. However, I never cease to be inspired and motivated by what we are able to achieve, especially under such circumstances. In a year of financial constraint, conflicting operational priorities and significant scrutiny, we saw improvements in our staff and patient surveys, our Maternity Service achieved CNST Level 3 and we concluded a number of service and estate developments which all improved the quality and experience of services that we offer. One of our more notable estate achievements was the completion of our new £22.8m Critical Care and Theatre rebuild. This has delivered state-of-the-art facilities for the local population and will ensure these services are sustainable for the future.

However, the year has not been without its disappointments and I am always the first to acknowledge that we do not always get it right for our patients. I was particularly disappointed that the Trust had a number of Never Events and although no patient came to serious harm, they should not have happened. We have learned from these and a number of changes have been made to how we deliver care for our patients, to prevent these from happening again. Even though we remain a high performer in respect of healthcare acquired infections, we were very disappointed that we had more Clostridium difficile and MRSA than we had the previous year. We also continue on our journey to improve our mortality rates and the Annual Report will provide greater detail on how we aim to achieve this.

The previous paragraphs provide just a brief insight into some of our successes and challenges and the Annual Report will provide far greater



detail on our journey over the financial year. It will also provide an outline of our hopes and aspirations for the forthcoming year and how we plan to achieve these. I am delighted to be able to introduce our new Quality and Safety Improvement Strategy, which commenced on 1 April 2014, which details what we aim to achieve for our patients over the next two years. Additionally, the Quality Account (Chapter 8) provides significant detail on how we performed against our previous five-year strategy.

It also gives me great pleasure to introduce to you our new Chairman, Mr Dennis Dunn MBE. Dennis will start in his role on 1 July 2014 and for many of you will require no introduction as he is already well-known to the Trust through his current role as a Non-Executive Director and previous role as a Governor on our Governing Council. I very much look forward to working with Dennis and continuing our journey of quality improvement ensuring we have successful, vibrant and sustainable hospitals for the future populations of our local community and surrounding areas.

Finally, and also on behalf of the Board of Directors, I would like to give a very warm thank you to our staff, volunteers, Governors and stakeholders who work with us and support us diligently. Your energy and enthusiasm supports the Trust to sustain and provide excellence to the patients and population that we serve.



Tracy Bullock Chief Executive



Chapter 2

Strategic Report

About the Trust

Mid Cheshire Hospitals NHS Foundation Trust became registered as a Foundation Trust on 1 April 2008, following authorisation by the independent regulator, Monitor.

Services are provided to a population of approximately 300,000 living in and around Alsager, Crewe, Congleton, Knutsford. Middlewich, Nantwich, Northwich, Sandbach The Trust is registered with and Winsford. the Care Quality Commission (CQC), without conditions, and provides a comprehensive range of acute, maternity, child health and intermediate care services, through four Clinical Divisions. The Trust's Estates & Facilities Division is a Non-Clinical Division that supports the Clinical Divisions by providing a range of services to maintain and improve the environment whilst the Corporate Division delivers a full range of back office functions.

Introduction

2013/14 has been a challenging year for the Trust but also a year of opportunities. This Strategic Report details a review of the Trust's business for the financial year including detail of the Trust's strategy and performance. It also provides detail of some of the Trust's achievements whilst also noting the principal risks and uncertainties facing the Trust in 2014/15.

Trust Strategy

In 2011 the Board of Directors developed a Ten-Year Vision 2011–2021 and Five-Year Strategy 2011–2015. However, to be financially sustainable the NHS requires radical transformation which will include what, how and where services are delivered in the future. As these developments take place, Acute Providers and their partners, will need to adapt and ensure their strategies remain aligned and

supportive of the changes. The Trust's strategy is reviewed and revised at least annually thus ensuring it remains current and is able to underpin business priorities and financial decision making.

Combined, NHS Vale Royal and NHS South Cheshire Clinical Commissioning Groups commissioned 95% of the Trust's work in 2013/14. Approximately 85% of funding came from these two Clinical Commissioning Groups and, as such, both Clinical Commissioning Groups have been engaged in the development and revisions of the Trust's Strategy.

At the highest level the Trust's strategy for maintaining clinically and financially viable services is twofold:

1. External Transformation

There are a number of strands to the external transformation strategy:

Partnership Working

The Trust fully understands that strong partnerships must be formed in order to meet significant efficiency challenges whilst at the same time meeting quality standards and maintaining clinical sustainability (brought about by the increasing sub specialisation and centralisation of specialist activity). During 2013/14 a programme of work was established with the University Hospital of North Staffordshire NHS Trust (UHNS) which will support the clinical and financial sustainability of services.

Partnership Reviews

The Trust has a significant number of partnerships with a range of providers within the North West. Over a two-year programme, these will be reviewed to ensure they continue to align to the Trust's strategy; deliver the right clinical outcomes and patient experience, meet the changing needs of the population and are value for money. Where this is not the case, following consultation, where appropriate, changes to these partnerships will be made.

Vertical Integration

The Trust is a key member of the local health economy's Connecting Care Board, working closely with key stakeholders to achieve sustainable

healthcare for the population of Cheshire. The aim of the Connecting Care Board is to jointly develop a health economy strategy that will redesign existing service provision and develop new services to better manage patients out of hospital and reduce emergency admissions. This jointly developed health economy programme will have a significant impact on the way the Trust, as an acute provider, delivers services. It will require major transformation.

To support the transformation, a Provider Board, as a sub-group of the Connecting Care Board, was established to lead a new multi-provider collaborative contracting approach. This new approach embodies the transformational vision, aspirations, outcomes and key integration workstreams as set out within the Connecting Care Programme and includes the areas specified in the Cheshire Better Care Fund transitional plans. The overarching Connecting Care Board will lead the development and implementation of a range of interventions, through targeted investment into a range of primary, community and social care services to:

- Ensure people are accessing the most appropriate level of care
- Prevent and/or reduce the demand for urgent secondary care services, ambulatory.

As a key member of this Board, the Contract agreed with the Clinical Commissioning Groups for 2014/15 allows the transformation to be done in an environment which supports the alignment of the Trust's income to costs hence giving financial sustainability for all partners. This is a valuable precursor to the introduction of the Better Care Fund in 2015/16 which will see £3.8bn pooled into a single budget for health and social care services and will require health and social care providers to be closely involved in designing and planning services to manage patients in more appropriate settings.

2. Internal Transformation **Programmes**

The internal transformation programmes have a number of strands aimed at ensuring the Trust delivers the highest possible standard of care in the most efficient and effective manner. The main strands of the internal work programme are:

Theatre Productivity including Critical Care and Theatre Rebuild

The new build offers opportunities to further develop existing ways of working in a way that will maximise the benefits of new theatre designs such as 'barn theatres' and 'integrated theatres'.

Outpatients Productivity and Developments

This will specifically address the lack of future capacity and more effective and efficient scheduling of appointments. Out of Hospital (OOH) settings will provide future capacity, for example, in GP Surgeries and a review of space utilisation and appointment scheduling will maximise utilisation of the current Outpatient space.

Bed Productivity

This will streamline how emergency admissions are more effectively managed to reduce avoidable admissions, length of stay and expedite discharge.

Repatriation of Elective Activity

This aims to bring back elective work from border areas currently delivered by other providers. This will increase the Trust's income without having a financial detriment to the local Clinical Commissioning Groups, thus supporting the sustainability of the Trust's services and the local health economy.

Improvements in the Trust's Estate and Information Technology Infrastructure

These are important aspects of further improving the safety and experience of patients and staff. The Trust has received overwhelming public support for its main Charity which will contribute in excess of £3m in 2014/15. The Trust will also borrow £4.3m in 2014/15 and a further £1m in 2015/16 to support the level of investment required. This will ultimately lead to an electronic patient record and will provide an estate infrastructure which is fit for purpose and fit for the future.

Achievements

Although a challenging year, a number of significant service developments and improvements have taken place.

Estate and Technology

Critical Care and Theatre Rebuild

Building work on the new multi-million pound Operating Theatres and Critical Care facilities continued to completion throughout 2013/14, on budget and in time. The £22.8m project, supported by Government funding of £21.69m, will enable the Trust to further improve the quality and safety of patient care and secure its future sustainability. The new building replaces the previous 43-year-old theatres, along with the Intensive Care and High Dependency units, with state-of-the-art facilities.

Chemotherapy e-Prescribing

In March 2014, the Macmillan Centre commenced the implementation of electronic prescribing (e-Prescribing) in chemotherapy. The Trust's ChemoCare project brings a number of benefits in the areas of safety, innovation, efficiency and improved patient experience. It will also assist in meeting requirements set by National Cancer Peer Review Measures and Service Level Agreements for Commissioning Specialised Services, as well as helping to drive the Trust towards paper-light 21st century working.

ChemoCare is only the second project in the Trust to utilise the benefits of e-Prescribing and over the coming years the Trust will be looking to expand electronic prescribing facilities to bring further benefits to patients by improving the quality and safety of the care provided.

e-Handover

In 2012, the Trust's submission to Health Education England, to implement an electronic handover system, was successfully selected as one of their pilots. The Emergency Care Division introduced the electronic handover system during 2013 which records all acute medical admissions and ensures effective prioritisation and management of patients based on clinical need. Due to its success and positive feedback from the doctors involved in the initiative, plans are now in hand to extend the electronic handover process to the Surgery & Cancer Division. In addition to this development, routine ward-based tasks will be added to the system which will further support patient safety and will be integral to the development of the Hospital at Night project. This project is viewed as a beacon of best practice by Health Education England.

Medical Imaging

A second CT (computerised tomography) scanner was installed in December 2013 which has enabled the Trust to offer shorter waiting times and a greater range of scans such as cardiac, bowel and kidney imaging to be undertaken. These examinations are less invasive and more patient friendly than the equivalent non-CT tests.

Sexual Health - Electronic Patient Record

The Centre for Sexual Health successfully implemented full electronic patient record and medication prescribing during 2013/14, becoming the first department in the Trust to prescribe electronically. This has significantly improved the staff and patient experience through a smoother, faster, patient booking-in process on arrival with the patient's records immediately available to the clinical team. Investigative results are sent directly from the laboratory into the patient's electronic record and this has significantly reduced the time it takes to notify patients of laboratory results and therefore commence the appropriate treatment. The Centre has also implemented SMS "texting" and emailing for appointment and results notification. The electronic patient record has supported the service to provide a full sexual health clinic twice a week at Victoria Infirmary in Northwich bringing sexual health care nearer to home for the residents of Northwich and Winsford.

Service Developments and Quality

Maternity - You're In Safe Hands

Women having babies at the Trust are provided with some of the safest care in the country, according to an external assessment which awarded the Maternity Service the best possible rating. The Clinical Negligence Scheme for Trusts (CNST) awarded the Trust with level 3 status after scoring 48 out of 50 against indicators which included staffing levels of midwives, obstetricians and anaesthetists, numbers of incidents and complaints, the care of women in labour, screening of their mental health and whether

they are supported to breast feed. The Trust is enormously proud of this achievement.

Surgical Assessment

Following an initial pilot, the Surgical Assessment Area (SAA) became operational during 2013/14, thus ensuring surgical GP emergency admissions are rapidly assessed, treated and where appropriate transferred to a ward. The benefits gained from this development include:

- Improved patient flow with increased capacity available during peak demand times
- Reduced waiting time for non-elective admissions in the Emergency Department, thus supporting the delivery of the Four Hourly target by diverting patients directly to SAA
- Timely assessments and requesting of investigations
- Prompt initiation of pain relief, antibiotic therapy, IV therapy and/or surgical intervention
- Increased number of discharges in less than
 12 hours following assessment
- Prevention of admissions into elective surgical beds
- Implementation of a 'Rapid Access Clinic' with four available clinic slots per day.

Bowel Screening

During the year the Cheshire Bowel Cancer Screening Programme, based at Leighton Hospital received formal approval to start Bowel Scope Screening for the local 55year old population. This is a significant achievement as the Trust is in the 'first wave' of centres commencing nationwide. This service complements the Faecal Occult Blood Test Screening Programme for patients aged 60-74 years. The Trust anticipates a high uptake for Bowel Scope Screening which will enable it to increase the detection rate of cancers for the populations that it serves. This will position the Trust as one of the highest performing screening centres in the country.

Dobutamine Stress Echo Service

The Trust appointed a Consultant Cardiologist who specialises in Imaging and Heart Failure, allowing the implementation of a new Dobutamine Stress Echo Service at Leighton Hospital. This means

that patients suffering from coronary heart disease are treated closer to home rather than having to travel to a Tertiary Centre for their diagnostic test.

The development of the Dobutamine Stress Echo Service, along with the excellent cardiac imaging services already available, means the Trust is the only District General Hospital in the North West that houses a full non-invasive diagnostic suite for cardiac conditions.

UNICEF Baby Friendly Initiative – Improving the Long Term Health of Babies

The Maternity service was awarded Stage 2 Baby Friendly accreditation from UNICEF in September 2013. Baby Friendly accreditation focuses on staff knowledge and skills to support families with their infant feeding choices. The assessment reviewed the Trust's infant feeding and related policies, staff training records, compliance with the international code of marketing of breast milk substitutes and staff knowledge and skills relating to breastfeeding management. The work undertaken by the Infant Feeding Team has led to improved health outcomes for mothers and their babies with the highest breast feeding rates and lowest smoking rates during pregnancy in eight years. The Maternity service is now actively working towards the Stage 3 assessment which focuses on mothers' experiences of care relating to infant feeding.

Hyperacute Stroke Service

The Trust currently provides a Hyperacute Stroke Service Monday to Friday, 0900hrs to 2100hrs. The introduction of telemedicine has enabled the development of a strategy to deliver thrombolysis 24 hours a day through a regional telemedicine network which includes the University Hospital of North Staffordshire NHS Trust, Burton Hospitals NHS Foundation Trust and Shrewsbury and Telford Hospital NHS Trust.

Planned Intervention Unit

The Planned Intervention Unit has been rehoused, within the Leighton site, facilitating an expansion of its hours and the scope of its services. This is an exciting initiative as the Emergency Care Division has increased its clinic capacity to undertake heart failure,

respiratory and other rapid access clinic slots thus reducing the necessity to admit patients to hospital. Patient pathway initiation work has also commenced across the health economy which will improve the patient journeys for emergency blood transfusion and hepatitis treatment.

Paediatric Diabetes Service – Excellent Patient Satisfaction

Improvements to the Paediatric Diabetes Service have included the purchase of a Point of Care Analyser for monitoring diabetes treatment programmes, expansion of dietician hours and implementation of a new patient database. A child psychologist will also shortly begin to work with the team. These improvements have led to the Paediatric Diabetes Service achieving best practice standards.

The personal diabetes record developed the previous year has been rolled out across all the children and young people with diabetes who are patients of the Trust. The team achieved excellent results in national audits of patient satisfaction and patient outcomes, including one of the highest percentages of patients with excellent overall control in the country. The team has been developing a local Paediatric insulin pump service which plans to commence in the next year.

Dermatology

The Dermatology department has recently purchased equipment that will support the development of a mole mapping service. The electronic equipment provides a system for total body photography that links images of individual skin lesions to specific body locations and allows the capture, storage, review and monitoring of changes to individual lesions that can be monitored long term. The incidence of all types of skin cancer has increased steadily over the past decade with approximately 100,000 new cases registered nationally each year. Early detection of lesions within the population of patients with atypical moles (whose risk of skin cancer is high) will enable appropriate treatment at an earlier stage that will in the long term save lives.

Workforce

The health service has a high proportion of female staff nationally; however, for senior positions in particular, the Trust aims to achieve greater equity. As at 31 March 2014, the Trust had the following female and male Directors (Senior Managers) and staff:

- 5 female Directors
- 7 male Directors
- 2,819 female staff
- 697 male staff

Advanced Practitioners

The Trust has continued to develop its Advanced Practitioner workforce, particularly in ENT (Ear Nose and Throat), Urology, Acute Medicine and the Emergency Department. The roles, which are part of the longer term workforce strategy, assist medical teams to deliver safe, effective and timely care for patients. Future developments for these roles will potentially include the provision of additional support to the out of hours on-call. There are plans to further extend this valuable workforce with the Trust being successful in attaining six funded places for the Advanced Practice course. These advanced roles have ensured the Trust provides high quality, safe services for patients and ensures that important national standards are met.

Having such roles has enabled the Trust to become one of the best in the North West in reducing ambulance handover times when they arrive at the Emergency Department.

The year has also seen substantial incremental investment in nursing and other clinical staff groups. The ongoing monitoring of acuity data has seen an increase in the dependency of patients and the Trust has responded proactively in the recruitment of qualified nurses. Investments have also seen an increase in Consultant cover on site at the weekend.

Further detail on the Trust's workforce can be found in Chapter 5 – Staff & Stakeholders.

Performance

Throughout 2013/14, the Trust has maintained a high standard of performance delivering the vast majority of national and local standards. Detail in relation to performance against standards can be found in Chapter 3 – Directors' Report under Operational Review.

The Trust is committed to minimising the impact of its activities on the environment and becoming a good corporate citizen. The objectives of the Trust together with performance evaluation for 2013/14 can also be found later in this Chapter.

Financial Position

On financial performance the Trust ended the 2013/14 financial year in a stronger position than initially anticipated and plans to break even over the next two years (before exceptional items) maintaining a positive cash balance and ensuring that liquidity and the ability to service the debt remains at an acceptable level. The Trust has achieved a Continuity of Service Rating of 4 against a plan of 4, remaining fully compliant with its provider Licence.

Further detail on the Trust's financial performance in 2013/14 and concerns for 2014/15 are detailed under the Director's Report.

Risks & Challenges

The risks faced by the Trust in 2013/14 were as follows:

The Trust delivers many services on a seven-day basis, such as the full range of diagnostics. However, workforce plans are being put in place to ensure this national requirement is met across all services. Where this is not possible, due to national shortages, then other options will be considered such as joint appointments and partnerships with other service providers.

Year-on-year the Trust has seen significant investment in frontline staff to improve nursing ratios on the wards and to increase onsite Consultant numbers, in particular at the weekends. This level of

investment will continue into 2014/15 and will support delivery of seven-day services ensuring patients see the right healthcare professional at the right time in the right location with access to the appropriate diagnostics.

Higher than expected Summary Hospital-Level Mortality Indicator (SHMI)

Led by the Medical Director, the Trust is delivering a significant work programme to reduce SHMI which encompasses - REMEL:

Reliable clinical care
Effective clinical care
Medical records and clinical coding
End of life care
Leadership.

The effectiveness of this work programme is monitored through the Hospital Mortality Reduction Group and the Board subcommittee - Quality, Effectiveness & Safety (QuESt).

Failure to deliver all local and national targets and standards

Throughout 2013/14 the Trust maintained a high standard of performance delivering the vast majority of national and local standards and targets. Of particular note is the delivery against all the Cancer targets for the period and, with the exception of Quarter 1, the Referral To Treatment targets. The Four Hourly Target, whilst not achieved in one quarter, was also delivered against the year end target.

The Trust had four cases of MRSA during the year and whilst performance in relation to Clostridium *difficile* was maintained, due to a significantly reduced target, the Trust did not achieve the year end target. For 2014/15 a more achievable target has been set whilst internal procedures are being reviewed to ensure the incidence of hospital acquired infections are reduced where possible.

Further detail of the risks for 2013/14, together with detail of the risks for 2014/15, can be found in the Annual Governance Statement, Chapter 10 of this Report.

Challenges for 2014/15 include a difficulty in recruiting to some professional posts. For example, there is a national shortage of Consultants in Emergency Care and a shortage in some nursing posts. This will be further compounded by the shortage of trainee doctors across the North West region and as a result the potential reduction in the allocation of middle and junior grade doctors. This may impact on the Trust's ability to deliver 24/7 cover across all specialties.

Delivering seven-day services across all specialties will also be a challenge due to the increasing sub-specialism of services, for example, Colorectal and Upper Gastrointestinal surgery. This may present further risks around rota cover 24/7.

To mitigate against the above workforce challenges, the Trust has taken a number of actions including:

- A number of successful national and international recruitment campaigns
- Development of Advanced Practitioner roles
- Intelligent partnerships and joint appointments with neighbouring Trusts
- Exploring rotational opportunities for key roles with other providers, increasing the attractiveness and therefore uptake of posts
- Developing joint clinical leader development courses along with other providers.

Continued growth in demand may also be a challenge and whilst growth in emergency demand has plateaued, the complexity and frailty of the patients that are treated by the Trust has significantly increased, which is aligned to the increasing elderly population The Trust has also that the Trust serves. seen a considerable increase in GP referrals for elective or planned work. This creates an affordability issue for the health economy and creates capacity issues within the Trust for both elective and emergency activity, ultimately impacting on the quality, safety and experience of care that patients receive, in addition to the delivery of performance standards. However, the Trust is working with its stakeholders in developing alternative pathways which will reduce demand on the acute hospital services. Failure to effectively manage demand may affect operational delivery and subsequently risk the achievement of targets and standards going forward.

Furthermore, although managing the transition of the Better Care Fund into a pooled budget with social care presents a challenge in its own right, this is also a considerable opportunity for providers to work closely together to ensure the right patients get the right care in the right setting.

The Trust is well positioned to meet the challenges, as briefly outlined, and has the necessary skills, expertise and partnerships to enable the successes of 2013/14 to continue into 2014/15.

What our Patients Say

Throughout 2013/14 the Trust has worked to further improve the patient experience. During the year, two national surveys were undertaken - the National Inpatient Survey and the National Maternity Survey, whilst the Trust also undertook 41 local surveys of its own. Any issues raised within the survey feedback form the basis of action plans to address the issues identified. During 2013/14 the Trust also conducted an extensive engagement programme based on the themes from the Francis Inquiry into the failings at Mid Staffordshire NHS Foundation This consultation exercise informed the Trust's new Quality & Safety Improvement Strategy 2014-16. Further detail on the Quality Strategy and results of the surveys can be found in the Quality Account - Chapter 8.

In support of the Quality and Safety Improvement Strategy there is an Equality, Diversity & Human Rights Strategy in place to ensure that all of our services are inclusive and meet the needs of the community.

Future Developments

2013/14 saw a number of changes in the health service environment following the enactment of the Health & Social Care Act on 1 April 2013 and also a number of high profile national reviews such as that of Francis, Berwick and Cavendish. Trusts nationally are constantly seeking to improve the patient experience through enhanced quality of care and patient safety whilst also maintaining sustainability.

In 2014/15 the Trust will continue to implement its internal and external transformation strategies. It will remain a key stakeholder of the Connecting Care Provider Board seeking to achieve sustainable healthcare in Cheshire. The Trust will continue to undertake its partnership reviews whilst continuing to deliver its internal transformation programmes.

31 March 2014 saw the conclusion of the Trust's 10 out of Ten Quality Strategy and on 1 April 2014 the Trust launched its Quality Improvement & Safety Strategy 2014-2016. The Trust will focus on the three key areas for improvement – the patient experience, clinical effectiveness and patient safety.

The Trust will also continue its capital investment programme with key investments for 2014/15 including the remodelling of the Treatment Centre and expansion of the Endoscopic service, the completion of the refurbishment of the Neo-Natal Unit and the purchase of a second MRI scanner. Also, Mid Cheshire Hospitals Charity's appeal aims to raise £1m to provide an additional MRI Scanner at Leighton Hospital. This will bring benefits to patients including a larger size to accommodate a variety of body shapes, sizes and clinical conditions, as well as reducing claustrophobia; additional MRI scanning capacity, reduced failure rates and faster scan times; a reduction in MRI wait times; and a generally improved patient experience.

Summary

2013/14 has been a demanding year for the Trust with a number of significant achievements, challenges and ongoing service transformation programmes, a number of which are highlighted throughout this Annual Report.

Without doubt, the challenges will continue through 2014/15 and the Trust will continue to build on the strong foundations and strategic developments already underway.

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. This conclusion has been reached after reviewing the 2014/15 plan which gives a breakeven position and a positive cashflow throughout the year and maintaining reasonable cash balance moving into 2015/16.

Preparation of the Report and Accounts

The accounts for the year ended 31 March 2014 have been prepared by Mid Cheshire Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 in the form which Monitor, the Independent Regulator of NHS Foundation Trusts has, with the approval of the Treasury, directed.

I confirm the Board of Directors consider the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the Trust's performance, business model and strategy.

I confirm there have been no important events since the end of the financial year which affects the content of this Annual Report for Mid Cheshire Hospital NHS Foundation Trust. As noted in the Foreword, however, the Trust has recruited a new Chairman who starts in post substantively from 1 July 2014.



Tracy Bullock
Chief Executive

Chapter 3

Director's Report and Business Review

About the Trust

Mid Cheshire Hospitals NHS Foundation Trust became registered as a Foundation Trust on 1 April 2008, following authorisation by the independent regulator, Monitor.

As at 31 March 2014, the Board of Directors comprised seven Non-Executive Directors, including the Chairman, and six Executive Directors with voting rights, including the Chief Executive. Further information on the Board of Directors including Member Profiles can be found in Chapter 4 of this Report.

Services are provided to a population of approximately 300,000 living in and around Alsager, Crewe, Congleton, Knutsford, Middlewich, Nantwich, Northwich, Sandbach and Winsford. The Trust is registered with the Care Quality Commission (CQC), without conditions, and provides a comprehensive range of acute, maternity, child health and intermediate care services, through four Clinical Divisions;

Diagnostic and Clinical Support Services Division with services provided including:

- Medical Imaging
- Pathology including Mortuary Services
- Dermatology
- Clinical Haematology
- Medical Records
- Intermediate Care Centre
- Outpatient Services
- Pharmacy
- ECG (Electrocardiogram).

Emergency Care Division with services provided including:

- Emergency Department and Minor Injuries (at Victoria Infirmary)
- · Urgent Care Centre
- Acute Medicine
- General Medicine
- Cardiology

- Respiratory Medicine
- Gastroenterology
- · Diabetes and Endocrinology
- Care of the Elderly
- · Stroke Care
- Rheumatology.

Surgery and Cancer Division with services provided including:

- · Critical Care & High Dependency
- Anaesthesiology
- · Ear, Nose and Throat
- General Surgery
- Ophthalmology
- Orthopaedics
- Urology
- · Cancer Services
- Pain Services.

Women's, Children's and Sexual Health Division with services provided including:

- · Genito-Urinary Medicine
- Neonatology
- Obstetrics and Gynaecology
- · Acute and Community Paediatrics.

The Trust employs approximately 3,500 staff and the principal site is at Leighton Hospital, Crewe. Services are also provided from Victoria Infirmary in Northwich and Elmhurst Intermediate Care Centre in Winsford.

The Trust provides a number of outreach services in community settings to ensure, where possible, services are available closer to home for patients. Services available in the community include community midwifery, child health, paediatric home care, phlebotomy, anticoagulation, a home intravenous antibiotic service and a number of outpatient services.

The Trust's Estates & Facilities Division is a Non-Clinical Division that supports the Clinical Divisions by providing a range of services to maintain and improve the environment. In addition, this Division delivers a range of high quality support services such as laundry, cleaning and catering.

The Trust's corporate teams deliver the full range of back office functions. These include:

Finance, Procurement and

Business Intelligence

- Human Resources and Payroll
- Learning and Development
- Service Change & Development
- Infection Prevention and Control
- Occupational Health, in collaboration with East Cheshire NHS Trust
- Communications
- Patient Experience Services (including customer care team, bereavement services, complaints and legal services)
- Information Management and Technology
- Integrated Governance
- Patient Placement Team
- Integrated Discharge Team.

Together, clinical and non-clinical staff work tirelessly, day in day out, to deliver the vision for Mid Cheshire Hospitals NHS Foundation Trust;

"To Deliver Excellence in Healthcare through Innovation and Collaboration"

Business Review

Detailed information on the opportunities, achievements, challenges and risks for 2013/14 and 2014/15 are detailed in the Strategic Report – Chapter 2. This Chapter considers, in more detail, the operational and financial performance.



Operational Review

	2013/14	2012/13	2011/12	2010/11	2009/10
Emergency episodes of care requiring the use of a bed	29,404	31,270	29,934*	32,766	31,347
Attendances at Accident and Emergency and Minor Injuries	82,140	83,320	79,579	77,416	75,461
Elective episodes requiring a procedure to be performed	28,483	28,345	28,659	27419	28644
Total attendances at outpatient clinics	254,626	239,210	239,977	242,322	246,760
Births	2,732	2,827	2,879	3,004	2,991
Requests for medical imaging	207,980	192,574	181,457	172,764	164,784
Average number of beds open in the year	561	585	569	584	605
	2013/14	2012/13	2011/12	2010/11	2009/10
Average % Occupancy					
Overall	85.70%	87.40%	84.10%	84.40%	87.10%
General Medicine	91.40%	91.80%	89.10%	89.60%	91.90%
General Surgery	84.40%	89.50%	84.60%	89.40%	88.70%
Orthopaedics	82.52%	86.60%	82.90%	83.40%	90.80%

For the year 2013/14, the Trust performed well in terms of improving its delivery of elective activity for day cases and inpatients as well as outpatient attendances. Continued expansion of capacity enabled some previously challenged specialties such as Ophthalmology to reduce waiting times and ensure follow up appointments were available within appropriate timeframes. However, other specialties such as Gastroenterology remain challenged with a continued increase in growth of referrals. To maintain service delivery whilst further increasing the workforce, the Trust sought aid from external providers to ensure timely access and this continues to be in place to ensure safe and reliable services in areas of increased demand whilst further capacity is introduced.

The reduction of emergency episodes continues to support the Clinical Services Strategy of avoidable admissions and early discharge where safe to do so. The success of the Primary Assessment Unit and Surgical Assessment Area has evidenced that where patients can be assessed and have early diagnostics at the portals of entry then alternative options can be supported that reduce the need for admission. However, this has, to some extent conflicted with

the complexity and levels of acuity (sickness) of those patients who do require admission and as such the Trust evidences longer inpatient stays with extended discharge planning requirements for these patients. These factors have impacted on the bed occupancy rates, particularly in General Medicine, and will be a focus for improvement as the Trust progresses further service developments into 2014/15 with other community partners such as social services and community intermediate care.

Performance Standard	National Target	Trust Performance Year End 2013/14	Trust Position
Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from referral	95%	96%	Achieved
Percentage of admitted patients starting treatment within a maximum of 18 weeks from referral	90%	91%	Achieved
Percentage of patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	92% 95.63%		Achieved
Percentage of patient records	>=85%	Outpatients 90.7%	
with recorded ethnic group information	>=70%	Finished Consultant Episodes 91.4%	Achieved
Maximum time of waiting of four hours in A & E from arrival to admission, transfer or discharge	>95% <95% BUT >94% <94%	95.26%	Achieved
Percentage of patients referred urgently with suspected cancer by a GP, waiting no more than two weeks for a first outpatient appointment	93%	95.57%	Achieved
Percentage of patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for a first outpatient appointment	93%	95.21%	Achieved
Percentage of patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	96%	99.62%	Achieved
Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100%	Achieved
Percentage of patients waiting no more than 31 days for subsequent treatment what that treatment is surgery	94%	99%	Achieved

Performance Standard	National Target	Trust Performance Year End 2013/14	Trust Position
Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	85%	90.44%	Achieved
Percentage of patients waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers	90%	95.19%	Achieved
MRSA hospital acquired Bacteraemia	Target <= 0 MRSA	4	Not Achieved
Clostridium <i>difficile</i> hospital acquired	<= 15 Clostridium <i>difficile</i> cases in year	26	Not Achieved

The Trust performed well overall in terms of the Monitor standards of performance with good performance against all cancer standards and Referral to Treatment, times with the exception of Quarter 1 for Referral to Treatment of admitted performance which achieved at 87.3% against a target of 90%. Furthermore, the Trust achieved the Four Hourly standard for all quarters except Quarter 4 which achieved 93.1% against a target of 95%. This was largely due to winter pressures and a higher incidence of Norovirus affecting a number of wards resulting in higher levels of bed occupancy and increased numbers of patients who were unable to be discharged back to nursing and residential homes.

The Trust, however, did not sustain its previous performance for MRSA (meticillin-resistant staphylococcus aureusis) with four cases during the year and, as expected, the numbers of Clostridium difficile hospital acquired infections were higher than the very low target of 15 and the deminimus Monitor target of 12. For 2014/15 it has been recognised that this target was highly unlikely to be achieved and a more realistic and achievable target of 24 for Clostridium difficile has been set. Further internal measures are being reviewed to reduce the incidence of hospital acquired infections where at all possible.

Research and Development

The number of patients receiving NHS services provided or sub-contracted by the Trust between April 2013 and December 2013 that were recruited to participate in research approved by a Research Ethics Committee was 304. Further detail on Research and Development carried out by the Trust can be found in the Quality Account, Chapter 8.

Health and Safety

In 2013/14 there were 14 reportable incidents to the Health and Safety Executive (HSE) as required by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (previously 1995) (RIDDOR). This represents an approximate reduction of 36% compared to 22 reported incidents in the previous year.

The number of Health and Safety incidents reported in 2013/14 increased by approximately 15% compared to the previous year. However, this was due to an increase in the number of 'no harm' incidents reported. The rate of harm incidents reported was very similar to the previous year, showing a 0.02% reduction overall, with a slight increase in seriousness (ten incidents rated as 'Moderate' or above compared with eight in the previous year).

During the year the Trust continued with its major Asbestos Removal Programme and fire infrastructure improvements alongside an extensive new build

project for Theatres and Critical Care Unit.

The two fire infrastructure improvements projects continue to be:

- Upgrading structural fire integrity of the 'Hospital Streets' (corridors) throughout the Leighton Hospital site. Progress has continued, with the project near completion and most Hospital Streets have now been upgraded to meet modern day building standards. There are two small sections outstanding which will be completed by December 2014 following completion of works associated with the new Theatres and Critical Care Unit build
- Upgrading structural fire integrity on the wards is continuing at a rate of two wards per year and is currently planned to complete in 2019.

The Trust introduced a new system for workstation assessments for computer users during 2013/14 to reduce the potential of associated incidents.

Sustainability

As a nation, we are all much more knowledgeable about how individual and joint actions can impact on the environment, and how we can have a positive influence if we make the right choices in what we do. The NHS is the UK's largest public sector organisation and, as such, has a major part to play in reducing the effect of carbon emissions and waste resulting from daily activities and leading on approaches that promote long-term health and wellbeing, such as Good Corporate Citizenship (GCC).

Waste Management

The Trust is committed to minimising the impact of its activities on the environment and becoming a good corporate citizen. The table below highlights the changes over the last year with regard to waste management:

Definition	Tonne 2012/13	Tonne 2013/14	Disposal Cost 2012/13	Disposal Cost 2013/14
Total amount of waste produced by the Trust	1,089	1,154	£308,467	£258,162
Method of disposal (Landfill)	385	391	£56,980	£51,484
Method of disposal (Heat treated then deep land fill)	429	412	£169,828	£127,205
Method of disposal (Incinerated then deep landfill)	70	77	£43,775	£41,424
Method of disposal (Recycled) *	202	273	£43,516	£38,049

Summary Position – Waste Management

- Waste produced has increased by 5.93%
- Waste going to Landfill has increased by 1.5%
- Heat treated waste has decreased by 3.88%
- Incinerated waste has increased by 10.84%
- Recycling has increased by 35%

Finite Resources

The Trust is committed to meeting overall Government (and NHS) carbon reduction targets and minimising the use of finite energy resources. The table below highlights the changes over the last year with regard to finite resources:

Definition	Consumption 2012/13	Consumption 2013/14	Cost 2012/13	Cost 2013/14
Water	101,490 M ³	109,609 M ³	£299,261	£306,056
Electricity	9,309,770 kWh	10,369,929 kWh	£843,895	£866,879
Gas	23,362,142 kWh	24,923,351 kWh	£806,490	£761,022
Oil	100,639 kWh	136,623 kWh	£6,897	£7,902

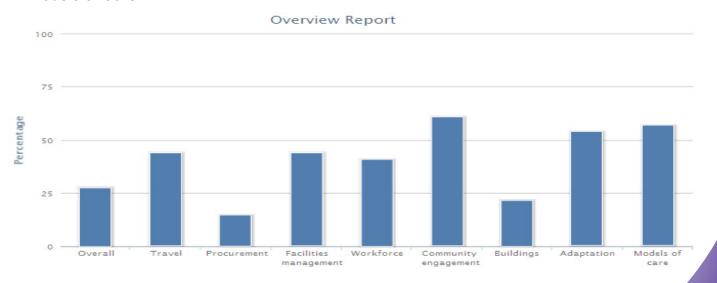
Summary Position – Finite Resources

- Water usage has increased by 8%
- Electricity consumption has increased by 11%
- Gas consumption has increased by 7%
- Oil consumption has increased by 36%.

Good Corporate Citizenship

The NHS Good Corporate Citizenship Assessment Model was changed in 2012. The model now features eight sub-sections and hence the overall progress has reduced since last year:

- Travel
- Procurement
- Facilities Management
- Workforce
- Community Engagement
- Buildings
- Adaptation
- Models of Care.



Financial Review

Overview of charitable activities

In line with the Foundation Trust Accounting Reporting Manual, the Trust consolidated the accounts of the Trust's principal charity with the Foundation Trust accounts. The Foundation Trust's accounts have been separated out throughout the financial statements with the columns headed "Group" reflecting the consolidated performance.

A summary of the Trust's charitable accounts can be found in Note 35 to the accounts which shows a net outgoing in year of £65,000, with retained funds at 31 March 2014 of £2.9m, of which £1.1m is held in cash balances and £0.9m reflects the market value of funds held in other investments. The balance of £0.9m is held in Debtors and Creditors.

Early 2013 saw the formal closure of the One in Eleven Appeal following a successful charitable appeal. The work on the Neo-Natal Unit has now commenced with the works expected to be completed in Summer 2014. Following on from the success of the One in Eleven appeal, Spring 2014 saw the launch of the Trust's appeal for an MRI Scanner.

Overview of Foundation Trust performance

The statement of Comprehensive Income for the year ending 31 March 2014 shows a deficit of £14.6m. However this position has been affected by the revaluation of the Trust's land and buildings which has created an impairment charge of £16.0m. Adjusting for this exceptional non cash item gives an adjusted surplus of £1.3m against a planned surplus before donated income of £0.6m, demonstrating the Trust's continued strong financial stewardship. In context of the continued significant downward pressure on the tariffs which the Trust is paid for its services, maintaining performance in line with the 2013/14 position is very positive.

This financial performance maintains the Trust's compliance with its obligations under the provider licence.

Looking forward to 2014/15, the efficiency challenge remains

significant with a further 4% real terms deflator in the tariff driving more financial efficiency to be delivered at the same time as increasing quality and moving towards increasing service provision to seven days a week.

The Trust has developed a two-year plan which delivers a breakeven position in each of the next two years.

Analysis of Income

The total income received by the Trust in 2013/14 was £183.3m, which represents an increase of £6.1m (or 3.4%) on 2012/13. An analysis of the key income streams can be seen below:

Income Source	2013/14 £000s	2012/13 £000s	Change £000s	%
Patient Care Activities	163,954	157,524	6,430	4.1
Education and Training	5,321	5,258	63	1.2
Non Patient Care Services to Other bodies	10,136	10,752	(616)	(5.7)
Other non- clinical Income	3,923	3,661	262	7.1
Total	183,334	177,195	6,139	3.4

The increase in income from patient care activities has been driven by increased levels of activity in elective services, in particular elective surgery and Outpatient appointments in response to increased demand. In addition to the elective and outpatient increases, a significant increase in high costs drugs has been seen which are recoverable from Specialist Commissioning at NHS England.

The reduction in income under Non Patient Care Services to Other Bodies is attributable in the main to a reduction in the overhead charges the Trust levies on East Cheshire NHS Trust in respect of the provision of Therapy services. This reduction reflects a change in the commissioning responsibility for outpatient activity and is offset by reduced charges to the Trust shown in its operating expenses.

Analysis of Operating Expenses

The total operating expenses incurred in the year were £195.9m, an increase of £14.3m compared with the previous year. However, £8.0m of this is associated with the impairment charge resulting from a revaluation exercise. The key movements are shown below:

Expenditure	2013/14 £000s	2012/13 £000s	Change £000s	%
Employee expenses – staff	123,780	119,954	3,826	3.2
Supplies and Services – Clinical	14,278	13,000	1,278	9.8
Drugs	11,096	9,440	1,656	17.5
Premises costs	6,886	6,626	260	3.9
Clinical Negligence Insurance	3,637	3,555	82	2.3
Services from NHS bodies	4,998	5,751	(753)	(13.1)
Other	15,178	15,222	44	0.3
Total costs prior to impairments	179,853	173,548	6,305	3.6
Impairments	16,001	8,001		
Total	195,854	181,549		

During the year the Trust employed an average of 3,157 full time equivalent staff, an increase of 53 on the previous year. The average staff cost increased from £38,600 to £39,200, an increase of 1.5%, which is primarily due to staff passing through incremental gateways. In addition, in response to the increased demand on services, a number of waiting list initiatives have been undertaken to maintain waiting time standards, in particular in Ophthalmology and Gastroenterology.

The increase in staffing numbers has been seen in frontline professions with an additional 33 qualified nurses, 24 Health Care Assistants and 10 additional medical staff, despite the closure of a medical ward part way through the year. This demonstrates the Trust's commitment to improving the nurse and doctor ratios per bed, which will be further improved during 2014/15 in plans approved by the Board

of Directors.

A feature of the year has been the significant increase in elective activity responding to increased GP referrals of 7% over the year. These services have a significant impact on drug and clinical supplies, where significant increases in costs have been experienced.

A change in the methodology in the calculation of Trust's contribution to the Clinical Negligence Scheme for Trusts (CNST) to reflect previous claims history has seen the costs in this area increase by only 2.3%. In comparison with the national picture of premium increases of 10% per annum, this demonstrates good performance and is one indicator of safe effective care.

The reduction in monies received from other NHS bodies is, in the main, due to the reduction in charges for Therapy services which are provided by East Cheshire NHS Trust. This reflects a change in responsibility for Outpatient treatments, which became chargeable to the Clinical Commissioning Groups rather than directly to the Trust.

Capital Investments

2013/14 has been another exciting year for the Trust in respect of its capital investments. During the year the remaining £17.1m of the Public Dividend Capital was utilised and the new Operating Theatres and Critical Care build is substantially complete and equipped with the latest state-of-the-art technology providing cutting edge facilities.

In total, the Trust has seen capital additions in year of £21.7m with a further £1.7m funded through new finance leases. The key development has clearly been the fantastic new Operating Theatres and Critical Care Unit which will benefit patients for many years. In addition, other capital developments have been:

- Ward refurbishments, in particular the refurbishment of maternity wards and Neonatal Intensive Care are both substantially under way
- Significant progress on the refurbishment of the Leighton

Hospital's corridors and improvements in fire compartmentation

- Work has now begun on Leighton Hospital's main entrance which will provide improvements not only in image but also catering facilities for staff and visitors
- A significant bed replacement programme was completed in year with almost half the Trust's bed stock being renewed.
- Information Management & Technology systems and Infrastructure, including new systems to improve the management of patients going through operating theatres and a number of clinical systems to support the prescribing and management of chemotherapy drugs and systems to improve clinical handover.

Non-NHS Income

The Trust is assured that the income from the provision of goods and services for the purposes of the health service in England is greater than the income from the provision of goods and services for any other purposes which has no impact on the provision of health services.

Payment of Suppliers

The Trust operates a policy of payment of invoices within terms agreed with suppliers; in most cases this is within 30 days of the invoice date. During the year ended 31 March 2014, the Trust paid 94% by value (2012/13:94%) of invoices within this timescale. No interest payments have been made under the Late Payment of Commercial Debts Act.

Private Patient Cap

In accordance with the Health and Social Care Act 2012, from 1 October 2012 Foundation Trusts are obliged to make sure that the income they receive from providing goods and services for the NHS (their principal purpose) is greater than their income from other sources.

The Trust can confirm that the provision of services to private funded health care either directly or indirectly through other parties had no negative impact on the provision of NHS services.

Cost Allocation and Charging Requirements

The Trust can confirm it has complied with the cost allocation and charging requirements set out in Her Majesty's Treasury and Office of Public Sector Information Guidance.

Charitable and Political Donations

The Trust has not made any charitable or political donations during the year. No charitable donations from any political party have been received within the year.

Management Costs

In line with best practice, the Trust continues to monitor expenditure on management costs in accordance with the Department of Health definitions. In 2013/14, 4.92% of total income was incurred on management costs.

This represents a decrease on the previous year (2012/13:4.95%), this is in line with the Trust's commitment to divert funds towards direct patient care and has been delivered through reductions in corporate management positions.

Senior Manager Remuneration and Benefits

Pension arrangements for the Chief Executive and all Directors are in accordance with the NHS Pension Scheme, the accounting Policies for Pensions and relevant benefits are set out in the Notes to the Accounts – Accounting Policies.

Full details of the remuneration can be found in Note 5.4 in the accounts on Page 183. Benefits in kind relate to the provision of lease cars.

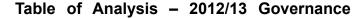
Performance against Monitor's Compliance Framework

Monitor's compliance regime requires a quarterly submission of financial data which identifies the overall financial risk facing the Trust. The anticipated risk score for 2013/14 was at level 4, against a plan of 4, as shown below:

Metric 2013/14	Achieved Rating	Plan Rating
Liquidity ratio	4	4
Capital servicing capacity	3	3
Overall Rating	4	4

The Compliance Framework covers a risk rating from "1" (very high risk) through to "4" (minimal risk) with "3" representing the minimum expected level defined in Monitor's Risk Assurance Framework. All financial monitoring returns were submitted on time and were complete and correct.

Monitor's compliance regime requires a quarterly submission of governance data which identifies the anticipated risk score for 2012/13 was amber red, as shown below:





	Annual Plan 2013/14	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14
Governance Risk Rating	AR	AG (Referral to Treatment admitted not achieved)	G	G* (Clostridium difficile not achieved)	TBC**
Mandatory Services	G	G	G	G	G

G = green rating; AG = amber/green rating; AR = amber/red rating

*Please note that from Quarter 3, the ratings changed from Green, Amber and Red to Red or Green only with an option for Monitor to include a narrative decision in between. This occurred for the Trust in Quarter 3 in relation to the Clostridium difficile target not being achieved but Monitor acknowledged the work the Trust was doing to improve healthcare acquired infections and that the target was very low, therefore the Trust received a Green rating.

**At the time of the completion of the Annual Report and Accounts 2013/14, the Governance Risk Rating for Quarter 4 was awaited.

Ratings

In relation to the Referral to Treatment (RTT) target in Quarter 1, the Board of Directors, at its meeting of 8 April 2013, considered the selfdeclaration to Monitor that it would remain at a governance rating of Green for each month of the next twelve months and agreed the Trust was unable to give such an assurance at that stage. The Trust Board took into account the additional non recurrent ophthalmology activity of cataracts which had been commissioned by the Clinical Commissioning Groups to reduce the backlog of patients waiting over 18 weeks. This had been caused by significant increases in patients being listed for treatment during the latter part of 2012. The action plan agreed was to deliver increased activity in Quarter 1 through internal additional capacity and also external partner arrangements. The Trust continued to meet the 18 week standard from Quarter 2 going forward.

The Four Hourly target was not delivered in Quarter 4 but the Trust did achieve the overall target for the year at 95.5%. The reasons for the target not being achieved included:

- A delay in national planning and release of funding for winter pressures which subsequently delayed the Trust's ability to introduce additional measures
- An outbreak of Norovirus at Leighton Hospital which closed a significant number of beds from 31 December 2013 through much of January and February 2014.

In relation to Clostridium *difficile*, the Trust's target for 2013/14 was for no more than 15 Clostridium *difficile* cases to be reported. In 2013/14 the Trust reported 26 cases. A full review of each case has been undertaken and the only area for improvement highlighted has been the timeliness of sampling and this has been addressed directly with the wards and departments.

Through data provided by Monitor on the performance of other Foundation Trusts, a review was undertaken against 83 acute Trusts. Four Trusts in the North West were identified as delivering against their target, and the Trust contacted each organisation to understand their approach in relation to:

- Cleaning methods and types
- Sampling and testing practices
- Training and Education
- Health economy/community approach
- · Antibiotic usage
- Any additional actions the organisation has taken.

This process of review did not reveal any additional actions that the Trust are not already undertaking.

Quality Governance The Trust takes due regard of Monitor's Quality

The Trust takes due regard of Monitor's Quality Governance Framework in arriving at its overall evaluation of the Trust's performance, internal controls and Board Assurance Framework, and conducts a formal review using the Quality Governance Framework annually. Action plans arising out of the review are monitored on an ongoing basis.

More detailed information on quality and quality governance can be found in the Quality Account in Chapter 8 and the Annual Governance Statement in Chapter 10 of this report.

Staff and Stakeholders

Detailed information on patient care activities and stakeholder relations can be found in the Strategic Report (Chapter 2), Quality Account (Chapter 8) and further information is also sited in Chapter 5 – Staff and Stakeholders.

Chapter 5 also contains information in relation to the Trust's staff including details on engagement and the provision of information and policies in relation to disabled members of staff.

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 nominated a Local Counter Fraud Specialist (LCFS) who is professionally trained and experienced in this area of expertise. The LCFS combines both proactive and investigative work to deliver an

effective counter fraud service for the Trust and the LCFS works to ensure a strong antifraud culture across the Trust.

External Auditors

The existing Auditor (Deloitte LLP) was appointed in October 2008 on an initial five-year period with the option to extend for a further two agreed in January 2013 by the Council of Governors.

There are no known conflicts of interest that need to be addressed by the Auditor or the Audit Committee.

Register of Interests

There is full disclosure of all Directors and Governors interests in the Register of Directors Interests which is available upon request from the Acting Trust Secretary. Should you wish to view the register please contact the Trust on 01270 612128.

Disclosure to Auditors

The Board of Directors confirm, at the date of the approval of this report, that

- so far as the Directors are aware, there is no relevant audit information of which the Auditors are unaware
- each Director has taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's Auditors are aware of that information.

Data Loss

The Trust has had no serious untoward incidents involving data in 2013/14, therefore no incidents have been reported to the Information Commissioners Office (ICO). Raising staff awareness continues to be a priority on the Information Governance agenda which has been illustrated by the Trust attaining, for the first time, 98% of all staff completing Information Governance training during their employment. The Information Governance Toolkit (Version 11) score for 2013/14 was 78%, an increase from 72% in 2012/13.





Board of Directors

Introduction

As at 31 March 2014, the Board of Directors comprised seven Non-Executive Directors, including the Chairman, and six Executive Directors with voting rights, including the Chief Executive.

Name	Position
Mrs T Bullock	Chief Executive
Dr P Dodds	Medical Director & Deputy Chief Executive
Mrs D Frodsham	Chief Operating Officer
Mr M Oldham	Director of Finance & Strategic Planning
Mr D Pitt	Director of Service Transformation & Workforce
Mrs J Smith	Director of Nursing & Quality
Mrs J Smith	Director of Nursing & Quality
Mr J Moran	Chairman
Dame P Bacon	Non-Executive Director
Mr J Barnes	Non-Executive Director
Mr M Davis	Non-Executive Director
Mr D Dunn	Non-Executive Director & Deputy Chairman
Mr D Hopewell	Senior Independent Director
Mrs R McNeil	Non-Executive Director

The Board is collectively responsible for the delivery of healthcare services and performance of the Trust. It is accountable for ensuring compliance and decision making in relation to the terms of its authorisation, constitution, mandatory guidance issued by Monitor, all relevant statutory requirements and for fulfilling contractual obligations.

The Board accounts for its stewardship to the Council of Governors and the Members of the Foundation Trust (for details of the Council of Governors see Chapter 6).

The Board meets monthly throughout the year and delegates matters as appropriate to Board Committees within the Integrated Governance Structure. Minutes of the Board Committees are presented to the Board of Directors meetings

with individual items raised by exception. The Chairman and Chief Executive meet with the Chair of each Board Committee on an annual basis to agree the workplan for the forthcoming year and review the Terms of Reference. An Annual Report of each Board Committee is received by the Audit Committee.

There is a very clear division of responsibilities between the Chairman and the Chief Executive. The Chairman is responsible for leadership of the Board of Directors and the Council of Governors, ensuring effective delivery on all aspects of the work of the Board and Council. The Chairman facilitates contribution from all Non-Executive and Executive Directors to ensure constructive relations exist and are maintained between the Directors and with the Council of Governors. The Chairman is also responsible for making sure the Board and the Council work together effectively. The Chairman ensures effective and efficient communication channels exist between the Board and Council and also with patients, Members, clients, staff, partner organisations and key stakeholders.

The Chief Executive is accountable for executing the Trust's strategy as agreed by the Board of Directors and the delivery of all key targets, statutory responsibilities and contractual requirements. The Chief Executive allocates decision making and responsibilities accordingly.

The Board is satisfied that there are no direct conflicts of interest for any of its members and none of the Executive Directors serve elsewhere as a Non-Executive Director. All Non-Executive Directors, including the Chairman, have confirmed in writing that they are able to honour the necessary time commitments to undertake their various roles and responsibilities at the Trust and are considered to be fully independent.

The Trust constantly reviews the skills and expertise of the Board and considers there to be a balance of appropriate skills amongst the Board members with a sufficient breadth of skills to ensure balance, completeness and appropriateness to the requirements of the Trust.

The Board also undertook a development programme for the year which is critical to its continuous learning and development. This was developed by the Chairman and Chief Executive and consisted of a range of inputs and speakers.

The Board recognises the value of a regular performance review and conducts a half-yearly Board Effectiveness Survey. The survey is also circulated to staff and Governors annually for their views. The results of the survey form an action plan which is regularly reviewed by the Board of Directors. There was no external evaluation of the Board of Directors undertaken during the period.

Each Executive Director has monthly individual one-to-one meetings with the Chief Executive and an end of year final appraisal. Each Non-Executive Director has an annual appraisal with the Chairman. The Board has a Senior Independent Director who leads the process of appraising the Chairman. The appraisal process for the Chief Executive is conducted by the Chairman.

Board Member Profiles



Julie Smith
Director of Nursing
and Quality



Mark Oldham
Director of Finance



Tracy Bullock
Chief Executive



Dr Paul DoddsMedical Director
and Deputy Chief
Executive



Denise FrodshamChief Operating
Officer



David PittDirector of Service
Transformation and
Workforce



John Barnes Non-Executive Director



Dame Patricia Bacon Non-Executive Director



Dennis Dunn Chairman



David Hopewell
Non-Executive
Director



Ruth McNeil Non-Executive Director



Mike Davis Non-Executive Director

Non-Executive Directors

Mr John Moran, Chairman (to 31 March 2014) John Moran originally took up the role as Chair on 1 July 2008, with his tenure extended, effective 1 July 2012, for a further 3 years. An investment and commercial banker by profession, John's considerable business experience will prove invaluable as the NHS Foundation Trust continues to develop and improve its services and facilities to the public.

Dame Patricia Bacon

Prior to joining the Trust, Patricia worked in Further Education for over 30 years, the last ten of which as Principal of St Helens College. In 2011 Patricia was awarded the DBE in recognition of her contribution to Education, both locally and nationally, including 12 months as the elected President of the Association of Colleges. Patricia has extensive experience of corporate governance both regionally and nationally, including seven years as a Non-Executive Director of the University Hospitals North Staffordshire NHS Trust.

Mr John Barnes

John joined the Trust as a Non-Executive Director in February 2013. John is a chartered engineer with over ten years' experience at Board level

in a FTSE 50 utility company. These days, John has his own company, offering consultancy in the areas of sustainability, the utility sector, change management and leadership. He is a member of a number of business groups, and is the Interim Executive Chair of the All Change for Crewe Partnership Board.

Mr Mike Davis

Mike joined the Trust on 1 February 2013 after a career in the business services, facilities management and project finance industries of which 25 years were as Managing Director or CEO of industry leading companies. Between 1997 and 2010 he was closely involved in the design, financing, construction and operation of eight hospital PFI projects and is currently Chairman of three large hospital PFI companies operating in the North West and East Midlands.

Mr Dennis Dunn MBE

Dennis is Pro Vice Chancellor International of the Manchester Metropolitan University (MMU) and Dean of MMU in Cheshire. A specialist in Business Information Technology, Dennis has advised commercial organisations and universities around the world on aspects of information systems strategy and is currently an expert advisor on a European Commission project in the Czech Republic developing Lean Organisations. He is a visiting professor at universities in China and the Czech Republic. Dennis was awarded an MBE in the Queen's Birthday Honours list 2010 for his services to Higher Education. Dennis is also Deputy Chairman of the Trust, his appointment being approved by the Council of Governors in April 2013.

Mr David Hopewell

David is a chartered accountant by profession. He spent several years working with Shell, both overseas and in the UK, before taking up a post at the Government Office North West and moving on to become Resources Director at Cheshire Peaks and Plains Housing Trust. David has also worked as Finance Director for Retrak, a UK charity which supports street children in Africa He is currently involved with Guinness Northern Counties Housing Association. David was appointed Senior Independent Director of the Trust in April 2013.

Mrs Ruth McNeil

Ruth worked in Local Government for 21 years for Manchester City Council of which she was Chief Officer for some 19 years responsible for a broad range of customer orientated commercial trading services. Prior to joining local Government, Ruth worked for Shell UK. Ruth's early career was mainly within the Hotel and Catering industry. In 2007 Ruth retired from full-time work and in October 2008 joined Cheshire Police Authority as an independent Board Member where she is currently Chairman of Staff Committee.

Executive Directors

Tracy Bullock, Chief Executive

Tracy joined the health service in 1983 and gained 18 years clinical experience as a nurse before embarking on a variety of managerial and corporate roles. Additionally, Tracy spent two years periodically seconded to the Commission for Health Improvement/Healthcare Commission to conduct investigations and governance reviews across the country. Tracy subsequently spent four years working nationally supporting challenged NHS organisations to achieve turnaround

and latterly Foundation Trust status. During this time she gained experience working in Acute, Primary Care, Ambulance and Mental Health Trusts. Tracy joined Mid Cheshire Hospitals in October 2006 as the Director of Nursing and Quality and very quickly took on additional responsibilities of Operations and Deputy Chief Executive, before being appointed to the Chief Executive role in October 2010.

Dr Paul Dodds, Medical Director and Deputy Chief Executive

Paul studied medicine at the University of Manchester and was appointed Consultant Physician with an interest in Cardiology at the Trust in 1994. Prior to becoming Medical Director, his managerial roles at the Trust included Chairman of the Medical Advisory Committee, Clinical Director for Medicine and Divisional Clinical Director for Emergency Care.

Denise Frodsham, Chief Operating Officer

Denise has worked in the NHS for over 30 years, including ten years at the Trust in a progressive career which began as the Trust's Associate Divisional Director for Diagnostic and Clinical Support Services before joining the Board of Directors. More recently as the Chief Operating Officer, Denise has been involved in and led the development of the Trust's Strategy and Clinical Services Strategy, progressing a number of service expansion and modernisation programmes to improve quality, efficiency and capacity, as well as reducing costs and increasing income. Denise has a special interest in, and experience of, leading organisational change and working with individuals and teams to improve service delivery and performance.

Mark Oldham, Director of Finance & Strategic Planning

Mark joined the NHS in 1989, originally working at Crewe Health Authority. In 1990, Mark began his work at Mid Cheshire Hospitals as it received NHS Trust status. Since then Mark has had a number of promotions internally, giving him exposure to all elements of the NHS financial regime. His notable achievements during this period are a successful business case to build the Trust's Treatment Centre and a significant contribution to achieving Foundation Trust status. Mark is a member of the Chartered Institute of Public Finance Accountants.

David Pitt, Director of Service Transformation & Workforce

David joined the NHS through the General Management Training Scheme over 26 years ago and has experience of working in Acute, Community and Mental Health Trusts, Primary Care Trusts and with a Strategic Health Authority. He has over ten years experience as an Executive Director and has completed roles in service and corporate change, strategy, marketing, workforce, organisational development and has led a multi-NHS partner Batch PFI. David holds a BA from Robert Gordons University, Aberdeen, an MBA from Durham University, and an MSc from Lancaster University in project management.

Julie Smith, Director of Nursing & Quality

Julie has worked in the NHS for over 20 years in a variety of clinical roles from staff nurse through to matron before moving into general management. Julie held roles regionally and nationally working for both the Modernisation Agency and the Department of Health in areas of quality improvement and redesign of the delivery of clinical services. Before being

appointed as Director of Nursing at the Trust, Julie undertook the positions of Deputy Director of Nursing at a large Acute Teaching Hospital and Associate Director of Nursing at NHS East Midlands leading on Patient Experience.

Attendance of Board Members at Meetings

The Board of Directors has established the following Board Committees:

- Audit Committee
- Infrastructure Committee
- Performance & Finance Committee (PAF)
- QuESt (Quality Effectiveness & Safety)
 Committee
- Appointments & Remuneration Committee
- Strategic Integrated Governance Committee (SIG).

Attendance at the Board of Director meetings, Board Committees and Council of Governor Meetings is recorded as follows:

	Board of Directors	Council of Governors	PAF	SIG	Infrastructure	QuESt
Number of Meetings in 2013/14	14	5	12	12	6	6
Mr J Moran	14	5	-	-	-	6
Dame P Bacon	12	4	-	-	-	3
Mr J Barnes	14	1	10	-	-	-
Mr M Davis	13	2	-	11	6	-
Mr D Dunn	12	3	-	-	6	-
Mr D Hopewell	12	5	10	-	-	-
Mrs R McNeil	12	2	-	11	-	-
Dr A Wood	1 (of 1)	1 (of 1)	1 (of 1)	-	-	-
Mrs T Bullock	14	4	-	-	-	5
Dr P Dodds	14	2	-	12	6	5
Mrs D Frodsham	13	0	11	-	-	-
Mr M Oldham	14	2	11	-	6	-
Mr D Pitt	14	4	12	11	-	
Mrs J Smith	13	3	-	10	-	5

Attendance at Council of Governors meetings is not obligatory for the Executive Directors. Executive Directors have an open invitation to every Council meeting and attend as and when requested either by Council or the Chief Executive. There were no formal requests for attendance during 2013/14.

Members' Interests

A Register of Directors' Interests is maintained, and is available for inspection by the general public during normal office hours by appointment with the Acting Trust Secretary. The following interests were recorded for 2013/14:

Director	Interest	Seeking to do business with health authorities	Has business dealings with the Trust
Mr J Barnes	Director of Practiq Consulting Limited	Yes	No
	ASC Renewables Limited	Yes	No
Mr M Davis	Director of Alpraham Hall Barns Management Company Limited	No	No
	Chairman of the Board of Central Nottinghamshire Hospitals Plc.	Yes	No
	Chairman of the Board Derby Healthcare Plc.	Yes	No
	Chairman of the Board of New Hospitals (St Helens and Knowsley) Plc.	Yes	No
Mr D Dunn	Pro Vice Chancellor of Manchester Metropolitan University	Yes	No
	Director of Marketing Cheshire	Yes	No

All Non-Executive Directors satisfy the requirements to be an independent director.

In addition, the Chairman confirmed to the Trust that he had no other significant interests that adversely impacted on the time he had available to discharge his duties to the Trust.

Codes of Conduct, Accountability & Openness

The Board of Directors adopted the Code of Conduct and Code of Accountability for NHS Boards on 1 August 1994 and has incorporated these in its Standing Orders and Standing Financial Instructions. Health Service Guidance (HSG (93)5) sets out the strict ethical standards in the conduct of NHS business.

Since 1 April 1995, the Chief Executive has been identified as the Trust's Accountable Officer, directly accountable to Parliament for the stewardship of public money and for the quality of services provided.

The Trust has also adopted the Code of Practice on Openness in the NHS. The Chief Executive (or other Executive Director) addresses Cheshire East Council's and Cheshire West & Chester Council's Health and Wellbeing Scrutiny Committees at least once a year, and updates the Committee on matters such as the Trust's Annual Report, Quality Accounts and Business Plan.

Regular consultation takes place with other local groups, voluntary organisations and MPs, in order to make the aims of the Trust clear to a wide audience and obtain comprehensive feedback.

During 2013/14 the Trust continued to work with its key partners on the health economy Connecting Care Board. The remit of the Board was to develop a number of strategic priorities to ensure sustainable healthcare for the population of Cheshire. Subsequent to this a newly formed Provider Board has been established to bring together a range of providers to collaborate effectively thus ensuring the development and delivery of care in the most appropriate setting and delivered by the most appropriate healthcare professional.

The Trust publishes a large number of patient information booklets covering a wide range of conditions and procedures. These are systematically reviewed and updated. In addition, posters and information boards are strategically placed to assist patients and staff. Internet and intranet websites are available to further enhance staff and public access to this information.

Audit Committee

The Audit Committee consists of six independent Non-Executive Directors and is chaired by a Qualified Accountant. In addition, the Trust's External and Internal Auditors and the Trust's Finance Director are normally in attendance whilst Executive Directors and Senior Managers attend as required.

During 2013/14 the Committee met on the following occasions and attendance is as below:

Name	15.04.13	28.05.13	12.08.13	14.10.13	04.12.13	10.02.14
Mr D Hopewell (Chair)	Yes	Yes	Yes	Yes	Yes	Yes
Dame P Bacon	Yes	1	-	Yes	1	Yes
Mr J Barnes	Yes	Yes	Yes	Yes	Yes	Yes
Mr M Davis	Yes	Yes	-	Yes	1	Yes
Mr D Dunn	-	Yes	Yes	Yes	-	-
Mr R McNeil	Yes	Yes	Yes	Yes	-	Yes
Dr A Wood	Yes	n/a	n/a	n/a	n/a	n/a

During the year, the Committee undertook the following in discharging its responsibilities:

- Reviewed the construction and utilisation of its Corporate Governance Manual;
- Reviewed the establishment and maintenance of an effective system of integrated governance, risk management and internal control
- Reviewed assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of management of principal risks, and the appropriateness of the above disclosure statements
- Reviewed the policies and procedures for all work related to fraud and corruption
- Reviewed the Trust's Risk Assurance Framework
- Reviewed and approved the Internal Audit Strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Risk Assurance Framework
- Reviewed the work and findings of the External Auditor and considered the implications of, and management's responses to, their work
- Reviewed the Annual Report and Financial Statements before their submission to the Board of Directors
- Considered the circumstances when Standing Orders, Standing Financial Instructions or Standing Instructions for non-financial risks have been waived or otherwise breached.

During the year, the Committee considered the work of the Trust's External Auditors, Deloitte LLP, the Trust's Internal Auditors and the Local Counter Fraud Specialist. It received reports and statements from the Directors and Officers of the Trust. As a result of its work, the Committee was in a position to advise the Board that the system of audit and internal control were operating effectively.

Organisational Controls

The Directors have prepared an Annual Governance Statement. Over the last few years, the Trust has undertaken a significant piece of work to build these systems across the organisation.

Appropriate investments have been made to ensure that the systems are properly established.

The Trust's compliance with the NHS Foundation Trust Code of Governance has been reviewed and it was considered compliance was achieved through governance documents, policies and procedures of the Trust. Further details on the governance arrangements can be found in the Annual Governance Statement.



Chapter 5

Staff and Stakeholders

The provision of high quality services delivered by the Trust continued to be a priority for 2013/14 and this has involved continued partnership working with patients, relatives, carers as well as the joint delivery of services between the Trust and other voluntary and statutory organisations. It is also important the Trust continues to value its staff as the Trust recognises it would not be able to provide high quality services without the dedication, hard work and standards of professionalism demonstrated by all staff.

Staff

The Trust employs approximately 3,500 staff in an extensive range of specialties and professions. The Board of Directors recognises the valuable contribution its workforce makes to the delivery of high quality services and patient safety and knows staff work tirelessly to ensure services to patients and families remain a priority.

Health and Wellbeing

The Trust continues to focus on the health and wellbeing of its staff, recognising the association between improved wellbeing and improved performance, productivity and engagement. A Health and Wellbeing Group, comprising members of staff from across the organisation, meet quarterly to review, plan and implement wellbeing related activities. The focus of the group for 2013/14 included:

- Emotional Wellbeing (Counselling, Resilience, Employee Support Advisors, Mediation and Coaching)
- Physical Wellbeing (Walking, Cycling, Running)
- Nutrition (Healthy Eating and Dietary Advice)
- Workplace Design (Management Development Programmes, Investors in People, Staff Survey, Appraisals and Change Management)
- Health Partnerships (Network partnerships with wellbeing agencies and local NHS

Trusts)

Communications (Internal and External).

A key highlight in 2013 was the NHS Cheshire Games which was planned and delivered by the Health and Wellbeing Group in close working partnership with colleagues from East Cheshire NHS Trust. The event was attended by staff, family and friends wanting to be part of a local sporting occasion and a great family fun day out. Teams and individuals from both Trusts entered a number of sporting events including table tennis, netball, football, touch rugby, rounders and even a tug of war.

Interest in participating in 2014 has been expressed by other NHS organisations and the Health and Wellbeing Group is busy planning for another successful event.

Celebration of Achievement Evening

The Trust holds an annual Celebration of Achievement Evening with staff encouraged to nominate their colleagues across the Trust in ten categories. 2013/14 also saw the introduction of a Patient Choice Award giving patients, carers, relatives and visitors the opportunity to nominate individuals or teams who have gone the extra mile to ensure the best possible experience for all Trust service users.

Listening to Staff

National Staff Survey

Listening to the views of staff is hugely important and the Trust was delighted that the response rate for the 2013 annual national NHS Staff Survey increased from 65% in 2012 to 70%, putting the Trust in the top 20% of the Trust's peer group and second highest Acute Trust nationally.

The survey comprises questions relating to the four pledges to staff in the NHS Constitution, focusing on 28 Key Findings indicators together with additional themes of Staff Satisfaction and Equality & Diversity.

A review of the findings shows the Trust's score for Staff Engagement for 2013 was 3.76 out of 5 (1 indicating that staff are poorly engaged and 5 indicating that staff are highly engaged)

demonstrating an increase on the 2012 score and a score which was better than the national average. The Trust also saw an improvement in the number of staff who would recommend the Trust as a place to work and receive treatment, and was delighted to note that the response to both these questions was also better than the national average.

Other areas of significant improvement include staff feeling they are able to deliver the patient care they aspire to, care of patients/service users is the organisation's top priority and communication between senior managers and staff is effective.

Divisional Action Plans will be developed based on the 2013 outcomes and will focus on issues that staff identified as being of real importance to them and that will have a marked effect on their future levels of engagement and satisfaction. Areas of concern highlighted in the 2013 survey results and which will be a focus within the Divisional Action Plans are:

- Reducing violence bullying and harassment towards staff
- Improving effective team working
- Reducing the number of staff experiencing

- discrimination
- Further improving communications between managers and staff
- Improving the health and wellbeing of staff.

Progress against Action Plans will be monitored through forums including Workforce Assurance Committee, Divisional Performance Reviews (DPR) and Divisional Workforce meetings. The Staff Survey and any related Action Plans are also incorporated in to the Trust's Organisational Development Strategy.

The Trust also holds focus groups with staff across all Divisions in June and October to gain further in-depth feedback from the Staff Survey questions. The feedback from these groups is shared widely across the senior management teams and at Board level meetings and is used to inform new developments and changes to practice. Staff are informed of changes and actions taken as a result of their feedback through the "You said... We did..." poster campaign which runs throughout the year.

Details of the Trust's top five ranking and bottom five ranking scores are noted below:

Top Five Ranking scores

Question	Trust Score	National Average for Acute Trusts
KF14. Percentage of Staff reporting errors, near misses or incidents witnessed in the last month	95%	90%
KF15. Fairness and effectiveness of incident reporting procedures	3.65	3.51
KF 27. Percentage of staff believing the trust provides equal opportunities for career progression or promotion	92%	88%
KF7. Percentage of staff appraised in last 12 months	89%	84%
KF12. Percentage of staff saying hand wash materials are always available	66%	60%

Bottom Five Ranking scores

Question	Trust Score	National Average for Acute Trusts
KF16. Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	17%	15%
KF26. Percentage of staff having equality and diversity training in the last 12 months	48%	60%
KF4. Effective Team Working	3.70	3.74
KF10 Percentage of staff receiving health and safety training in last 12 months	71%	76%
KF20. Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell	30%	28%

Investors in People

The Trust maintained the Bronze Status of the Investors in People Standard that it originally achieved in January



achieved in January INVESTORS IN PEOPLE 2011 following a full

review which took place during 2013. Annual internal reviews are undertaken between the formal external assessments to provide a "temperature check" and triangulate the information collected as part of the staff survey and staff focus groups that are also conducted twice a year.

Training to support staff

Resilience

The Trust has three staff who have been trained by the Occupational Psychologist company, Robertson Cooper, to deliver a one-day programme to managers and supervisors on how to build resilience both in themselves and in their teams. This is also offered as half-day sessions for teams going through changes.

Leadership Development

The Trust runs a number of in-house development programmes

- Bands 1 5 NVQ in Management
- Bands 3 & 4 'Learning to Lead'
- Bands 5 and 6 'Becoming a Mid Cheshire Hospitals NHS Foundation Trust Manager'
- Master classes for senior leaders.

Coaching

- The Trust continues to provide one-to-one coaching for senior staff from the team of ten internal coaches
- The Trust also runs one-and-a-half day workshops on Essential Coaching skills for all managers
- Team coaching is also available.

Apprenticeships

The Trust is still committed to the development of staff and adult apprenticeships. Staff not only gain a competency qualification but it also provides an opportunity to update numeracy, literacy and ICT qualifications.

Work Experience

The Trust continues to provide and develop an equitable, high quality, work experience programme, responsive to changing availability of placements within the Trust, and to the evolving needs of local schools/colleges and students.

Mandatory Training

The Biennial Mandatory Update (BEMU) includes sessions on Equality, Diversity and Human Rights and Integrated Risk Management as well as areas such as Fire, Dementia Awareness and Safeguarding children and adults. A review of the appraisal paperwork took place in 2013 and from 1 April 2014 the process and paperwork will be simplified and aligned with organisational objectives and values and behaviours. From this system a Talent Management recording system has now been established.

Health Care Assistant (HCA) support

three-day HCA training programme commenced in April 2011 for both new and existing staff. The programme includes training sessions on infection control; nutrition; accountability; pressure ulcer risk assessment; undertaking ward based observations: fluid balance recording; urinalysis; incident reporting; bereavement services; palliative care services; falls prevention, dementia and learning disability awareness. Evaluations are positive and complementary. A recent analysis demonstrated a definite increase in the confidence of HCAs in performing key skills after their training. A new one-day programme launched in September 2013 to provide "key messages" refresher training for experienced HCAs.

Communications

The Trust underwent a review of staff and stakeholder communications in 2013/14, with the updated methods of interaction commencing in October 2013. A summary of the Trust's Communications is as follows:

The Chief Executive briefs all staff on a weekly basis via email on a wide range of topics such as upcoming initiatives, events and NHS matters in general including information on matters of concern to staff. The Chief Executive also holds regular briefing sessions to update staff across the organisation on the Trust's performance, strategy, challenges and opportunities as well as holding weekly 'drop in' sessions whereby staff can meet with her to share experiences of their work or details of any achievements or concerns.

A number of newsletters are produced by the Trust's Communications Department:

- Each member of staff is sent an electronic copy of Trust Update, a fortnightly summary of some of the main internal news items, with a hard copy also sent to all wards and departments
- A bi-monthly newsletter focussing on staff as individuals is produced to accompany payslips, with topics including policy changes, payroll and pension information and health and wellbeing initiatives
 - A new newsletter was introduced in late 2013, called All Together.

This newsletter, produced three times a year, provides an overview of some of the major developments within the organisation. The Trust previously produced separate newsletters for staff (Staff Matters) and Foundation Trust Members (IN), but it was felt that merging the two would save costs and reduce content repetition

 A bi-monthly newsletter is produced for local GP colleagues, containing articles such as service improvements.

The Executive Directors are continuing regular ward/department visits, meeting with staff and discussing any issues which may be occurring in that area. The Directors also hold briefing sessions if there are any urgent communications for the Trust.

In March 2014, the Trust launched its first official presence on Social Media by creating an account on Twitter. The Trust's username on the micro-blogging site is @MidCheshireNHS.

Staff Engagement

The Trust continues to encourage staff to get involved in identifying solutions to the challenges it faces and actively seeks the involvement of staff in improving service delivery.

Changing and improving how the Trust delivers services will be one of the main thrusts of the Trust Strategy moving forward. Staff engagement is one of the key ingredients which will support the Trust in meeting these challenges and evidence states that transformational change will only take place with meaningful staff engagement. The Chief Executive has conducted a large number of engagement sessions for staff across the last year to share information on where the Trust is now and what its future plans are. The Trust was also reaccredited with the Bronze status Investors in People (IiP) award in 2013 and has an above-average score for Acute Trusts on the engagement guestions in the National NHS Staff Survey for 2013.

Occupational Health

The Trust hosts the collaborative Cheshire Occupational Health Service which is delivered in partnership with East Cheshire NHS Trust. The service provides occupational health facilities to staff in both Trusts as well as to a

number of other NHS organisations and the private and public sector.

The Service supported the Trust in exceeding the national target for the annual influenza campaign ensuring that staff and, in turn, patients were protected. The service also worked in conjunction with the Human Resources Department to deliver significant improvements in the management of both long and short term sickness absences.

The Service continues to work collaboratively with other NHS Occupational Health Units to explore innovative ways of ensuring sustained future delivery of services.

Sickness Absence Data

Trusts which have lower sickness absence, turnover and agency spend nearly always have better patient satisfaction, quality of care, and use their resources more effectively. The Trust has reviewed data in this area and in 2013 saw a turnover rate of 8.49% which was within the target range of 5-12% (depending on specific location). The Trust also had a sickness absence rate of 3.6% which was approximately 0.7% less than the 2012 year, representing an in-year 15.7% reduction in sickness absence. 2014 will see a continued focus on supporting staff to improve their health and wellbeing in order to promote better health and prevent sickness absence.

Formal Arrangements for Consultation and Negotiation

Effective communication and engagement between the Trust and its staff-side representatives is supported in a number of ways. The formal consultation and negotiation arrangements in place within the Trust are the Joint Consultative and Negotiation Committee and the Joint Local Negotiation Committee for medical staff. These committees meet regularly in accordance with their Terms of Reference and are attended by both management and trade union colleagues who represent staff from across the Trust. As part of the Terms of Reference, the committees are responsible for providing information and assurances to the Board of Directors that the Trust is safely and appropriately managing all issues relating to the formal consultation and negotiation of terms and conditions of employment, policies and procedures, employee relations issues and employee engagement.

Where organisational change takes place in a particular department or services area, consultation takes place in accordance with the Trust's Managing Organisational Change Policy. The aim of the policy is to mitigate the effect of any such change wherever possible, with the intention of retaining the valuable skills and experience of the workforce whilst engaging and involving staff throughout this process.

Policies in relation to Disabled Employees & Equal Opportunities

The Trust has an Equality, Diversity and Human Rights in Employment Policy which provides a framework within which the Trust will ensure that the legislative and regulatory requirements in Equality Diversity & Human Rights in employment are fully met and works towards excellent practice.

The Trust's Recruitment & Selection Policy is applied for selection processes. The Trust is a 'two ticks employer' and as such will offer an interview to all disabled applicants who meet the essential requirements for the job. This policy applies to both new staff and promotional appointments.

The Trust's Managing Attendance Policy sets out the arrangements for how the Trust will manage attendance and look to make reasonable adjustments to enable staff be able to continue their current or alternative role. Support is provided by Occupational Health as appropriate.

The Trust's Mandatory and Essential Learning Policy and the Study Leave Policy apply to all staff including disabled staff.

Equality information, including that related to disabled staff, is available on the Trust's website. In further relation to disabled employees, the Equality, Diversity and Human Rights Policy states the Trust will be a provider of first class services that are equally accessible to, and appropriate for, all who are entitled to use them. In producing the policy, the Disability Resource Centre and the

Disability Information Bureau were consulted and one of the specific equality strands covered by the policy is Disability.

All Trust policies and services must be equality impact assessed and this includes the impact on people with a Disability, for example learning disabilities, physical disability, sensory impairment and mental health problems. All employment practices are monitored against Equality, Diversity and Human Rights metrics.

Stakeholders Relations and Partnerships

Details of strategic alliances and collaborations can be found in the Business Review in Chapter 3 with information on partnership working with patients, relatives, carers and the public noted below. Further detail can be found in the Quality Account in Chapter 8.

Partnering Patients & the Public

The Local Government and Public Involvement in Health Act (2007) relates to the duty of NHS bodies to involve and consult service users. According to the Act, NHS bodies including Foundation Trusts must make arrangements for people who receive or may receive services to be involved in:

- The planning of the provision of services
- Developing and considering proposals for changes in the way those services are provided
- Decisions to be made affecting the operation of those services.

Whether through direct consultation, the provision of information, or in other ways, the Trust continued to directly involve service users (or their representatives) in planning both the provision of new services and changes to existing services. The Quality Account (Chapter 8) details examples of involving services users and/or their representatives in service provision.

The Quality Account also provides information on Patient & Public Involvement activities such as collecting patient feedback either through patient surveys, patient stories, the Friends & Family Test and Patient Register Group meetings.

The Customer Care Team also plays a key role in providing advice, information and support for patients and relatives.

Partnering Volunteers

The Trust's volunteer team continues to grow with nearly 300 registered volunteers. Last year saw several changes in the Voluntary Services Department including a review of training, expansion of volunteer roles and partnerships with new organisations. New volunteers now benefit from an induction programme specifically tailored to meet their needs including training on Awareness of Dementia, End of Life situations, Patient Passports whilst also hearing from ward managers on their expectations.

Volunteer roles have also been developed. The Trust now has volunteers on Ward 21B who interact with patients either through talking, reading or playing board games. A joint venture with the JET Library saw the securing of funding to purchase books designed to stimulate memory and discussion and a collection of short story books and poems to support this new role. Other new volunteer areas include Cardiac Rehabilitation, Anti Coagulation Clinic and Pathology.

One of the most exciting new developments in the department has been the discussion with, and formation of partnerships, with other community groups and businesses. Future projects will include the tidying up and replanting of garden areas of Ward 6, Ward 21B and Neonatal Intensive Care. Representatives from the 'Men in Sheds' and students from Reaseheath College will be participating in these future garden projects.

Volunteers bring a wide variety of skills and talents, and the Voluntary Services department will continue to find new roles to utilise these. The Voluntary Services department is committed to delivering a positive and engaging volunteer programme which volunteers will find rewarding and fulfilling.

Chapter 6

Council of Governors

Welcome from the Lead Governor

As Lead Governor, I am again pleased to be able to make my own comments, which I believe are shared by all our Governors, on the way we fulfil our obligations to represent the views of Members and the public on the running of the Trust. Governors have an important role in holding the Board of Directors to account for continuing to deliver high quality patient care.

It has been a challenging year for the Trust with increasing patient demand and resources continuing to remain stretched. Despite this. however, the Council of Governors and I continue to receive positive remarks from patients and their relatives about the care they receive. We do take adverse comments seriously but these are far outweighed by enlightening reports from Governors communicate satisfied patients. with a wide range of individuals and groups, both formally and informally, and we continue to seek new ways in which we can improve our representative role with all members of the community.

Governors welcome the improvements to the Trust's Estate in the Maternity Unit and the new Theatres and Critical Care provision. These developments ensure that the Trust's infrastructure provides the most up to date facilities for the local community. We also look forward to the new Main Entrance to the Leighton site.

From a Governor perspective there is an effective working relationship with the Board of Directors, characterised by open, frank and honest discussions. Governors are kept informed of, and are consulted about, performance, challenges and developments in patient services. Without this mature relationship we could not meet our obligations.

I am pleased to put on record my thanks to all Governors, including those who have recently stood down, for the many and varied ways in which they contribute to the success of the Trust. Attendance at committee meetings is an important element, but equally, if not more important, is Governor interaction with patients and relatives through a variety of means, such as the Patient Safety Walkrounds and volunteer activities.

To conclude, I feel privileged to be associated with the Trust and I wish to thank my fellow Governors for their support and confidence.

John Lyons Lead Governor

Introduction

The Board of Directors is held to account for its stewardship of the Trust by the Council of Governors who, in turn, are elected largely by the Members of the Trust. The Trust's Council of Governors was formed with effect from 1 April 2008 and comprises 30 Governors, consisting of 23 elected Governors who represent membership constituencies, as follows:

Public Constituency – 10 Governors

- The area of Congleton (and other surrounding areas) part of Cheshire East (2)
- The area of Crewe & Nantwich (and other surrounding areas) part of Cheshire East (4)
- The area of Vale Royal and all other parts of Chester & Cheshire West (4).

Patient & Carer Constituency – 6 Governors

- The class of Patient (4)
- The class of Principal Carer of a patient aged 16 years or more (1)
- The class of Principal Carer of a patient aged 15 years or less (1).

Staff Constituency – 7 Governors

- The class of Medical Practitioners and Dental Staff (1)
- The class of Qualified Nursing & Midwifery Staff (1)
- The class of Other Professionally Qualified Clinical Staff (1)
- The class of Clinical Support Staff
 (1)

- The class of Non-Clinical Support Staff (1)
- The class of Recognised Representatives of Trades Unions and Staff Organisations (1)
- The class of Volunteers (1).

The Trust's Constitution also notes that seven appointed Governors who represent a range of lay partner organisations were selected to enhance the Trust's ability to contribute more widely to the public and social benefit. There are currently six appointed Governors on Council, representing the following organisations:

- Cheshire East Council (Mandatory Appointment)
- Cheshire West & Chester Council (Mandatory Appointment)
- Chamber of Commerce (Non Mandatory Appointment)
- Manchester Metropolitan University (Non Mandatory Appointment)
- NHS South Cheshire Clinical Commissioning Group (Mandatory Appointment)
- NHS Vale Royal Clinical Commissioning Group (Mandatory Appointment).

As at 31 March 2014 there were three Governor vacancies, as follows:

Community and Voluntary Service Cheshire

- East and Cheshire Community Development Trust (Appointed Governor)
- Carer of a Patient aged 15 Years or less (Elected Governor)
- Carer of a Patient aged 15 Years or more (Elected Governor).

A term of office for Governors is three years and the term of the majority of the Trust's Governors expired on 31 March 2014. In January 2014, the Trust, working with Electoral Reform Services, went to election in a number of Constituencies and also invited those partnership organisations to appoint a Governor, effective 1 April 2014. The results of the election can be found in Chapter 7.

The names of the Governors and details on the constituency they represented, as at 31 March 2014, are noted below. Details of attendance at Council of Governor meetings are also noted. Since 1 April 2013 the Council of Governors has met formally on five occasions:

- 25 April 2013
- 25 July 2013
- 17 October 2013
- 30 January 2014
- 28 March 2014 (Extraordinary Meeting).



Appointed	Term Expires	Council Meeting Attendance				е		
		25 April	25 July	17 Oct	30 Jan	28 Mar		
rea								
Elected	31 March 2014	Yes	Yes	-	Yes	Yes		
Elected	31 March 2014	-	Yes	Yes	Yes	Yes		
ntwich Area								
Elected	31 March 2014	Yes	-	Yes	Yes	-		
Elected	31 March 2014	Yes	Yes	Yes	Yes	Yes		
Elected	31 March 2014	Yes	Yes	Yes	Yes	Yes		
Elected	31 March 2014	Yes	Yes	Yes	Yes	Yes		
Area								
Elected	30 May 2015	Yes	Yes	Yes	Yes	Yes		
Elected	31 March 2014	Yes	-	-	Yes	-		
Elected	31 March 2014	Yes	Yes	Yes	Yes	-		
Elected	31 March 2014	Yes	Yes	Yes	Yes	-		
Elected	31 March 2014	-	-	Yes	Yes	_		
Elected	31 March 2014	Yes	-	-	Yes	-		
Elected	31 March 2014	-	Yes	Yes	Yes	Yes		
Elected	21 Jan 2016	Yes	Yes	-	Yes	Yes		
ntal Practitio	ner							
Elected	31 March 2014	-	Yes	Yes	Yes	Yes		
sing & Midwi	ferv Staff							
Elected	31 Dec 2016	n/a	n/a	n/a	Yes	Yes		
ionally Ouali	ified Clinical							
		Yes	_	_	Yes	Yes		
	5 : Maion 2014	100				1.00		
ort Staff								
Elected	31 March 2014	-	Yes	-	Yes	-		
Staff – Non Clinical Support Staff								
Elected	30 June 2016	Yes	-	-	-	-		
Staff Organisa	ations & Trade Ur	nions						
Nimmo, Peter Elected 31 March 2014			Yes		-	Yes		
olunteers								
Elected	31 March 2014	Yes	Yes	-	Yes	-		
	rea Elected	Elected 31 March 2014 Elected 31 March 2014 Intwich Area Elected 31 March 2014	Elected 31 March 2014 Yes Elected 31 March 2014 Intwich Area Elected 31 March 2014 Yes Elected 31 March 2014 Sing & Midwifery Staff Elected 31 March 2014 Yes Interview of the property o	25 April 25 July rea Elected 31 March 2014 - Yes Yes Elected 31 March 2014 - Yes Yes Elected 31 March 2014 Yes Yes Yes Elected 31 March 2014 Yes Yes Yes Elected 31 March 2014 Yes Yes	25 April 25 July 17 Oct	25 April 25 July 17 Oct 30 Jan		

Continued overleaf

Constituency Elected/ Appointed Te		Term Expires	Council Meeting Attendance				
			25 April	25 July	17 Oct	30 Jan	28 Mar
Appointed Governor	rs						
Colman, Paul – Chamber of Commerce		31 March 2014	Yes	ı	-	Yes	-
Flude , Dorothy – Cheshire East Council		31 March 2014	Yes	ı	-	-	-
Fowler, Neil – Manchester Metropolitan University		31 March 2014	n/a	n/a	Yes	Yes	Yes
Griffiths, Jonathan – Clinical Commissioning Group		31 March 2014	-	Yes	-	Yes	Yes
Moore Dutton, Eveleigh – Cheshire West & Chester Council		31 March 2014	-	Yes	-	Yes	-
Wilson, Andrew – Clinical Commissioning Group		31 March 2014	n/a	-	-	Yes	-

The term of the Governor representing the Class of Carer of a Patient aged 16 Years or more came to an end on 2 July 2013 with the Governor choosing not to re-stand for election.

Name	Constituency	Retirement Date	Council Meeting Attendance			•	
			25 April	25 July	17 Oct	30 Jan	28 Mar
Stalker, Pat	Patient & Carer – Carer of a Patient Aged 16 years or more	July 2013	Yes	n/a	n/a	n/a	n/a

2013/14 saw the resignation of two Governors from the Council of Governors.

Name	Constituency	Retirement Date	Council Meeting Attendance			•	
			25 April	25 July	17 Oct	30 Jan	28 Mar
Coombes, Sarah	Staff & Volunteers Constituency – Qualified Nursing & Midwifery Staff	28 August 2013	Yes	Yes	n/a	n/a	n/a
West- Burnham, Dr Joss	Appointed Governor – Manchester Metropolitan University	31 August 2013	Yes	-	n/a	n/a	n/a

Roles & Responsibilities

2013/14 saw a review of the Trust's Constitution which included incorporating requirements under the Health & Social Care Act, Monitor's revised Model Constitution, current practice and advice from the Trust's Legal Advisors. The review included a revision of Governor roles and responsibilities and the appropriate section of the Trust's Constitution is included below:

The Council of Governors is accountable for several key functions that form part of the governance framework of the Trust:

- to provide advice to the Board of Directors, which the Board of Directors shall take into account in setting the strategic direction of the Trust within the overall policies and priorities of the Trust and the NHS, defining its annual and longer term objectives, and agreeing plans to achieve them
- to exercise leadership, enterprise, integrity and balanced judgment in the discharge of its role and functions within the Trust
- to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole Trust
- to oversee the overall delivery of planned results by monitoring performance against objectives and ensuring appropriate action is taken when necessary
- to develop effective dialogue with the Board of Directors so that there can be effective dialogue between the Trust and the local community on its plans and performance, and that these plans and performance are responsive to the community's needs
- · to maintain relationships with members.

The statutory duties of the Governors are to:

- Hold the Non-Executive Directors, individually and collectively, to account for the Performance of the Board of Directors
- Represent the interests of the members of the Trust as a whole and the interests of the public
- Appoint and, if appropriate, remove the Chair
- Appoint and, if appropriate, remove the other Non-Executive Directors
- Decide the remuneration and allowances and other terms and conditions of office of the Chair and other Non-Executive Directors

- Approve (or not) any new appointment of a Chief Executive
- Appoint and, if appropriate, remove the NHS Foundation Trust's Auditor
- Receive the Trust's annual accounts, any report of the auditor on them, and the annual report at a meeting of the Council of Governors
- Approve a Significant Transaction
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution
- Approve proposals to increase by 5% or more the proportion of the Trust's total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England
- Determine whether the level of non-NHS work specified in any financial plan by the Trust would significantly interfere with its principal purpose which is to provide goods and services for the health service in England, or performing its other functions and to notify the Board of Directors of its determination
- Approve amendments to the Trust's Constitution.

The Council of Governors also has a number of additional functions, as follows:

- In preparing the Trust's forward plan, the Board of Directors must have regard to the views of the Council of Governors
- The Council of Governors may require one or more of the Directors to attend a Governors' meeting to obtain information about performance of the Trust's functions or the Directors' performance of their duties and to help the Council of Governors to decide whether to propose a vote on the Trust's or Directors' performance
- The Council of Governors may refer a question to Monitor's new Advisory Panel for Governors as to whether the Trust has failed or is failing to act in accordance with its constitution or the NHS Act 2006.

The Foundation Trust Network continues to host a Governor Development Programme, known as Governwell, and the Council of Governors has been advised of future sessions should individual

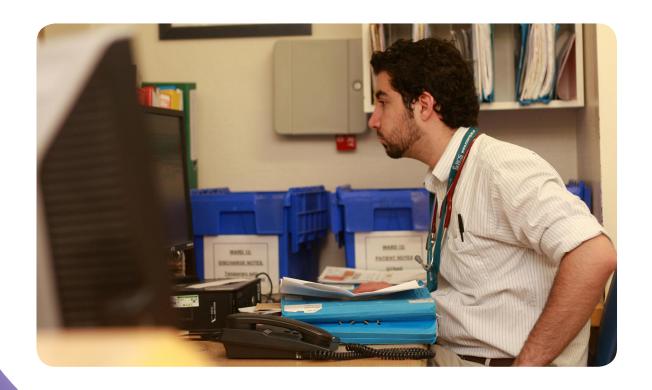
Governors wish to attend. 2013/14 also saw the continuation of the Trust's Governor Development Programme with Governors receiving information sessions on a number of key topics including those which were pertinent to the Trust.

A full induction programme was scheduled for April 2014 for those new and existing Governors. This programme will be supported by additional training and information sessions throughout 2014/15 to ensure Governors have the ongoing skills and knowledge to carry out their duties whilst also keeping them informed of key items.

Governors are also encouraged to attend North West Governor Forums to be kept abreast of topical national issues and also to network with Governors from local Trusts.

The Acting Trust Secretary holds a register of Governors' Interests which is available for public inspection at the Foundation Trust Headquarters. Should you wish to view the register please contact the Trust on 01270 612128. The following interests were recorded for 2013/14:

Governor	Interest	Seeking to do business with health authorities	Has business dealings with the Trust
Mrs C Cooper	Ray of Hope (Voluntary Organisation)		Yes
Dr J Griffiths	NHS Vale Royal Clinical Commissioning GroupGP Partner at Swanlow Practice	Yes	Yes
Dr A Wilson	 NHS South Cheshire Clinical Commissioning Group GP Partner at Ashfields Primary Care Centre 	Yes	Yes



Governor Involvement

A number of Council of Governor committees are established and membership is shown below. Governors also continue to be involved in other work at the Trust, details of which are also outlined.

Membership of Council Committees as at 31 March 2014

Committee	Current Members	Meeting Dates
Membership & Communications Committee	Barbara Beadle Paul Colman Kevin Dawson John Lyons Jerry Park Gerry Phillips	15 April 2013 13 May 2013 8 July 2013 12 August 2013 9 September 2013 14 October 2013 13 November 2013 9 December 2013 13 January 2014 14 February 2014 14 March 2014
Nominations & Remuneration Committee	Dorothy Flude Michael Hadfield John Lyons Jerry Park	4 April 2013 10 July 2013 3 October 2013 13 January 2014 22 January 2014 25 February 2014 12 March 2014
Strategy Committee	Donald Bone Christine Cooper Nigel Dibben Michael Hadfield John Lyons Harry Mawdsley Eveleigh Moore-Dutton	8 April 2013 3 June 2013 5 August 2013 7 October 2013 2 December 2013 3 February 2014

Governors are also invited to sit on Trust Committees and Governor representation, as at 31 March 2014, is detailed below:

Patient Experience Committee: Jenny Creed

Kevin Dawson Dorothy Flude Norman Harris Andrew Ritchings Heather Williams

Infrastructure Committee: Brian Walton

QuESt Committee: Harry Mawdsley

Christine Cooper

Strategic Integrated Governance Committee: Paul Colman

Heather Williams

Governors were given the opportunity to become more involved in important Trust activities through a number of additional forums including:

- Clinical Services Strategy development
- Complaints Review Panel
- Patient Safety Walkrounds
- Patient Representatives on Divisional Boards
- Annual Plan Workshop
- Member and Public Engagement Events
- Patient Surveys (through the Public & Patient Involvement Programme)
- Patient Falls Group
- Clinical Audit Committee
- · Research & Development Committee
- Task Group to review the Trust's Constitution
- Attending Chief Executive Briefing/ Engagement Sessions.

The Trust also ensures Governors are made aware of events being hosted by other local health organisations such as the Clinical Commissioning Groups which may be of interest to them and which will enhance their knowledge and understanding within their role as Governor.

Lead Governor

Mr John Lyons was re-appointed as Lead Governor effective from 1 April 2013. In his role as Lead Governor, Mr Lyons attended a number of Board of Directors meetings and was able to meet with the Chairman following the Board of Directors meeting where there was the opportunity to raise any issues of concern or seek clarity on any agenda items discussed.

Senior Independent Director and Deputy Chair April 2013 saw the retirement of Dr Alan Wood, the Trust's Senior Independent Director and Deputy Chair. At the Council of Governors meeting of 25 April 2013, Mr Dennis Dunn was appointed as Deputy Chair following a proposal by the Governor Nomination & Remuneration Committee. Council also noted the appointment of Mr David Hopewell as Senior Independent Director following his appointment by the Board of Directors.

General engagement with Governors and Members

In addition to the Council of Governor's meetings and the membership on various committees and groups, the Trust continued to focus on gaining the views of Governors and Members as follows:

- Annual Plan Workshop for Governors
- An extensive engagement programme based on the key themes from the Francis Inquiry into the failings at Mid Staffordshire NHS Foundation Trust, the themes from which have informed the Trust's Quality Improvement Strategy 2014-16
- Moving Forward Event. An event hosted by the Trust which saw a number of local health organisations come together and present on the future of health and social care services in Cheshire
- Attendance by Governors at the Trust's Clinical Service Strategy events
- Work continues with the Youth Committee to be a voice for young people
- Meetings with local community groups
- Governors have attended, at the invitation of members, local community groups to meet and discuss activity of the Trust.

2013/14 saw a review of the Membership Strategy with a key focus for 2014/15 continuing to be membership engagement with the Engagement Plan being reviewed regularly by the Governor-led Membership & Communications Committee. The period also saw the appointment of a Membership & Communications Support Officer who, as part of their role, is working to establish further links with the community.

A number of forums are in place to ensure the Board of Directors, and in particular the Non-Executive Directors, have the opportunity to meet with Governors to understand and discuss their views and those of the Members and the public. As noted, members of the Board of Directors attend Council of Governor meetings. At the end of the public meeting, the public and members of the Board of Directors leave the Council of Governors, who then have a private

meeting with the Chairman. Non-Executive Directors have also attended Governor-led Committee meetings such as the Membership & Communications Committee and the Governor Strategy Committee. Non-Executive Directors, with Governors, also carry out Patient Safety Walkrounds. Board Members and Senior Managers from the Trust also attend other forums in which Governors became involved.

Also, Governors are invited to attend a Governor Planning Event (Annual Plan Workshop) where they are given the opportunity to give their opinion and that of their Members and representative bodies on the Trust's forward plans. In 2014/15 the Trust will put in a place a more structured process for collating the views of the Members and the public.

2013/14 also saw a number of informal meetings of the Non-Executive and Council of Governors. A number of additional meetings will be scheduled throughout 2014/15.

Nominations & Remuneration Committee

The Committee is established by the Council of Governors in accordance with the Constitution and chaired by the Chairman of the Trust. The work of the Committee is to:

- Assist in the process to select and appoint the Chairman and Non-Executive Directors of the Trust;
- Determine the remuneration of the Chairman and Non-Executive Directors;
- Assist in monitoring and evaluating the performance of the Chairman and Non-Executive Directors.

The Committee report back recommendations to the Council of Governors for approval.

The Chairman shall not be present where the Chairman's performance or appointment is under discussion.

The Committee met seven times during 2013/14 and the dates of the meetings together with details of attendance are noted below:

	4 April 2013	10 July 2013	3 Oct 2013	13 Jan 2014	22 Jan 2014	25 Feb 2014	12 March 2014
Mr J Moran (Chairman)	Yes	Yes	Yes	n/a	n/a	n/a	Yes
Ms S Coombes	Yes	Yes	n/a	n/a	n/a	n/a	n/a
Cllr D Flude	n/a	Yes	Yes	Yes	Yes	Yes	Yes
Mr M Hadfield	Yes	-		Yes	Yes	-	-
Mr J Lyons	Yes	-	Yes	Yes	Yes	Yes	Yes
Mr J Park	Yes	Yes	Yes	Yes	Yes	Yes	Yes

The Committee were supported in their duties by the Chief Executive, the Senior Independent Director and the Director of Service Transformation & Workforce.

	4 April 2013	10 July 2013	3 Oct 2013	13 Jan 2014	22 Jan 2014	25 Feb 2014	12 March 2014
Mrs T Bullock	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mr D Hopewell	n/a	n/a	Yes	Yes	Yes	Yes	Yes
Mr D Pitt	n/a	n/a	n/a	Yes	Yes	Yes	Yes
Dr A Wood	Yes	n/a	n/a	n/a	n/a	n/a	n/a

The April 2013 meeting was held to discuss the Annual Appraisal of the Chairman and Non-Executive Directors and included for discussion was the overall skill-base/mix of the Non-Executive Directors. The Committee were satisfied that the appraisal process was fair. The Committee also discussed the appointment of a Deputy Chair and unanimously recommended the appointment of Mr Dennis Dunn which was proposed, for approval, to the Council of Governors meeting of 25 April 2013.

The meeting of July 2013 saw discussion on the remuneration of the Deputy Chair and Senior Independent Director. Previously Dr Wood had filled both roles and had received a supplement as appropriate. In dividing the role it was recognised that each role would require separate remuneration whilst also noting the remuneration and supplements had previously been agreed in 2008, and had not been increased since to reflect inflation. The Committee agreed to a revised individual supplement for each role and this was proposed for approval to the Council of Governors at the meeting of 25 July 2013.

The meeting scheduled for 3 October 2013 was held to discuss the Chairman's and Non-Executive Director's Interim Appraisals. Discussion also took place on the tenure expiry dates of the Non-Executive Directors during 2014/15.

In January 2014, the Chairman, Mr John Moran, notified the Trust of his retirement effective 31 March 2014. A number of Governor Nomination & Remuneration Committee Meetings took place and the Committee were involved in and directed the recruitment process culminating in the appointment of Mr Dennis Dunn as Chairman of the Trust. Gatenby Sanderson were appointed to assist in the search process with the Committee members agreeing the long list and short list of candidates. The final interview panel had a majority of Governor members and the appointment of Mr Dunn was agreed by Council on 31 March 2014 (Extraordinary Council of Governors meeting). Mr Dunn will commence substantively in post from 1 July 2014 for a three-year period and in the interim Mr Dunn will act as Interim Chairman, supported by Mr David Hopewell, Senior Independent Director.

The meeting of 12 March 2014 also saw discussion on the Chairman's and Non-Executive Directors' Appraisals and Non-Executive Director Remuneration. The Committee also discussed the tenure of the Non-Executive Directors.



Chapter 7

Membership

Membership Commentary The Foundation Trust membership in total has

The Foundation Trust membership in total has declined by 2.8% over the year. The table below shows the membership size and movement with estimates for 2014/15.

Membership Size and Movements

Public constituency	Last year	Next year (estimated)
At year start (1 April)	4,378	4,100
New members	168	325
Members leaving	446	225
At year end (31 March)	4,100	4,200

Staff constituency	Last year	Next year (estimated)
At year start (1 April)	2,869	2,980
New members	502	400
Members leaving	391	380
At year end (31 March)	2,980	3,000

Patient constituency	Last year	Next year (estimated)
At year start (1 April)	1,403	1,329
New members	51	220
Members leaving	125	100
At year end (31 March)	1,329	1,449

The key focus for the coming year will continue to be engagement with Members.

The Trust undertook a data cleanse of the Membership database during 2013/14 and the figures highlighted a number of Members who had moved away or were deceased. Work continues to contact those Members who are recorded as 'possible move aways'. The

Trust will continue to ensure the Membership target of 8,000 is retained whilst also ensuring proportional representation of Membership.

The Trust has worked to encourage Members from the Class of Carer of a Patient aged 15 years or less and the Class of Carer of a Patient aged 16 years or more to stand for election however, vacancies remain for these Classes on the Council of Governors. We will continue to work with the local Carer support groups to promote and encourage Membership.



Analysis of Current Membership

Public constituency	Number of Members	Eligible Membership
Age (years) :		·
0 – 16	5	132,650
17 – 21	105	39,715
22+	3,801	532,563
Undisclosed	189	
Ethnicity:		
White	3,427	678,965
Mixed	10	6923
Asian or Asian British	28	10,157
Black or Black British	17	2,310
Other	5	1,380
Undisclosed	613	5,193
Socio-economic groupir	ngs:	
AB	1,203	59,521
C1	1,189	63,510
C2	868	41,313
DE	822	49,195
Unknown	18	491,389
Gender:		
Male	1,724	345,095
Female	2,251	359,833
Undisclosed	125	
Patient constituency	Number of Members	Eligible Members
Age:		
0 – 16	0	n/a
17 – 21	13	n/a
22+	1,316	n/a

Membership Engagement

The Trust continued to engage with Members throughout the year, via:

- Health Matters Information events including tours of Trust sites/departments
- Regular newsletters
- Website
- Annual Members meeting
- Governor meetings to which Members are invited
- Recruitment drives
- Attending staff induction events.

Governors are involved in outreach to their Members, and initiatives were held to engage with existing Members and recruit new Members at events held in the local area. Events will continue throughout 2014/15 with a particular focus continuing to be attendance at Outpatient clinics across the Trust and also attendance at Community Events across the local community.

In last year's report it was noted that the Trust was to prepare a response following the release of Robert Francis' report on the system and regulatory failures at Mid Staffordshire NHS Foundation Trust. It was also noted that the Board of Directors had agreed that it should be a patient/public led response. During 2013/14, the Trust conducted an extensive engagement programme based on the key themes from the Francis Inquiry and the consultation exercise has informed the Trust's new Quality & Safety Improvement Strategy that will run from 2014 to 2016 inclusively.

During 2013/14, the Trust also hosted a number of public engagement events such as the Moving Forward event which saw a number of local health organisations come together and present on the future of health and social care services in Cheshire. Follow-up events have been scheduled for 2014/15.

Work continues with the Trust's Youth Committee to engage with young members.

Reports on Membership and plans for developing, recruiting and engaging Members are presented to the Performance & Finance Committee and the Council of Governors, through the Governor-led Membership & Communications Committee.

Members can contact the Board of Directors and Council of Governors through the Membership Office.

How to become a Member of Mid Cheshire Hospitals NHS Foundation Trust

Members of the public and patients treated at the Trust who are interested in its affairs t can become a Member. Eligibility criteria are as follows:

Public Member: an individual can become a public Member if he/she is aged 16 years or over and lives within the specified areas of Cheshire East Local Authority and Cheshire West & Chester Local Authority, namely the area of Congleton (and other surrounding areas) of Cheshire East, the area of Crewe & Nantwich (and other surrounding areas) of Cheshire East and the area of Vale Royal and all other parts of Cheshire West and Chester.

Patient & Carer Member: an individual can become a patient & carer Member if he/she is aged 16 or over and has been a patient or carer of a patient at the Trust within five years preceding the application for Membership.

Staff & Volunteers Member: Staff automatically become Members unless they choose to optout. An individual may become a Member if they are registered with the Trust to undertake voluntary work or is registered with a voluntary organisation that is accredited by the Trust to undertake voluntary work at the Trust's premises or in services managed by the Trust.

Analysis of Election Turnout

The Trust went out to election three times during 2013/14.

In April 2013, Members in the Staff & Volunteers Constituency, Class of Non-Clinical Support Staff, were invited to stand for election, following the expiry of tenure of Mr Brian Walton. Mr Brian Walton was re-elected, effective July 2014, with the following voting report received:

Number of eligible voters	850
Total number of votes cast	134
Turnout	15.8%
Number of votes found to be invalid	0
Number of votes blank or spoilt	0
No declaration forms received	0
Total number of valid votes to be counted	134

Members of the Patient & Carer Constituency, Class of Carer of a Patient aged 16 years or more, were also invited to stand for election. No Members came forward to stand.

November 2013 saw Members within the Staff & Volunteers Constituency, Qualified Nursing & Midwifery Staff, invited to stand for election, following the resignation of Mrs Sarah Coombes. Mrs Elizabeth Price was appointed unopposed, effective 1 January 2014.

The third term of the Trust's Council of Governors commenced on 1 April 2014, with the exception of a small number of Classes which were appointed during 2013/14. In January 2014, the Trust invited Members to stand in the remaining constituencies to stand for election.

Elections to the remaining Public, Staff & Volunteers and Patient & Carers constituencies, were held in accordance with the Trust's Constitution and were hosted by the Electoral Reform Service. Within the following constituencies the candidates were elected unopposed:

Public Constituency

 The area of Congleton (and other surrounding areas) part of Cheshire East (2 Governors)

Staff & Volunteers Constituency

- Medical Practitioners and Dental Staff (1 Governor)
- Other Professionally Qualified Clinical Staff (1 Governor)
- Clinical Support Staff (1 Governor)
 - Recognised Representatives of Trade Unions and Staff Organisation (1 Governor)

In the remaining constituencies,

a number of candidates stood for election with the following voting reports received:

The Class of Patients (Three to elect)

Number of eligible voters:	1,243
Total number of votes cast:	271
Turnout:	21.8%
Number of votes found to be invalid:	4
Number of votes blank or spoilt	4
No declaration forms received	0
Total number of valid votes to be counted	267

The area of Crewe and Nantwich (and other surrounding areas) part of Cheshire East (Four to elect)

Number of eligible voters:	1,743
Total number of votes cast:	420
Turnout:	24.1%
Number of votes found to be invalid:	5
Number of votes blank or spoilt	5
No declaration forms received	0
Total number of valid votes to be counted	415

The area of Vale Royal and all other parts of Cheshire West & Chester (Four to elect)

Number of eligible voters:	1,524
Total number of votes cast:	360
Turnout:	23.6%
Number of votes found to be invalid:	2
Number of votes blank or spoilt	2
No declaration forms received	0
Total number of valid votes to be counted	358

Quality Account

Part 1 Statement on quality from the Chief Executive

Hello and welcome, I am pleased to present our fifth published Quality Account for the period of April 2013 to March 2014.

I am sure you will agree that the report demonstrates that 2013/14 has been a period of continued improvement for the Trust, with many significant achievements in quality, safety and experience. Although it has not been without its challenges and disappointments.

The Francis report published in February 2013 rightly brought about significant learning to the forefront for the NHS. The Trust viewed this as not the end of a public enquiry but the beginning of something much larger, a conversation for both the public and the professionals to take part in as owners and guardians of our hospitals services. Extensive listening events and conversations with staff and the public were held during 2013 and what we heard during these conversations helped shape and focus our new Quality Improvement Strategy for 2014 to 2016.

This Quality Account demonstrates delivery beyond the expected national standards and improved quality, safety and experience for our patients and staff through the delivery of the final year of our current 5 year Quality Strategy: 10 out of Ten.

Alongside this we have delivered additional quality improvements such as reducing pressure ulcers, reducing readmissions and cancellations amongst others.

We value and seek extensive feedback from patients through a range of sources, such as national and local surveys, the Friends and Family test, NHS choices. All show improvements in the care and service we offer whilst providing us with valuable feedback which we will use to continue our improvement journey.

There have also been significant challenges during 2013/14; we continue to prioritise reducing our mortality rate and are confident we are taking all appropriate actions to do so. Over the last two-three years, the Trust achieved exceptionally low rates of infection. However, sustaining this has been challenging during 2013/14. Whilst levels of infections remained low and we performed very well nationally in this area, we had more *c-difficile* and MRSA than in the previous year. As a result, significant work is underway to ensure we regain our position as one of the top performers in the country.

Finally, I want to take this opportunity to thank our staff, they do an incredible job, sometimes in very difficult circumstances and always with the patient in mind. I would also like to extend my appreciation to our Governors, Members, Patient Representatives and other Stakeholders who have helped shape our quality programme by taking time out to support and advise us.

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

This report also demonstrates that the Trust has a number of assurance mechanisms in place which demonstrate how we scrutinise the quality of the care that we deliver. Examples of these are the extensive audit program and the nursing acuity tool used to ensure correct staffing is in place.

I hope you enjoy reading this Quality Account and find it of value. We are continually striving to improve our care and would therefore welcome any feedback you may have.



Tracy Bullock

Chief Executive
Mid Cheshire Hospitals NHS Foundation Trust
tracy.bullock@mcht.nhs.uk



Throughout the document, there may be terminology that is not very familiar to readers. Where possible, the Trust has tried to write clearly in a user friendly way. However, some elements in the quality account are prescribed by the Department of Health or Monitor. To help readers, there is a glossary of terms at the back of the document in Appendix 1.

Part 2

Priorities for improvement and statements of assurance from the Board

Priorities for improvement in 2014/15

During 2013/14, the Trust conducted an extensive engagement programme based on the key themes from the Francis Inquiry into the failings at Mid Staffordshire Hospital NHS Foundation Trust. This consultation exercise has informed MCHFT's new Quality and Safety Improvement strategy that will run from 2014 to 2016 inclusively.

The overall purpose of the new strategy is to support the delivery of the organisation's vision and mission:

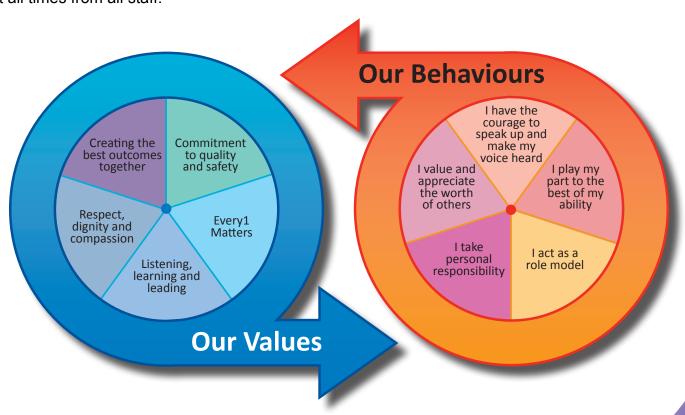
"To Deliver Excellence in Healthcare through Innovation and Collaboration"

The Trust will be a provider that:

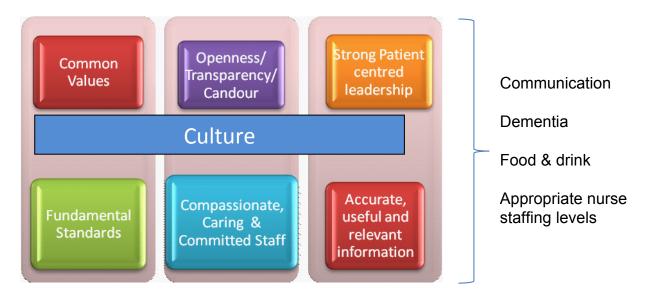
- Delivers high quality, safe, cost-effective and sustainable healthcare services
- Provides a working environment that is underpinned by values and behaviours
- Is committed to patient-centred care
- Treats patients and staff with dignity and respect.

The strategy links closely with other key strategies such as the Clinical Services strategy and the Organisational Development strategy. It is when these work hand in hand that collectively the Trust can deliver the vision and mission of the organisation.

The values and behaviours developed with the Trust's staff underpin the delivery and success of the strategy. The Trust recruits and nurtures its staff so that these values and behaviours are observed at all times from all staff.



The strategy is based on what the people of Vale Royal, South Cheshire and the surrounding areas told the Trust they wanted from their hospitals in addition to national priorities and contributions from Governors and staff. The public told the Trust they wanted a strong focus on:



In addition, staff, Governors and other stakeholders told the Trust they wanted the following areas to be included:

- Improving staffing levels
- Reducing cancelled appointments
- Improving paperwork and reducing duplication
- Reducing pressure ulcers.

The subsequent development of the Quality and Safety Improvement strategy has allowed the Trust to focus its key areas of improvement under the three domains of quality as determined by the Health and Social Care Act 2012. The strategy is ambitious but achievable.

Patient Experience

Improving nutrition and hydration for patients

"The Trust will continue to provide an environment that promotes healthy nutrition and is tailored to individual patient need."

Supporting patients with dementia and their carers

"The Trust will support patients who have concerns about their memory and will work with patients who have dementia and their carers to promote a positive experience whilst in hospital."

Improving communication

"The Trust will ensure that staff improve their understanding of patients and their care needs. The Trust will use this knowledge to communicate effectively with patients and involve them in their care."

Clinical Effectiveness

Improving documentation and reducing duplication

"The Trust will review and improve its paper documentation so that it is relevant, adds value to care and avoids duplication."

Reducing cancellations

"The Trust will reduce the number of hospital initiated outpatient clinic cancellations by 20% by 2016."

Improving staffing levels and skill mix

"The Trust will ensure it has levels of staffing and skill mix that meet the needs of its patients."

Patient Safety

Reducing pressure ulcers

"The Trust will eliminate avoidable hospital acquired pressure ulcers by 2016."

Sharing learning from feedback and incidents

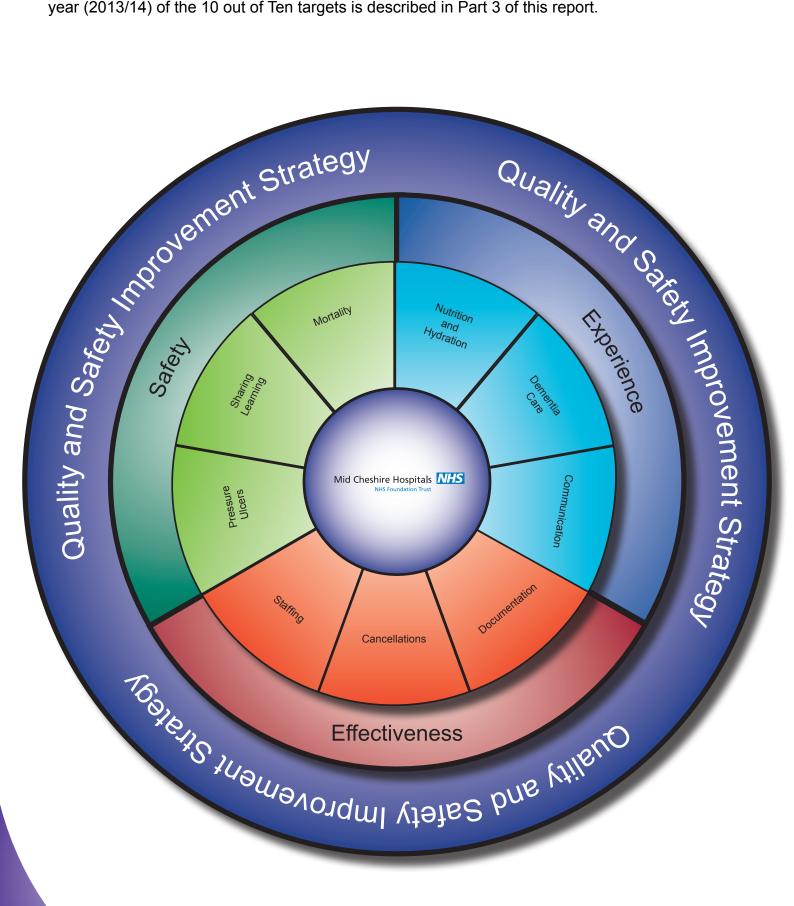
"All clinical staff will work together to respond to feedback from patients and carers and to learn from incidents that occur. The Trust will then ensure it responds to such learning and embed this into practice."

Reducing mortality rates

"The Trust will reduce its mortality rates each quarter so that they reach expected levels as measured by the Summary Hospital-Level Mortality Indicator (SHMI)."



The logo for the Trust's Quality and Safety Improvement strategy is shown below. This will be used to promote Trust-wide awareness of the strategy and has replaced the 10 out of Ten strategy on which the Trust has focussed its quality priorities for the past five years. Progress against the final year (2013/14) of the 10 out of Ten targets is described in Part 3 of this report.



Monitoring and reporting of the Quality and Safety Improvement Strategy

Each element of the strategy will have a responsible lead who will report progress bi monthly to the Quality, Effectiveness and Safety Committee (QuESt).

QuESt is responsible for providing information and assurances to the Board of Directors that the Trust is safely managing the quality of patient care, the effectiveness of quality interventions and patient safety. These elements of the strategy will have objectives that will require both qualitative and quantitative evidence of achievement.

QuESt will review the key areas of improvement at its meetings to ensure progress is being made in relation to the aims and keys areas for achievement.

In addition, progress of the key areas of improvement will also be reported in the annual Quality Account. This report will be made available to the public on the Trust's website and NHS Choices and will also be included in the Trust's Annual Report and Accounts.



Statements of assurance from the Board

Review of services

During 2013/14 the Trust provided and / or sub-contracted 39 relevant health services.

The Trust has reviewed all the data available to it on the quality of care in all of these services.

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

Feedback from patients

National Patient Surveys

To improve the quality of services that the NHS delivers, it is important to understand what patients think about their care and treatment. The Care Quality Commission use national surveys to find out about the experience of patients when receiving care and treatment from healthcare organisations.

National Inpatient Survey 2013/2014

Between October 2013 and January 2014, a questionnaire was sent to 850 adult inpatients who had been admitted to Leighton Hospital.

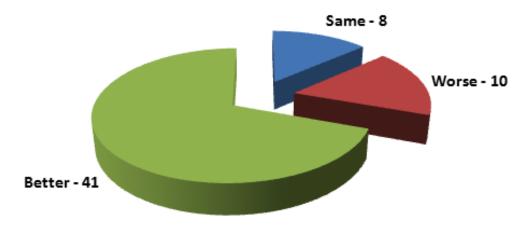
Responses were received from 442 patients which equates to a response rate of 54% of completed eligible returns.

The collated results of this survey show that the Trust performed about the same as other Trusts in all categories:

- The emergency department
- · Waiting to get a bed on the ward
- The hospital and the ward
- Doctors
- Nurses
- Care and treatment
- Leaving hospital
- Overall views and experiences.

The Trust's overall score has improved by 2.2% since the last survey undertaken in 2012.

Chart 1: Comparison of responses from 2013 national inpatient survey (when compared with results from the 2012 survey)



Areas identified for improvement

- Communication a "before you leave hospital checklist" has been developed to explain to patients what needs to happen to ensure they go home safely.
- Noise at night a 'quiet protocol' is being developed to reduce unnecessary noise at night. A good night's sleep is important for every patients' recovery. The 'quiet protocol' will be active from 11pm to 6am every night where staff will work hard to keep noise levels to a minimum.

Before You Leave Hospital Checklist

We undestand that, if the doctor or healthcare professional has add you can go home today, you will war to be sieve a soon as possible, However, we will need to sieve a soon as possible, However, we will need to sieve a soon as possible, However, we will need to sieve a soon as possible, However, we will need to sieve as soon as possible, However, we will need to sieve as soon as possible, However, we will need to sieve as soon as possible, However, we will need to sieve as soon as so

Patients also commented on what was particularly good about their care:

A very good atmosphere on the ward created by the medical staff, who were caring and professional and clearly loved working as a team on 'their' ward.

I was in hospital for one day and night and was impressed by care administered to all patients on the ward. The food was delicious and added to a patients' recovery.

I would like to say that the healthcare assistants were very helpful and kind to me. Also, I would like to say that all the staff were superb.

The care received during my hospital visit was excellent from Accident and Emergency through to my admittance to a ward. There was nothing to fault during my whole stay, the food and choice was also excellent.

The surgeon was pleasant, informative and spoke to me as an equal. I knew she was very busy but she didn't rush me at all.

National Maternity Survey 2013

During 2013, a questionnaire was sent to 300 women who had experienced the Trust's maternity services. The Trust achieved a 51% response rate, with 152 completed surveys returned.

The Trust scored better than other Trusts for one question: Being given appropriate advice and support at the start of labour.

The Trust also scored better than other Trusts on one section of questions in the survey: Labour and Birth.

The Trust performed about the same as other Trusts in all other categories and questions.

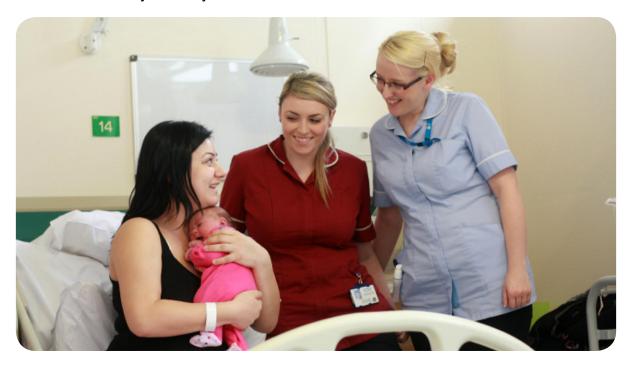
Women also commented on what was particularly good about their care:

I was very pleased with all of the care I had throughout all of my pregnancies and deliveries in this area. I always felt safe and happy with how I was treated. Thanks.

The new maternity unit with pools/balls/bean bags was excellent. Once in room (after assessment) the care from my midwives was outstanding.

Both my community midwife and the midwife whilst I was in labour were exceptional. I did come into contact with other midwives but my main midwife was fabulous.

In addition to the survey results, a significant programme of work is in place to improve breast feeding initiation rates. This has already delivered an increased rate and the maternity unit has also achieved Level Two Baby Friendly accreditation.



Local patient surveys

The Trust has an annual patient and public involvement programme which includes a variety of methods for patient involvement, such as local patient surveys.

In 2013/14, 41 local surveys were undertaken. Once feedback has been collated from these surveys, action plans are developed to address any issues identified from the results. These action plans are then monitored by the Action Group for Patient Experience.

A sample of the results from randomly selected surveys are highlighted below:

Early Pregnancy Assessment Unit

43 responses were received from a sample size of 97.

The results showed that:

- 91% said the waiting time was appropriate
- 100% said they were told what to expect at the appointment
- 97% said the care they received in the scan room was delivered in a sensitive manner
- 100% said that the sonographer explained things in a way they could understand
- 97% were treated with privacy and dignity
- 100% rated the care as very good or excellent.

Key issues included:

- · Patients felt signage could be clearer
- GPs did not always make patients aware of the referral criteria
- Patients were not always advised to take a seat in the dayroom.

Changes implemented following the survey:

- Patients now receive a telephone call to talk about their referral and where the unit is situated
- GPs have received verbal explanations of the referral criteria
- A sign has been introduced to advise patients upon arrival to take a seat in the day room.

Pharmacy Survey

128 responses were received via a touch screen survey kiosk. The kiosk is an electronic, mobile device which allows patients and visitors to complete surveys online.

The results showed that:

- 94% of patients said pharmacy staff were approachable
- 95% of patients found the information included in their medication helpful
- 95% of patients said they were treated with privacy and dignity when they visited the pharmacy department.

Key issues included:

- Lack of signage to the pharmacy department
- Patients not always informed of any delays upon arrival to pharmacy
- Lack of privacy when patients were having conversations with the pharmacist in the waiting area.

Changes implemented following the survey:

 New signage has been installed for the pharmacy department from both outpatients and the main entrance

- Patients are advised of any delays as soon as they arrive in the pharmacy department
- A new counselling room has been made available for patients to have confidential conversations.

Infection Control Survey

57 responses were received from a sample size of 75.

The results showed that:

- 96% of patients said the environment of the ward was clean, fresh and pleasant
- 100% of patients said the showers were clean and tidy and always ready to use
- 97% of patients said the alcohol hand rubs were readily available
- 98% of patients said the overall appearance of the ward was tidy and uncluttered.

Key issues included:

- Infection control leaflets were not always available for patients and relatives
- Infection control posters were not displayed on all wards
- Hand washing wipes were not always offered to patients before and after meals.

Changes implemented following the survey:

- Leaflets are readily available on all wards and posters are displayed in all areas to raise the importance of infection control for visitors and patients
- Patient meals are now accompanied with single use hand wipes.

Friends and Family Test: Patient Element

The NHS Friends and Family Test is a nationwide initiative to gain feedback from patients about the care and treatment they receive in hospital. Patients are asked whether they would recommend NHS services to their friends and family if they needed similar care or treatment. This is believed to be an important indicator of the quality of care they have received.

The Friends and Family Test is completed on the adult wards, the emergency department, assessment areas and maternity services. Every patient that receives treatment in those areas can give feedback about the quality of care they have received.

Responses are anonymous and patients are asked to complete a survey card which can be handed to a member of staff or posted into a confidential post box. Patients attending the emergency department can choose to complete the survey on a touch screen kiosk, which has a multi-language option.

In October 2013, the Friends and Family Test commenced in Maternity using SMS text messages at four points across the care pathway: antenatal, labour ward, postnatal ward and postnatal community.

How are the results calculated?

The results of the Friends and Family Test are calculated and reported in a consistent and transparent way using the net promoter score (NPS). The overall result can range from 0 to 100 and is calculated by the number of respondents who are extremely likely to recommend the service minus those who are neither likely, unlikely or extremely unlikely to recommend the service.

Patients are invited to comment on the reason for the answer they give. Comments have included:

My reason is the total and efficient willingness and care given to me when I needed it plus their friendliness and interest and I mean medical, household and any other staff - my sincere thanks to all.

From the first day the staff have been attentive, caring, and I have not waited for the toilet or medication. My only feedback is that beds should be ready for patient on day of operation and when you are being discharged, they should not be rushed out. All in all fantastic care.

I felt that I was given a level of care and respect that made me feel I wasn't just 'a number' on a very busy and multi-disciplined surgical ward. The nurses who cared for me demonstrated a good knowledge of my procedure and always encouraged me to ask for any additional help or support if I required it.

Trust Results

The following charts show the percentage response rate for patients and the Trust is delighted that the required national target specified as part of the CQUIN programme has been achieved. The charts also show the net promoter score results.

68 66 20% 64 62 15% 60 58 10% 56 54 5% 52 0% 50 Jul-Dec Mar Jun-Aug Sep Oct-Nov Jan-Apr 13 13 -13 -13 14 -14 -13 -13 13 -13 -14 13 F&FT A&E & Assessment Areas 11% 17% 17% 16% 15% 15% 21% 18% 12% 14% 14% 18% Response Rate

57

65

Net Promoter Score

64 60

56 58

66

58

59

59

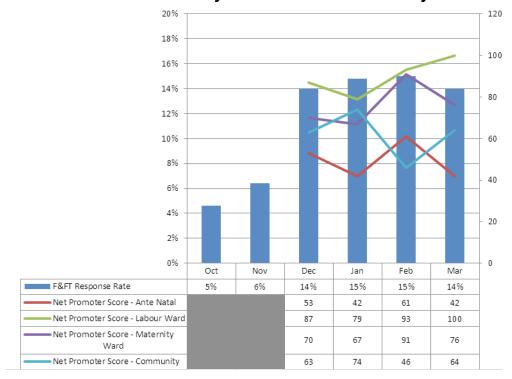
63

Chart 2: Friends and Family Test results from the Emergency Department (A&E) and the Assessment Areas

Chart 3: Friends and Family test results from the inpatient wards



Chart 4: Friends and Family test results from maternity services



Posters are displayed in the emergency department, assessment areas, the wards and maternity unit to promote the score achieved and to highlight patient comments.

What could be improved?

The Trust is carefully monitoring comments from patients if they indicate they are unlikely to recommend our services to understand where improvements can be made. Nearly 10,000 responses have been received to the Friends and Family test, with 94% of patients indicating that they are likely or extremely likely to recommend services or treatment to their family or friends.

Examples of actions taken so far have been a change in the hospital menu to include soup as a lunch time option, reducing unnecessary noise at night and offering ear plugs to help patients sleep.

The Friends and Family results are published on the NHS Choices website: www.nhs.uk/Services/hospitals/Overview/DefaultView.aspx?id=505 www.nhs.uk/Services/hospitals/Services/Service/DefaultView.aspx?id=208744

NHS Choices

Patients can comment about their experience on the NHS Choices website. There were a total of 130 new postings on the NHS Choices website in 2013/14. Proportionally, the Trust receives more postings than most other Acute hospitals in the country. Leighton Hospital is currently achieving a star rating of 4.5 stars out of a maximum rating of 5 stars and the Victoria Infirmary in Northwich is achieving the maximum 5 stars.



The Trust displays examples of postings on notice boards and takes action following any suggestions for improvement.

Staff in the Macmillan Unit were polite, friendly, helpful, caring and they knew exactly what I needed.

I gave birth to a lovely baby boy thanks to a lovely midwife and doctor.

The eye care clinic is highly professional and I would certainly recommend the unit to anyone who needs to be treated here.

Staff were first class, the treatment and attention I received was outstanding at the minor injuries unit at Victoria Infirmary Northwich.

The care given to me on ward 12 was fantastic. Thank you all very much.

The team who dealt with me in the Urology department were first class professional; they treated me with dignity and patience.

I have been and continue to be impressed by the care which I received in the Dermatology clinic.

All the staff were fantastic and I am seriously considering a change in career to join them.

Other patient and public involvement programme activities

Patient register group meetings

These meetings are held at local libraries. The group consists of volunteers and members of the public who assist the Trust with various methods of involvement and is an opportunity for the Trust to share news of developments and seek views from members. This year, the meetings covered many topics, including presentations about the new theatre rebuild project, the enhanced recovery programme and the neonatal unit project.

Readers' panel

The panel has increased its membership by 17 over the past year and now has 77 members. The panel has reviewed a total of 17 leaflets including information about eye care, attending the fertility clinic and the paediatric audiology service.

The panel has submitted many suggestions including grammatical changes and diagram or picture changes. Overall, feedback about the information reviewed has been that the leaflets are enlightening and will be very helpful to patients.

Patient information committee

Membership of the committee has recently been expanded and now includes three patient representatives, staff from orthopaedic outpatients, the emergency department, the treatment centre, information governance, the Macmillan unit, pharmacy and the maternity unit. In 2013, the committee reviewed and approved 23 local patient information leaflets.

In 2012, the Trust introduced a patient information bedside folder. The folder has subsequently been revised and includes information in relation to visiting times, staff uniforms, discharge information, a sample of the new inpatient menu and a 'your views count' section. The folder is also available in Polish.



INVESTOR IN PEOPL

All wards have been restocked with the updated version of the folder, along with the maternity and neonatal bedside folders which have also been recently updated.

Over the last 12 months the Trust has increased the number of leaflets available in easy read version, including caring for your plaster cast and having a blood test.

Patient stories

The Board of Directors' meetings continue to start with a patient story which is presented as a video clip, audio account or letter. The story relays the very real and personal experiences of an individual who has been a patient or carer at the Trust. A theme has emerged this year, highlighting the value of ensuring the carer's voice is heard. The patient's story is always shared with the relevant team, ward or department and examples are included in customer care training.

The stories are a combination of positive and negative experiences which ensure that the Trust's agenda is grounded in the value of listening to and learning from the experience of patients and carers.

Planning the delivery of services

Whether through direct consultation or through the provision of information the Trust continued to directly involve service users (or their representatives) in planning both the provision of new services and changes to existing services.

The Ophthalmology department have set up a support group for patients who have glaucoma and their friends / family. Feedback from attendees to date has been excellent and has allowed the Trust to discuss plans to undertake diagnostic tests at glaucoma clinics by senior ophthalmic technicians, which will improve the quality of tests being undertaken and reduce appointment times.

Similar support group meetings have taken place with people who have had a stroke and people who have head and neck cancer to discuss how services can be redesigned to improve experiences of patients.

During 2013/14, the Trust has been an active member of the local area partnership which has resulted in links being developed to support health and wellbeing of the local community. The Trust has also continued to work with its youth committee to increase the involvement of young people across the Trust and ensure their feedback is included in service redesign.

Customer care team

The role of the customer care team is to provide on-the-spot advice, information and support for patients and relatives if they wish to raise concerns. The team can also support patients when dealing with issues about NHS care and provide advice and information about local health services. The customer care team aims to respond to patients' concerns and issues on time and effectively, irrespective of whether they have been raised as an informal concern or a formal complaint. The majority of concerns can usually be resolved swiftly by staff who care for patients. However, sometimes patients or a family member may want to talk to someone who is not involved in their care and the customer care team are then able to help.

A new 'Tell us what you think' poster has been developed and displayed across the Trust. It provides information on how to contact the team and reinterates that the Trust welcomes feedback in relation to concerns, complaints, advice, information, suggestions and compliments.

Compliments

2,112 formal compliments were received by the Trust during 2013/14 which expressed thanks from patients and families about the care received. This is a significant increase compared with previous years. All compliments are shared with the relevant teams who are mentioned.

Table 1: Overview of compliments received by the Trust

	2011/12	2012/13	2013/14
Number of compliments received	495	644	2,112

Review of Complaints

The Trust adheres to the Local Authority Social Services and National Health Service Complaints Regulations (England) 2009 and follows the Principles of Good Complaint Handling outlined by the Parliamentary and Health Service Ombudsman.

It is recognised that the NHS landscape, in terms of legal and statutory duties in handling complaints, is undergoing a fundamental change of culture in response to the Francis Report (2013) and the Ann Clwyd and Professor Hart review of complaint handling within the NHS (2013). As part of the Trust's commitment to continuous improvement, the complaints policy is being reviewed to ensure that the recommendations identified are incorporated into the effective and compassionate management of complaints.

The Trust is committed to providing an accessible, fair and efficient service for patients and service users who wish to express their concerns or make a complaint with regard to the care, treatment or services provided by the Trust.

The Trust recognises the importance of having a robust and flexible process for the management of complaints to ensure complainants receive a timely and person-centred response to the issues they have raised.

The complaints review panel is chaired by a Non Executive Director and has membership which includes Director of Nursing, a Governor and Patient Representative. The panel reviews individual cases of closed complaints and follows best practice as recommended by the Patient's Association in monitoring progress against action plans undertaking and detailed reviews.

A poster has been introduced and shared with staff to illustrate improvements that have been made as a result of feedback from patients or their carers. An example is included opposite.



Patient Experience Feedback and Action Taken



Here are some examples to show how we have responded to feedback from patients

What you said:

"There was no mirror in the bathroom for me to shave nor a shelf for my toiletries" What we did: Replaced the mirror and installed a shelf



What you said:

"There is no seating outside the outpatient department for patients waiting for taxis" What we did: Installed a seat near the outpatients exit



What you said:

"Please make sure my wife is assisted with her drink as her hands shake due to Parkinson's disease" What we did: Introduced new cups with lids to avoid the risk of spills



What you said:

"The metal ramp at the entrance to A&E was uncomfortable for patients when arriving in the hospital on an ambulance trolley"

What we did: Replaced the ramp

Replaced the ramp with a smoother plate at the ambulance entrance to A&E



You Said, We Did Flyer January 2014

The following table shows the number of complaints received by the Trust and referrals to the Ombudsman over the past three years.

Table 2: Overview of complaints received by the Trust

	2011/12	2012/13	2013/14
Number of complaints received	192	199	228
Number of requests for review by Ombudsman	10	5	3
Number accepted for review by Ombudsman	3	4	1
Number upheld/partially upheld by Ombudsman	1	2	2

Proportionally, the Trust receives fewer complaints than in England and in the North West, and is in the upper quartile in terms of this performance.

Learning disability access

Healthcare for All (DH 2008) identifies six criteria for meeting the needs of people with a learning disability which should be met by all NHS Foundation Trusts. The Trust is pleased to declare that it meets all six criteria as described below.

 Does the NHS Foundation Trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure pathways of care are reasonably adjusted to meet the health needs of these patients?

The Trust has a flagging system in place for people with a learning disability coming into the Trust. Patients can then be identified as needing specialist support at the earliest opportunity. The list is kept updated through collaboration with the Trust's community colleagues. There is also a system to flag patients who have a specialist care plan in place which highlights individual needs and documents reasonable adjustments that will need to be made for this person. A reasonable adjustment care plan/risk assessment is also available for staff to use, which is particularly helpful in a pre-operative meeting.

• Does the NHS Foundation Trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: Treatment options, complaints procedures and appointments?

A great deal of work has been done at the Trust in respect of easy read literature. The Trust has its own picture pathways in place which uses service users from a local drama group (all with a learning disability) taking part in the process. This work is ongoing and staff are currently working on the emergency department pathway. Trust staff have worked with breast screening to arrange for easy read appointment letters to be sent out to appropriate patients and also with pharmacy to devise easy read medication information leaflets.

 Does the NHS Foundation Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?

The Trust has a Dignity Matron in post who works directly with parents and carers to support them whilst their relatives are in hospital. This may include arranging open visiting, staying with the patient and obtaining meals from the hospital. Support also includes emotional support and working collaboratively to get the best outcomes for both patient and carer. Home visits are undertaken and reasonable adjustments discussed with carers to ensure the admission to hospital goes as smoothly as possible.

 Does the NHS Foundation Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?

Awareness training forms part of the three-day Healthcare Assistant Development Programme. The Trust has also introduced Autism awareness as part of the Trust's training schedule. Adult Safeguarding training is now mandatory, includes case studies, covers the five principles of the Mental Capacity Act (MCA) and best interest decision making. Ad hoc learning disability training takes place on a regular basis and training and education is a standing agenda item for discussion at the learning disability development group. There are also staff electronic prompts and guidelines on the Trust's intranet advising staff on how to best manage patients in hospital with a learning disability.

 Does the NHS Foundation Trust have protocols in place to encourage representation of people with learning disabilities and their family carers?

The Trust has a learning disability development group that has carers as part of the membership. Service users and carers are utilised in the staff training programme and staff actively seek feedback from patients and carers from their stay in hospital. The Trust asked service users what particular investigations worried them most in hospital, and these were the first picture pathways that were undertaken. The Trust is also in the final stages of building its own Changing Places facility (modified toilet and changing facilities) in the hospital, and this has been undertaken through collaboration with patients and carers.

• Does the NHS Foundation Trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public boards?

The Trust audits the use of hospital passports for people with a learning disability and has also audited the use of the MCA and 'do not resuscitate' orders for patients. These will be repeated this year as part of the safeguarding audit programme. Staff are also working collaboratively with patient safety and the community learning disability teams to investigate all patients who die in the hospital who have a learning disability to share good practice and learn lessons.



Participation in clinical audits and research

Clinical audit evaluates the quality of care provided against evidence-based standards and is a key component of clinical governance and quality improvement. The Trust produces an annual forward plan for clinical audit which incorporates both national and local projects. Progress against the forward plan is reviewed by the clinical audit committee on a quarterly basis.

During 2013/14, 32 national clinical audits and two national confidential enquiries covered NHS services that the Trust provides.

During the same period, the Trust participated in 84% of the national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible for and actually participated in during 2013/14 can be seen in Tables 3 and 4. These tables also show 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.

Table 3: National clinical audit participation 2013/14

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National Clinical Audit / Programme	Participation	% Data Submission
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	100%
Emergency Use of Oxygen (British Thoracic Society)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	Data collection in progress
National Joint Registry (NJR)	Yes	98% consent
Paracetamol Overdose (care provided in emergency departments – CEM)	Yes	Data collection in progress
Severe Sepsis and Septic Shock (care provided in emergency departments – CEM)	Yes	Data collection in progress
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Currently 70%
Bowel cancer (NBOCAP)	Yes	88%
Head and neck oncology (DAHNO)	Yes	100%
Lung cancer (NLCA)	Yes	95%
Oesophago-gastric cancer (NAOGC)	Yes	80%
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	100%
National Heart Failure (HF)	Yes	46%
National Diabetes Inpatient Audit (NADIA)	Yes	100%
Diabetes (Paediatric) (NPDA)	Yes	100%
Inflammatory bowel disease (IBD)	Yes	Registered late 17 cases*
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	Data collection in progress
Rheumatoid and early inflammatory arthritis	Yes	Data collection in progress
FFFAP: National Hip Fracture Database	Yes	95% (2012/13)

National Clinical Audit / Programme	Participation	% Data Submission
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Elective surgery (National PROMs Programme)	Yes	82%
Child health clinical outcome review programme (CHR-UK)	Yes	100%
Epilepsy 12 audit (Childhood Epilepsy)	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%
Moderate or severe asthma in children (care provided in emergency departments – CEM)	Yes	Data collection in progress
Neonatal intensive and special care (NNAP)	Yes	100%
National Comparative Audit of Blood Transfusion programme: Patient Information and Consent	Yes	Data collection in progress
NCEPOD Lower Limb Amputation	Yes	100%
NCEPOD Tracheostomy Care Study	Yes	100%

^{*} Registered for the project in the last submission month

Table 4: National clinical audit non-participation 2013/14

National Clinical Audit / Programme	Participation	Reason
National Comparative Audit of Blood Transfusion programme: Use of Anti-D		Maternity Unit resource implications – preparing for NHSLA Level 3 assessment
National Audit of Seizures in Hospitals (NASH)	No	The Emergency Department saw no benefit from the first round audit
National Cardiac Arrest Audit (NCAA)	No	Nurse specialist resource implications
Diabetes (Adult) ND(A)	No	Consultant and data collection resource implications
Paediatric asthma	No	Consultant and data collection resource implications

The reports of 20 national clinical audits were reviewed by the Trust in 2013/14. Table 5 details the actions taken / to be taken to improve the quality of healthcare provided as a result of national clinical audits.

Table 5: National clinical audit participation 2013/14 – actions taken

National Clinical Audit / Programme	Actions taken / to be taken by the Trust
National Chilical Addit / Programme	
Adult critical care (Case Mix Programme – ICNARC CMP)	A formal review of unexpected deaths continues to take place within the Trust. There are plans in place to increase ITU capacity as part of new theatre build project.
Emergency Use of Oxygen (British Thoracic Society)	Continued guidance and education for doctors and nurses in relation to routine prescribing, recording and titration of oxygen is taking place following the introduction of new pre-printed prescription charts.
Severe trauma (Trauma Audit & Research Network, TARN)	Continuing improvements in times to CT scan and the number of patients being seen by a consultant, especially when the trauma team has been activated.
Bowel cancer (NBOCAP)	Continued education of ward nurses to optimise compliance with enhanced recovery pathways and reduce inpatient length of stay and outcomes. Further local understanding of data handling to improve data collection and submission.
Head and neck oncology (DAHNO)	Work is underway to define and agree submission routes/data capture in key fields and ensure the link between the Trust and Aintree Hospital allows improved representation of local data. A pathway is under review to include pre-treatment speech and swallowing assessment.
Lung cancer (NLCA)	A business case has been supported by the Trust to increase investment in the clinical workforce that supports inpatient care in respiratory medicine.
Oesophago-gastric cancer (NAOGC)	Real time MDT data capture and ongoing work to improve data completeness is in progress. Exploration of video links to improve co-ordination with specialist MDT and further support for CNS is being taken forwards.
Acute coronary syndrome or Acute myocardial infarction (MINAP)	A quarterly review of local data compared to national results has been circulated to stakeholders which shows marked improvement in revascularisation rates and primary PCI following the implementation of the UHNS primary PCI pathway for STEMI.
National Heart Failure (HF)	A target of 70% has been set for 2014/15 for data submission. An inpatient heart failure pathway has been approved for implementation.
National Diabetes Inpatient Audit (NADIA)	New referral pathways have been implemented and changes made to the admission care bundle together with increased centralisation and specialist management of diabetes related admissions.
Diabetes (Paediatric) (NPDA)	There is evidence of high quality care in the Trust compared to peer, therefore current quality improvement strategies will be continued.
FFFAP: National Hip Fracture Database	Work continues to recruit an ortho-geriatrian.

National Clinical Audit / Programme	Actions taken / to be taken by the Trust
Sentinel Stroke National Audit Programme (SSNAP)	The stroke thrombolysis service has now increased its hours to Monday to Friday 09.00-21.00 with full support from the stroke specialist nurse.
Elective surgery (National PROMs Programme)	A PROMS (Patient Reported Outcome Measures) database has been created to enable a full case note review of patients who have reported a negative health impact post-surgery or no change to health post-surgery.
Child health clinical outcome review programme (CHR-UK)	A peer review mechanism is under consideration and an epilepsy passport is under development.
Epilepsy 12 audit (Childhood Epilepsy)	The paediatric epilepsy nurse specialist has been in post since March 2013. The next stage of audit has just commenced with the collection of patient/carer questionnaires.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Evidence of a decreased stillbirth rate following implementation of standardised documentation and customised GROW charts, supplemented with improved training for recording and plotting of charts.
Neonatal intensive and special care (NNAP)	Issues with low admission temperatures and promptness of measurement have been addressed through local audit and improvements have been made. A system has been implemented to identify patients due for 2 year follow-up so data can be completed in clinic to address data collection issue.
NCEPOD Alcohol Related Liver Disease (Measuring the Units)	Alcohol liaison service on site at Leighton Hospital and a comprehensive assessment tool with associated care pathway is in place. Provision of a safe environment for patients undergoing detoxification with a protocol for managing violence and aggression in these patients is also in place.

Three College of Emergency Medicine reports for 2013/14 were delayed by the College due to online technical issues with data submission:

- Paracetamol Overdose (care provided in emergency departments CEM)
- Severe Sepsis and Septic Shock (care provided in emergency departments CEM)
- Moderate or severe asthma in children (care provided in emergency departments CEM).

Local clinical audits

The reports of 161 local clinical audits were reviewed by the Trust in 2013/14. 32% of these audits were re-audits and 29% were related to successfully demonstrating compliance with the Level 3 requirements of the Clinical Negligence Scheme for Trusts (CNST) Maternity Clinical Risk Management Standards 2013/14.

Table 6 highlights some examples of the actions taken / to be taken by the Trust as a result of local clinical audits to improve the quality of healthcare provided.

Table 6: Examples of actions taken following local clinical audits

Local Audit	Actions taken / to be taken by the Trust
Audit of Obstetric Pre- Existing Diabetes	A diabetic care record for pregnant women with pre-existing diabetes has been implemented. Patient information leaflets have been developed in conjunction with the diabetes team which have been included in updated clinical guidelines and staff awareness sessions.
Audit of Pre and Post Oncoplastic Breast Reconstruction	
Re-Audit Of Management Of Upper GI Bleeding	A new integrated care pathway pro-forma incorporating NICE guidelines and Rockall scoring system for patients presenting with Upper GI bleeding has been implemented. This includes assessment and documentation of the pre-endoscopy Rockall score.
Audit of the Efficacy of Saebo Upper Limb Splints for use with Stroke Patients	Clinical criteria have been established for the suitability of Stroke patients who will benefit from Saebo Flex and Saebo Stretch splints as part of their rehabilitation. All static Physiotherapists and Occupational Therapists working on the Stroke Unit have been trained to assess, fit and use the technology in accordance with the criteria.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust between April 2013 and December 2013 that were recruited to participate in research approved by a research ethics committee was 304.

The chart below shows the numbers of patients recruited to clinical trials over the past nine months. There were, on average, 33 patients recruited each month.

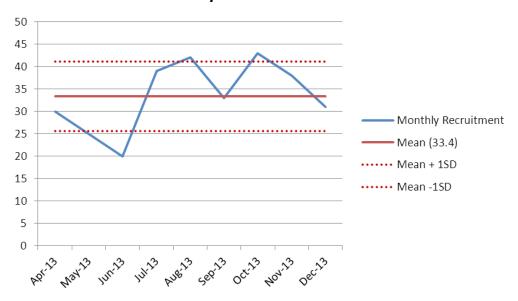


Chart 5: Numbers of patients recruited to clinical trials

There are ten clinical research staff participating in research approved by a research ethics committee during the reporting period. Participation in clinical research demonstrates the Trust's commitment to improving the quality of care offered and contributing to wider health improvements. Clinical staff keep up to date with the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

During 2013/14, the research department has increased the number of ways in which patients can be made aware of research in the hospital. This has been achieved through posters, leaflets, information on screens and via the 'research' tab on the Trust's internet site.

The Trust was involved in conducting 128 active clinical research studies during the reporting period including, but not limited to, the following areas:

- Cancer
- Cardiovascular
- Congenital Disorders
- Diabetes
- Eyes
- Ears
- Generic Health
 Relevance and Cross
 Cutting Themes
- Infection
- Inflammatory and Immune System
- Injuries and Accidents
- · Medicines for Children
- Musculoskeletal
- Oral and Gastrointestinal
- Primary Care
- Renal and Urogenital
- Reproductive Health and Childbirth
- Respiratory
- Skin
- Stroke.



Commissioning for Quality & Innovation framework (CQUIN)

A proportion (2.5%) of the Trust's income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2013/14 and for the following 12 month period are available online at www.mcht.nhs.uk/quality.

The financial value of the 2013/14 CQUIN scheme for the Trust was £3,725,482.

For 2013/14, there were four national CQUIN goals which focussed on the NHS Safety Thermometer, Dementia Care, Venous thrombo embolism (VTE) and the Friends and Family Test.

The Trust and the Clinical Commissioning Groups (CCGs) for Vale Royal and South Cheshire agreed a further 16 goals. The North West Specialised Commissioning Group (SCG) negotiated two goals in relation to the neonatal services provided at the Trust.

Table 7 briefly describes the goals included in this year's CQUIN and the Trust's performance against each of the CQUIN goals. It can be seen that, of the 22 goals, the Trust has achieved, or has plans to achieve, all CQUIN goals apart from implementation of the Advancing Quality (AQ) care pathway for hip and knee replacement. Actions are in place to improve the Trust's position against this element of the CQUIN.

For the Advancing Quality goals (5 - 9), the Trust has anticipated the final results. The reporting period for the advancing quality programme does not close until August 2014.

Key for Table 7 (overleaf)

Achieved

Off track but recoverable (applies only to advancing quality CQUIN where data is delayed by 4 months)

Not Achieved

Table 7: CQUIN results for 2013/14

Goal	Goal Name	Description of Goal	Status			
1	NHS Safety	To collect data in relation to pressure ulcers, falls,				
	Thermometer	urinary tract infection and VTE				
2	Dementia					
	Part 1: Assess and refer	The proportion of patients aged 75 and over to whom the case finding question is applied following emergency admission; the proportion of those identified as potentially having dementia who are appropriately assessed and the number referred on to GP services.				
	Part 2: Training	Named lead clinician for dementia and appropriate training for staff.				
	Part 3: Supporting carers	Ensuring carers feel supported.	\checkmark			
3	Venous Thrombo-embol	ism (VTE)				
		% of all adult inpatients who have had a VTE risk assessment on admission to hospital.				
	Part 2: Root cause analysis	The number of root cause analyses carried out on cases of hospital associated thrombosis.	\checkmark			
4	Friends and Family Test					
	Part 1: phased expansion					
	Part 2: response rate and improvement	Increased response rate.				
	Part 3: improvement on staff survey results	Improved performance on the staff friends and family test.				
5	Advancing Quality (AQ): Acute Myocardial Infarction	Implement the AQ care pathway for Acute Myocardial Infarction	\checkmark			
6	Advancing Quality (AQ): Heart Failure	Implement the AQ care pathway for Heart Failure	00			
7	Advancing Quality (AQ): Hip and Knee Replacement	Implement the AQ care pathway for Hip and Knee Replacement	8			
8	Advancing Quality (AQ): Pneumonia	Implement the AQ care pathway for Pneumonia	₽			
9	Advancing Quality: Stroke	Implement the AQ care pathway for Stroke	\widehat{v}			
10	Co-ordinated electronic patient records (EPR)	Implement a rolling 5 year plan with involvement from the CCGs to put in place hospital electronic patient records.	\checkmark			
11	Alcohol assessment	Implementation of a systematic assessment of alcohol consumption, provision of support and communication with primary care on discharge.	\checkmark			

Goal	Goal Name	Description of Goal	Status
12	Readmissions	Work with Commissioners to implement an action plan to reduce readmissions within 30 days of discharge.	
13	Cancellations	Reduce cancellations for elective surgery and outpatients appointments.	
14	Patient/carer focus groups	Work with Commissioners and three patient focus g develop service specifications and quality dashboard	
		Glaucoma	
		Head and Neck Cancer	
		Stroke	
15	Staff Engagement		
	Part 1: Care rounds	Implementation of care rounds.	\checkmark
	Part 2: Staff focus groups	Undertake three staff focus groups (glaucoma, head and nec cancers and stroke) to inform service specification and quality dashboards.	
		Glaucoma	
		Head and Neck Cancer	
		Stroke	
	Part 3: Shared decision making in outpatient services	Measure and evaluate shared decision making in our using the following services:	utpatients
		Cardiac rehabilitation	
		Women on the high risk antenatal pathway	
		Acne services	
16	Pressure ulcers:		
	Part 1: Training	Increase the number of eligible clinical staff in post who have attended training for pressure ulcer prevention, assessment and management.	\checkmark
	Part 2: Assessment and management	'' ' '	\checkmark

Goal	Goal Name	Description of Goal	Status
17	Prognostication and advance care planning	Identify and support patients in their last 12 months of life.	\checkmark
18	Medicines management	Reduce harm from omitted and delayed medicines in hospital.	
19	Improving inhaler technique	Measure and improve inhaler technique for inpatients.	
20	Advice line for GPs	Provide dedicated time where consultants are available on a regular basis to discuss patients' management with GPs.	\checkmark
21	Retinopathy screening	Achieve 95% screening rate for retinopathy of prematurity (RoP).	
22	Total parenteral nutrition administration	Timely administration of total parenteral nutrition (TPN) for preterm infants.	



Feedback from Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is **unconditional** which means there are no conditions on its registration.

The Care Quality Commission has not taken enforcement action against the Trust during the period April 2013 to March 2014.

The Trust has participated in the following reviews or investigations by the CQC during April 2013 to March 2014. Where required, actions taken by the Trust to address the conclusions or requirements by the CQC are described.

- 1. An unannounced inspection took place on 10 October 2013, which reviewed management of medicines (outcome 9) following minor concerns raised during the annual unannounced inspection in December 2012. The Trust was found to have made significant improvement, but the CQC felt that action was needed in relation to medication omissions. The Trust has developed an action plan to address the issues raised which has been monitored via the Trust's governance processes. The action plan included weekly ward audits to assess medication omissions which were reviewed via the divisional governance committees and monitored at the Trust's operational integrated governance committee. The requested evidence has been submitted and the Trust was reinspected against the standard on 5 March 2014 and the updated outcome from the CQC is awaited.
- 2. In January 2014, the CQC/Ofsted conducted a review of safeguarding arrangements with health providers of children and services for looked after children, young people and their families who receive services within the boundaries of Cheshire West and Chester. The combined report for health providers within the locality was overall positive and a joint action plan is in place.
- 3. The Trust received its unannounced annual inspection on 4 and 5 February 2014. This was a dementia-themed inspection. The outcomes inspected were:

Outcome 4: Care and welfare of people who use services

Outcome 6: Cooperating with providers

Outcome 14: Supporting workers

Outcome 16: Assessing and monitoring the quality of service provision.

Routine evidence requested by the CQC in relation to their inspection has been submitted. The final report is due to be published in May 2014.

In line with the new inspection approach by the CQC, the quality and risk profiles have been replaced with a new model: the Intelligent Monitoring report. This report is based on a number of statistical tests which are used to determine the thresholds of "risk" and "elevated risk" for each indicator. This information is released for every provider Trust on a quarterly basis. All Trusts have been categorised into one of six summary bands, with Band 1 representing highest risk and Band 6 the lowest risk. The Trust has been assigned Band 2.

Data Quality Assurance

NHS and General Practitioner registration code validity

The Trust submitted records during 2013/14 to the Secondary Uses service for inclusion in the Hospital Episodes 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:

- 99.8% for admitted patient care
- 99.9% for outpatient care
- 99.4% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Practitioner registration code was:

- 100% for admitted patient care
- 100% for outpatient care
- 100% for accident and emergency care.

Information Governance toolkit attainment

The attainment levels assessed provide an overall measure of the quality of data systems, standards and processes within an organisation. The Trust's Information Governance assessment report overall score for 2013/14 has increased from 72% to 78%.

There are 45 requirements in total within the toolkit. To be graded 'satisfactory', each requirement must be at level 2 or above. The Trust submission in 2013/14 showed 42 requirements are satisfactory, which is an increase from the 34 requirements submitted last year. However, the Trust remains graded as "not satisfactory" (status: red).

A Trust-wide information asset and sharing review was concluded in March 2014. The purpose of this review was to ascertain what information assets are held by the Trust and with whom information is being shared externally. This was a large piece of work which was linked to several requirements within the toolkit. Information Governance is continuing to conduct a project to renew all sharing agreements in place with third parties.

The Information Governance team supported the training of 3,781 staff, students and volunteers over the course of 2013/14 compared with 3,496 during the previous year. This is the first time the Trust has achieved the toolkit requirement of at least 95% of individuals being trained in information governance.

There have also been new policies and procedures developed within Information Governance during 2013/14, including a social media policy.

The Trust has a progressive Information Governance committee which meets quarterly and has an agenda specifically focused around the six sections of the toolkit. The outstanding requirements are highlighted at each committee and toolkit leads provide feedback on the progress of requirements.

Clinical coding error rate

In 2012/13, the Trust was one of the top performing Trusts in the payment by results clinical coding audit undertaken by the Audit Commission. This meant that the Trust did not require an external audit during 2013/14. However, an internal audit was undertaken and the error rates reported for diagnoses and treatment coding (clinical coding) were:

Primary diagnoses incorrect: 9.5%
Secondary diagnosis incorrect: 6.10%
Primary procedures incorrect: 6.4%
Secondary procedures incorrect: 8.2%.

The Trust remains very pleased with these results. Please note that the results shown should not be extrapolated further than the actual sample audited. A cross section of services was reviewed within this sample.

The Trust will be taking the following actions to improve data quality:

- Deliver the recommendations of the internal audit
- · Continue to deliver required training for all accredited coders
- Continually review coding resources and performance.



Performance against quality indicators and targets

National quality targets

 Table 8: National priority and performance standards

	2011- 2012	2012- 2013	2013- 2014	Target	Achieved?
MRSA bacteraemias	1	1	4	0	
Clostridium difficile infections	30	23	26	15	(3)
Percentage of patient who wait 4 hours or less in A&E	97.3%	95.04%	95.38%	95%	\checkmark
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways	91.1%	92.94%	91.39%	90%	V
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed non-admitted pathways	96.8%	96.96%	95.89%	95%	
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for incomplete pathways	N/A	95.6%	95.08%	92%	V
The percentage of patients waiting 6 weeks or more for a diagnostic test	N/A	0.87%	0.49%	<1%	
Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	95.4%	95.08%	95.56%	93%	V
Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected	94.6%	94.78%	95.39%	93%	V
Percentage of patients receiving first definite treatment for cancer within one month (31 days) of a cancer diagnosis	99.6%	99.25%	99.59%	96%	V
Percentage of patients receiving subsequent treatment for cancer within	98.9%	100%	99.3%	94% surgery	
31 days where that treatment is surgery or anti-cancer drugs		100%	100%	98% drugs	
Percentage of patients receiving first definite treatment for cancer within 62 days of an urgent GP referral for suspected cancer	87.9%	89.71%	90.82%	85%	\
Percentage of patients receiving first definite treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	92.9%	94.68%	94.84%	90%	V

National Quality Indicators

Since 2012/13, all Trusts have been required to report performance against a core set of indicators using data made available to the Trust by the Health and Social Care Information Centre (HSCIC).

For each indicator, the number / percentage / value / score or rate (as applicable) for at least the last two reporting periods should be presented in a table. In addition, where the data is made available by the HSCIC, a comparison should be made of the numbers / percentages / values / scores or rates of the Trust's indicators with

- a) the national average and
- b) those Trusts with the highest and lowest figures.

Table 9: The value and banding of the Summary Hospital-level Mortality Indicator (SHMI)

Date	Trust Performance	National Average	95% Upper Limit	95% Lower Limit
October 2011 - September 2012	1.13 Higher than expected	1.00	1.13	0.89
January 2012 – December 2012	1.16 Higher than expected	1.00	1.12	0.89
April 2012 – March 2013	1.16 Higher than expected	1.00	1.13	0.89
July 2012 – June 2013	1.15 Higher than expected	1.00	1.13	0.89

The Summary Hospital-level Mortality Indicator (SHMI) is one of the nationally-recognised measure of mortality used within the NHS. The Trust uses SHMI alongside the Risk Adjusted Mortality Index (RAMI) to assess its performance in this area of quality and safety.

The Trust has been working with the Health and Social Care Information Centre and the local Clinical Commissioning Groups to understand the Trust's SHMI data so that key areas for further work can be prioritised.

One factor which has impacted on the Trust's SHMI is the classification of admissions lasting less than 12 hours as assessments. Removing these low risk patients from the SHMI calculations caused the value to spike into the 'higher than expected' category. As a result, the Trust will be returning to national guidance as of 1 April 2014 and will be classifying these short-stays as admissions. This change should cause the Trust's SHMI to return to the more-accurate category of 'as expected' within 6-12 months.

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

 A series of inter-related projects to reduce the Trust's mortality rates which are currently in progress under the primary drivers of:

Reliable clinical care

Effective clinical care

Medical documentation, clinical coding and data consistency

End of life care

Leadership

The Trust invited the Advancing Quality Alliance (AQuA) to undertake a thorough review
of the Trust's mortality rates and this was concluded in March 2014. The internal
recommendations from the report are being incorporated into the Trust's mortality
action plan

- A driver diagram and gap analysis which has been developed to review the current position and develop areas for further work with regards to mortality
- A weekly mortality case note review group which is led by the Lead Consultant for Patient Safety
 has been established where themes are identified and areas for further work are developed with
 the Hospital Mortality Reduction Group.

Table 10: The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust

Date	Trust Performance	National Average	Highest Result	Lowest Result
October 2011 - September 2012	15.27%	19.0%	43.0%	0%
January 2012 – December 2012	15.67%	19.47%	42.7%	1.0%
April 2012 – March 2013	16.43%	20.38%	44.0%	1.0%
July 2012 – June 2013	14.86%	20.65%	44.1%	0%

This is an indicator designed to accompany the Summary Hospital-level Mortality Indicator (SHMI) and represents the percentage of deaths reported in the SHMI indicator where the patient received palliative care. The SHMI makes no adjustments for palliative care.

Using the same spell level data as the SHMI, this indicator presents the crude percentage rates of deaths that are coded with palliative care either in diagnosis or treatment specialty. The Trust is below the national average for palliative care coded deaths which is a positive position to be in and reflects accurate coding practice.

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

 Reviewing medical documentation, clinical coding and data consistency as part of a series of inter-related projects to reduce the Trust's mortality rates.

Table 11: The Trust's patient reported outcome measures scores (PROMS)

Date	Trust Performance	National Average	Highest Result	Lowest Result	Position Nationally
Groin Hernia	Repair				
2011-2012	10.1	8.3	21.0	0	
2012-2013	9.2	9.1	31.03	0.14	Top 60%
2013-2014	7.5	8.5	23.8	-14.4	Top 65%
Varicose Veir	n Surgery				
2011-2012	10.7	9.4	23.5	0	
2012-2013	8.2	9.3	27.2	0	Top 50%
2013-2014	NA	10	31.1	-4.33	NA
Hip Replacer	nent Surgery				
2011-2012	37.7	40.7	58.4	23.5	
2012-2013	49.9	43.7	69	0	Top 30%
2013-2014	46.8	43.8	72.4	20.4	Top 35%
Knee Replac	ement Surgery				
2011-2012	22.8	29.4	43.2	15.4	
2012-2013	52.7	31.2	52.7	0	Top performing Trust in country
2013-2014	41	34	61.4	14.4	Top 20%

The Trust considers that these results are as described for the following reasons:

• The numbers of patients undergoing varicose vein surgery at the Trust are minimal.

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

- Continuing to work closely with patients undergoing surgery within the clinical focus groups to encourage their full participation in the completion of the PROMS questionnaires before surgery and six months following surgery
- Continuing to use information leaflets which describe the process and value of the information collected through the use of the PROMS questionnaire
- Undertaking case note reviews for patients who undergo groin hernia surgery to identify opportunities to improve practice.

Table 12: The percentage of patients aged 0 to 15 readmitted to hospital within 28 days of being discharged

Date	Trust Performance	Peer Group Average
January 2011 - December 2011	9.3%	9.7%
January 2012 - December 2012	8.4%	10.3%
January 2013 - December 2013	8.8%	10.6%

The Trust is pleased to report that it continues to be significantly below peer and considers this is because of the following reasons:

- There is an open access process in place which allows the Paediatricians to discharge children
 and offer 'open' access for a limited time dependent on the child's diagnosis and where they are
 on the clinical pathway.
- In June 2011 April 2014 all paediatric admissions with a stay of less than 12 hours were revalidated and, dependent on their clinical interventions, some were reclassified as an assessment.
- The Child and Young Persons Home Care Team (speciality focused) work in conjunction with the Child and Adolescent unit and take referrals for children who are discharged and may require follow up at home. This service may prevent the need for children to be readmitted
- The reclassification of zero-day length of stay patients (those admitted for less than 12 hours) from admissions to assessments reduced re-admission rates. However, from 1 April 2014, those patients classed as assessment cases will be reclassified as admissions.

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

- Consultant paediatricians carrying out daily ward rounds seven days a week who are able to review all patients, make prompt clinical decisions and plan and co-ordinate their follow up care with the multi-disciplinary team
- The Trust is currently looking at the feasibility of introducing a nurse led 'hospital at home' service which would also support admission avoidance and reduce the need for readmissions (acute focused)
- In the last 6 months the Trust has introduced rapid access slots in Consultant clinics. The aim is
 to provide an alternative pathway for suitably identified children who would normally be seen as
 assessments or ward attender
- Introducing, in January 2014, a dedicated Advice and Guidance Service for GPs to request advice
 on the management of Paediatric patients. The aim of this pilot is to support GP colleagues and
 offer an alternative to acute admission or outpatient referral for specialist advice.

Table 13: The percentage of patients aged 16 or over readmitted to hospital within 28 days of being discharged

Date	Trust Performance	Peer Group Average				
January 2011 - December 2011	7.0%	6.6%				
January 2012 - December 2012	6.3%	6.3%				
January 2013 - December 2013	5.9%	6.7%				

The Trust is pleased to report that its readmission results continue to improve and that it is now significantly below peer and considers that this is for the following reasons:

- There has been focussed work on four specialities undertaken by the clinical divisions. They
 have reviewed readmissions for patients who have respiratory conditions, cardiac conditions,
 urology conditions or who have undergone breast surgery. Dedicated matrons have supported
 this work and implemented specific action plans to identify any issues identified
- Partnership working with a number of nursing homes within the local area, which includes joint planning for the patient's discharge back to the home.

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

- Continuing to progress collaborative working with community services
- Extending the work with nursing homes to support them in caring for their patients
- Embedding the use of patient passports for those patients with long term conditions.

Table 14: The Trust's responsiveness to the personal needs of its patients

Date	Trust Performance	National Average	Highest Result	Lowest Result
2011	72.7	75.7	87.3	68.2
2012	73.5	75.6	87.8	67.4
2013	75.9	76.9	Not published	Not published

The Trust considers that these results are as described for the following reasons:

- The result is slightly lower than the national average. The Trust has demonstrated an improvement compared with last year's results and has increased scores in every section of the Trust's responsiveness to the personal needs of its patients:
 - Access and Waiting
 - Safe, high quality, co-ordinated care
 - Better information, more choice
 - Building closer relationships
 - Clean, comfortable, friendly place to be.

Comments from patients completing the national inpatient survey reflect positive feedback following the implementation of care rounds. The highest number of comments made by patients relate to "kind and caring staff."

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

- Increasing nursing staffing levels and reviewing the skill mix on inpatient wards every six months
- Fully implementing care rounds to respond proactively to patients' needs
- Implementing a "quiet protocol" to reduce unnecessary noise at night
- Improving communication for patients when leaving hospital and fully implement a 'before you leave' checklist which fully explains what happens on the day of discharge.

Table 15: Staff employed by the Trust who would recommend the Trust as a provider of care to their family or friends (scores out of 5)

Date	Trust Performance	National Average	Highest Result	Lowest Result
2011 staff survey	3.52	3.50	4.05	2.84
2012 staff survey	3.59	3.57	4.08	2.90
2013 staff survey	3.79	3.68	4.25	3.05

The Trust is delighted to report that these results are above the national average and considers that these results are as described for the following reasons:

- Over the last year there has been a lot of focus and communication with staff about how important all staff are in improving the quality of care and services we provide
- The Trust's appraisal system has been redesigned to look at values and behaviours
- Engagement sessions with the Trust's Chief Executive have taken place which have had quality and patient experience at the heart of those discussions
- The Chief Executive delivers weekly briefs which focus on the patient safety and quality agenda
- Patient stories are told at Board meetings each month to ensure that patients are at the heart of all decisions being made by the Board
- All internal leadership programmes include a focus on patients and have had patients come and deliver presentations to participants about their experiences at the Trust
- Patients are on the Trust's judging panels for the Celebration of Achievement evening. Their perspective on what matters has been valued and we have added a Patient Choice category for nominations
- Staff focus groups run twice a year to ascertain their views and they are asked if they would they recommend the Trust as a place to receive treatment and any negative responses are discussed.

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

- Focussing on specific areas for improvement based on the national staff survey results. In particular, improving team working and communication, reducing violence and discrimination towards staff and improving the health and wellbeing of staff
- Renewing the Trust's focus on the Employee Support Advisor (ESA) service, which can support staff if they are experiencing difficulties at work, as well promoting the staff support helpline.

Table 16: The percentage of patients who were admitted to hospital who were risk assessed for venous thromboembolism (VTE)

Date	Trust Performance	National Average	Highest Result	Lowest Result
July 2013 - September 2013	97.18%	95.74%	100%	81.70%
October 2013 – December 2013	96.8%	95.8%	100%	77.7%

The Trust is pleased to report that these results are above the national average and considers that this data is as described for the following reasons:

- Patients are risk assessed for VTE on admission to the Trust. The VTE risk assessment has been included in the Trust's admission proformas to ensure that all appropriate patients have a risk assessment undertaken
- The Trust has a VTE Committee which reports into the integrated governance reporting structure.
 The group ensures that all national guidance is appropriately implemented and monitors the
 percentage of patients that are risk assessed on admission. Compliance is also monitored
 monthly by the clinical divisions
- The Trust has consistently remained above the national average for the previous two reporting periods in relation to the percentage of admitted patients who were risk assessed for VTE.

The Trust intends to take/has taken the following actions to improve this result, and therefore the quality of its service, by:

- Implementing the national guidance issued by the National Institute for Health and Clinical Excellence (NICE) relating to VTE risk assessment to ensure that all relevant patients are assessed on admission for their risk of developing a VTE
- The Trust has achieved the national CQUIN in relation to VTE risk assessment for the past three years. The VTE CQUIN target was 95% in 2013/2014.

Table 17: The rate per 100,000 bed days of cases of Clostridium difficile infection reported within the Trust amongst patients aged 2 or over

Date	Trust Performance	National Average	Average Highest Result	
2010-2011	58.3	29.6	63.6	7.1
2011-2012	16.83	21.82	50.89	4.08
2012-2013	12.9	17.3	30.8	0
2013-2014	14.6	Not published	Not published	Not published

The Trust considers this slight increase in performance is due the marginal increase in case numbers from 23 to 26 cases.

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

- Continuing use of chlorine for cleaning
- Greater reviews of antibiotic prescribing compliance and raised awareness within divisions following antibiotic audits performed by consultant microbiologists
- Case management of Clostridium difficile infection patients by the Infection Prevention and Control Service and on-going review of all side rooms used for isolation purposes to ensure effective isolation practice and appropriate clinical management
- Undertaking detailed root cause analysis on all Clostridium difficile infection cases, to highlight all relevant risk factors and potential risks for transmission to others
- Weekly Clostridium *difficile* infection clinical review group ensuring all aspects of patient management are assessed / actioned
- Two ring-fenced beds on the gastroenterology ward to ensure appropriate case management for Clostridium difficile infections
- A review of performance against other Foundation Trusts to identify any learning.

Table 18: The number of patient safety incidents reported within the Trust

Date	Trust Performance	National Average	Highest Result	Lowest Result
October 2011 - March 2012	2511	1782	3871	809
April 2012 - September 2012	2695	1812	4545	815
October 2012 – March 2013	3015	1964	4517	924

The above data demonstrates that the Trust reports more patient safety incidents than the national average and this has been consistent for all reporting periods.

Nationally, it is viewed that being a high reporter of incidents is a positive position as it demonstrates a risk aware culture within the Trust and highlights that staff are not afraid to report patient safety incidents. The majority of the incidents reported resulted in no harm to the patient, which again demonstrates a positive risk aware culture within the Trust.

The Trust intends to take/has taken the following actions to improve this result, and therefore the quality of its service, by:

- The Trust's commitment to a *Just Safety* culture which encourages staff to acknowledge when an error occurs without fear of punitive measure
- Training about incident reporting for all staff throughout the Trust. This training ensures that
 all staff in the Trust know how to report a patient safety incident and they also understand the
 importance of incident reporting.

Table 19: The number and percentage of patient safety incidents reported within the Trust that resulted in severe harm or death

Date	Trust Performance	National Average	Highest Result	
October 2011 - March 2012	2	17	64	0
April 2012 - September 2012	6	16	69	2
October 2012 - March 2013	3	16	56	1

The above data demonstrates that, whilst the Trust is a high reporter of patient safety incidents, the Trust is consistently below the national average when its data for patient safety incidents which result in severe harm or death is compared with other organisations. This is a very positive position for the Trust.

The Trust had four 'Never Events' (serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) during 2013/14. One was a drug error and three were related to retained swabs. None of the patients concerned came to harm as a result of the Never Events, although one patient had to go to Theatre for the removal of the swab. All patients involved were fully briefed on the incident.

The Trust intends to take / has taken the following actions to improve this result, and therefore the quality of its service, by:

- Undertaking a full root cause analysis for all incidents which result in severe harm or death. A
 review meeting is held following the incident investigation which is always chaired by an executive
 lead to ensure that lessons are learned and actions are implemented to prevent a recurrence
- Reporting all incidents which result in severe harm or death to the Board to ensure openness within the Trust
- Implementing the Trust's Being Open policy which ensures that, if an incident occurs which
 results in severe harm or death, the patient and / or their family are informed and the lessons
 learned and actions from the root cause analysis are shared with them in line with the Duty of
 Candour.

Performance against local quality indicators

Table 20: Performance against local quality indicators

Indicator	2011- 2012	2012- 2013	2013- 2014	Target	Achieved?
Cancelled operations (%)	1.46%	1.32%	0.83%	1.09%	
Cancelled operations – % breaching 28 day guarantee	7.9%	15.83%	16.06%	5%	8
Smoking during pregnancy	18.3%	20.55%	17.34%	< 15%	
Breastfeeding initiation rates	62.8%	60.91%	66.96%	65%	
Access to genito-urinary (GUM) clinics	100%	100%	100%	100%	\checkmark
Falls risk assessments completed	96%	96%	98%	90%	
Pressure ulcer risk assessments completed	95%	94%	99%	90%	\checkmark
Nutritional risk assessments completed	97%	95%	90%	90%	\checkmark
% of patients surveyed who felt they were treated with dignity and respect	100%	100%	100%	100%	\
% of patients surveyed who had not shared a sleeping area with the opposite sex	100%	100%	100%	100%	V



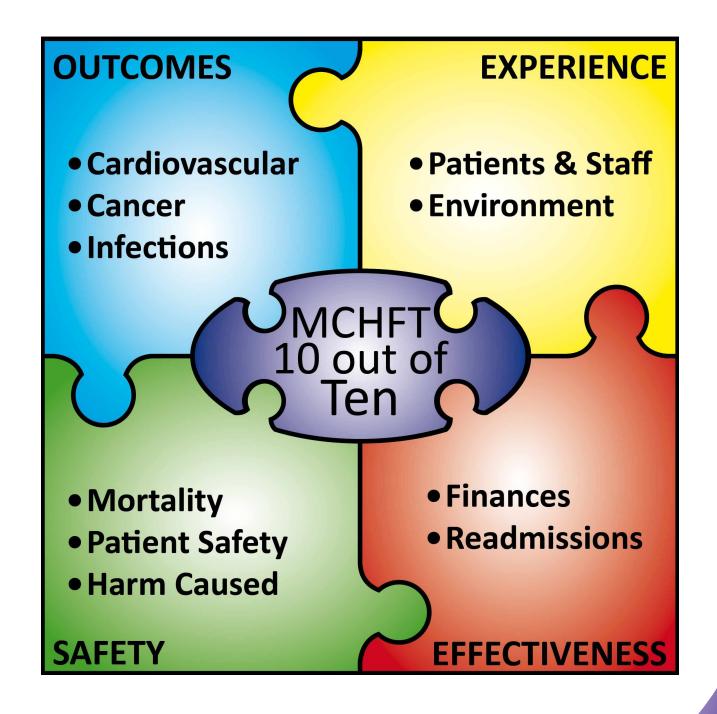
Part 3

Review of quality performance

This section of the Quality Account details progress against the final year of the Trust's five year 10 out of Ten strategy plus the Governors' choice of indicator.

This review of quality performance has been detailed under the following domains of:

- Safety
- Effectiveness
- Experience
- · Outcomes.



Summary of Overall Progress

Achievement Thresholds

As the Trust's 10 out of Ten quality indicators are stretch targets (over and above the national requirement), the achievement thresholds for the 2013/134 Quality Account have been set as Gold, Silver and Bronze.

Key



Achieved 10 out of Ten target (Top 10% of performing Trusts)



Performance in top 25% of performing Trusts or 10% away from 10 out of Ten threshold



Achieved better than peer or 25% away from 10 out of Ten threshold



Further work needed to achieve peer or better

Safety

Priority 1: Mortality – To reduce the 12 month rolling Risk Adjusted Mortality Index (RAMI) by 10 points annually



Priority 2: Patient safety - To monitor and reduce the number of unnecessary patient moves during a patient's stay in hospital



Priority 3: Harm caused - To monitor and reduce the number of patients who experience avoidable harm by 10% annually



Effectiveness

Priority 4: Readmissions – To reduce the number of patients who are readmitted to hospital within 30 days of discharge



Priority 5: Finance – To reduce the percentage of the Trust's budget that is spent on management costs



Experience

Priority 6: Patients & staff – To ensure that the ratio of doctors & nurses to each inpatient bed is appropriate for delivering safe high quality patient care



Priority 7: Environment - To monitor and eliminate mixed sex accommodation for all patients admitted to the Trust (unless based on clinical need)



Outcomes

Priority 8: Cardiovascular – To reduce the 30 day mortality rate in patients following Acute Myocardial Infarction (AMI)



Priority 9: Cancer – To reduce acute admissions and length of stay in hospital following early complications of diagnosis and / or treatment of cancer



Priority 10: Infections – To reduce the rates of Healthcare Associated Infections (HCAI)

- MRSA



Clostridium Difficile



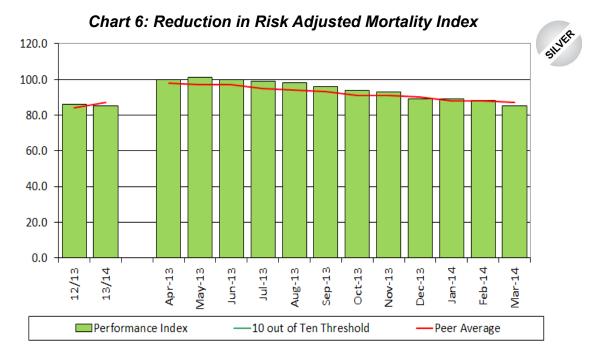
Safety

Priority 1: Mortality

To reduce the 12 month rolling Risk Adjusted Mortality Index (RAMI) by 10 points annually

In order to understand whether people are getting healthier or our Trust is getting safer, it is necessary to calculate the death rate. The crude death rate is the number of people who die in relation to the number of hospital admissions. The Risk Adjusted Mortality Index (RAMI) takes into account several factors including the relative risk of each patient's conditions and displays this as an index. In general terms, the rationale for calculating death rates in hospital is so they can be used as a measure of hospital quality.

Chart 6 shows the Trust's RAMI over the 12 month period between April 2013 and March 2014. The Trust has achieved its target to reduce its RAMI by 10 points in 2013/14. The RAMI has reduced from 100 to 89.



CHKS is the provider of comparative information for healthcare professionals. The Trust uses CHKS as its provider for its mortality data. The RAMI developed by CHKS uses regression analysis to predict the expected probability of death for each patient based on the experience of the national norm for patients with similar characteristics:

- Age
- Sex
- Diagnosis
- Procedures
- Clinical grouping
- Admission type.

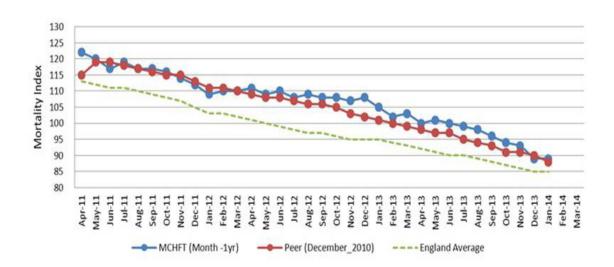
Work Programme to Improve Hospital Mortality Rates

Since 2009, the Trust has monitored the mortality rate through the Hospital Mortality Reduction Group. Data from CHKS submitted to the Board of Directors each month has shown that the Trust's RAMI has fallen year on year.

In January 2014, the Trust's RAMI was 89 compared with a peer result of 88 and an England average of 85. This is demonstrated in Chart 7. The results for February and March 2014 will be confirmed later in the year.

Chart 7: Reduction in rolling 12 month mortality trending and comparison with peer and the England average

(Source: Information Services 2014)



As mentioned on page 93, the Trust measures mortality using RAMI as well as the Summary Hospital-level Mortality Indicator (SHMI). The data provided in this report shows the Trust's SHMI as being 'higher than expected' - as a result, reducing mortality will remain as one of the Trust's key priorities and a rigorous plan of work is underway in this regard.

The work to reduce the Trust's mortality rates is being led by the Medical Director through the Hospital Mortality Reduction Group. This group reports directly to the Quality, Experience and Safety Committee (QuESt), a Board subcommittee chaired by the Chief Executive. A series of inter-related projects to reduce the Trust's mortality rates are currently in progress under the primary drivers of:

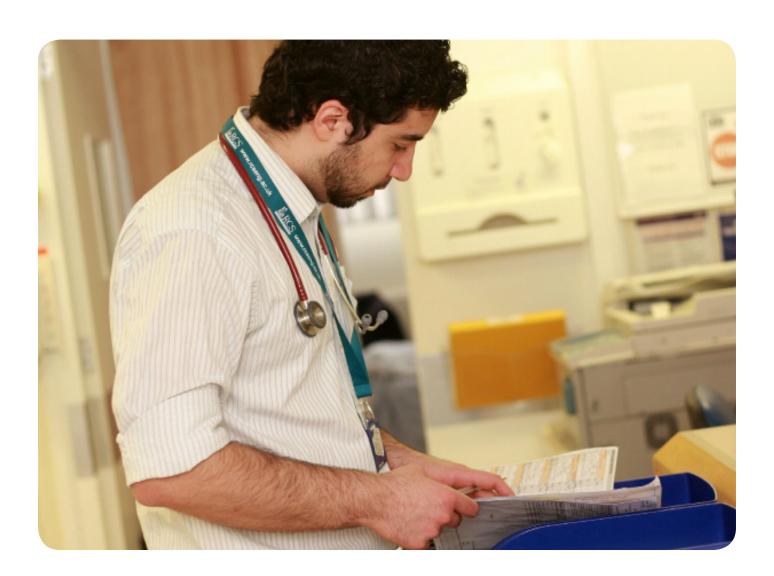
- Reliable clinical care
- Effective clinical care
- Medical documentation, clinical coding and data consistency
- End of life care
- Leadership.

A driver diagram and gap analysis has been developed to review the current position and develop areas for further work with regards to mortality. The action plan is reviewed monthly by the Hospital Mortality Reduction Group.

The Trust invited the Advancing Quality Alliance (AQuA) to undertake an in-depth review of the Trust's mortality rates in January 2014. The review was concluded in March 2014 and the internal recommendations are being incorporated into the Trust's mortality action plan.

The Trust has established a weekly mortality case note review group led by the Lead Consultant for Patient Safety. This involves a team of consultants reviewing all deaths that have occurred that week, followed by a more detailed review of all deaths where clinical care could have been more appropriate. This information is then collated at the Hospital Mortality Reduction Group in order to identify themes and areas for further work. Clinicians are also informed of any concerns or issues that have been identified and undertake a review of case notes where required.

There has also been an extensive education programme which has been compulsory for all medical staff to attend and this included case note reviews. Evaluations of this training have been very positive. A similar programme is being progressed for nursing staff over the next year.



Safety

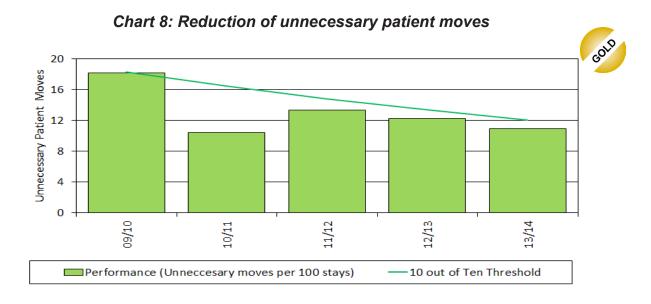
Priority 2: Patient safety

To monitor and reduce the number of unnecessary patient moves during a patient's stay in hospital

Patients appropriately move wards as part of their care pathway or if the patient's diagnosis has changed and their care transferred to another specialist. However, too many ward moves (for example to allow for the admission of acutely ill patients) can impact adversely on patient care and result in an increased length of stay in hospital. This has been particularly demonstrated for frail elderly patients and / or patients suffering from dementia. The documented goal for this priority is 'to reduce the number of times a patient is moved to another ward which is not connected with their care pathway'.

In 2010, following the launch of the Quality and Safety Improvement Strategy 2010-14, the Trust established a method of monitoring this quality indicator which involved gathering performance data from 2009/10 in order to set a target for improvement. The target set is to achieve an annual 10% reduction from the starting point in 2009/10 for the remaining four years of the strategy.

Chart 8 shows the average number of unnecessary patient ward moves per 100 hospital stays since April 2009. The chart demonstrates that the Trust has consistently over-achieved against the target on an annual basis, with an overall reduction of approximately 44% since the measure was introduced.



The Trust intends to continue to reduce the number of unnecessary patient ward moves in 2014/15 by progressing the following actions:

- Ensuring that patients are admitted to the appropriate specialty and ward to care for their needs
- Ensuring that the bed configuration matches the demand for each specialty. This is being addressed through the Clinical Services Strategy and regular bed modelling reviews with the Divisional and Corporate teams
- Continuing to reduce the time patients spend in hospital and therefore reduce any circumstance of unnecessary ward moves. This is a particular focus in the Emergency Care Division
- Ensuring that patients who have a diagnosis of dementia are not moved to another ward, unless for clinical reasons. This action is audited regularly and the last audit showed the Trust did not unnecessarily move any patients with dementia
- Working to minimise the 'night-time' movement of patients between wards, excluding patient transfers from the admissions unit to the appropriate ward.



Safety

Priority 3: Harm caused

To monitor and reduce the number of patients who experience avoidable harm by 10% annually

All patient safety incidents are reported within the Trust using the risk management system 'Safeguard Ulysses'. The Trust monitors patient safety incidents resulting in harm on a monthly basis through the Board performance report.

The Trust has a work stream for each of the top three reported incidents which are patient falls, hospital acquired pressure ulcers and safer medication. These work streams are each progressing towards reducing the number of incidents resulting in harm by 10%.

A 10% reduction in hospital acquired pressure ulcers was achieved in 2013/2014, but not for harm caused by patient falls or medication incidents.

Chart 9 shows the number of people cared for in the Trust during the last year and highlights that less than 0.5% of patients experienced harm during their treatment.

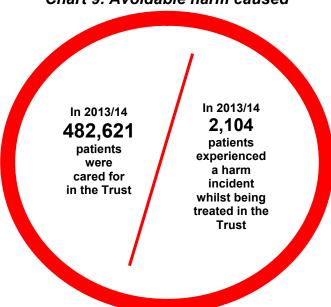


Chart 9: Avoidable harm caused

National Reporting and Learning System

The Trust reports all patient safety incidents to the National Reporting and Learning System (NRLS) on a weekly basis. The NRLS was established in 2003 and enables patient safety incident reports to be submitted from NHS organisations to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care.

The NRLS produce a comparative report on a six-monthly basis comparing similar sized acute Trusts. The most recent report was published in September 2013 and provides an overview of incidents reported by the Trusts to the NRLS between October 2012 and March 2013. This information is shown in Chart 10 which demonstrates that the Trust has a higher number of reported no harm incidents and fewer harm incidents when compared to other acute Trusts of a similar size.

The reporting of no harm incidents is seen as positive as it demonstrates that the Trust has a risk aware culture and that staff are not afraid to report patient safety incidents.

100% 90% 80% 70% 60% 40% 30% 20%

Chart 10: NRLS comparative data for October 2012 to March 2013

Unfortunately, the Trust has not achieved the stretch target of an on-going year on year 10% reduction in the number of patients that experienced an avoidable harm in 2013/14.

Low Harm

24.2%

21.4%

Moderate

Harm

6.9%

1.06%

Major Harm

0.6%

0.06%

Catastrophic

0.2%

0.03%

20% 10% 0%

All other Small Acute Trusts

■ MCHFT

No Harm

68.1%

77.4%

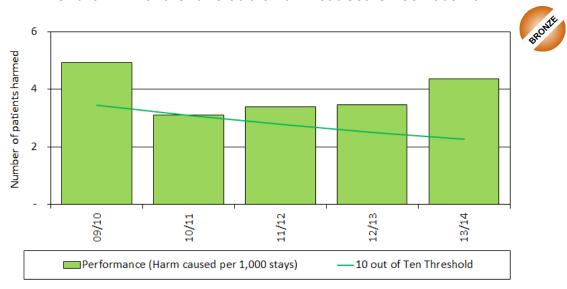


Chart 11: Trend of avoidable harm caused since 2009/10

Effectiveness

Priority 4: Readmissions

To reduce the number of patients who are readmitted to hospital within 30 days of discharge

The impact of effective discharge planning on the Trust's priority to reduce the number of patients readmitted to the hospital within 30 days has continued to demonstrate an ongoing reduction.

7% 6% 5% 4% 3% 2% 0% Apr-13 Mar-14 Jan-14 Feb-14 Jun-13 Jul-13 Aug-13 Sep-13 Oct-13 Nov-13 Dec-13 13/14 May-Performance --- Peer Average

Chart 12: Reduction in numbers of patients readmitted within 30 days

Chart 12 demonstrates that the number of emergency readmissions has fallen from 6.8% in April 2013 to 6.1% in February 2014 and, overall, the Trust's performance continues to be better than peer when compared against other acute Trusts in the North of England.

This ongoing improvement has been achieved through the continual daily monitoring of patients that are at high risk of readmission to ensure that the discharge planning meets their wider health needs.

There has been improved collaborative working with community services to ensure that patients have access to appropriate services for ongoing support together with the introduction of a patient passport for patients with complex long term conditions and specific health needs.

There has been specific work undertaken to support elderly patients admitted from nursing homes which has involved partnership working with 27 nursing homes within the local areas. This involves daily communication with the homes during the patient's stay, joint planning for discharge and a follow up phone call post discharge to the nursing home to ensure the continued wellbeing of the patient.

Further work for 2014/15 will focus on extending the work with nursing homes to support our elderly patients and embedding the use of patient passports for those patients with long term conditions.

Effectiveness

Priority 5: Finance

To reduce the percentage of the Trust's budget that is spent on management costs

On a quarterly basis, the Trust measures the percentage of income spent on management costs.

Chart 13: Trust's annual spend on management costs

During 2013/14, the Trust has continued to maintain a position lower than the target the Trust set itself.

Experience

Priority 6: Patients & Staff

To ensure that the ratio of doctors & nurses to each inpatient bed is appropriate for delivering safe high quality patient care

Nurses

Since 2008, the Trust has used the Safer Nursing Care Tool (SNCT), formerly known as the Association of UK University Hospitals Tool, to measure the acuity / dependency of individual adult inpatients to determine the required nurse staffing levels on its wards. This is the nationally recognised tool.

The acuity/dependency monitoring is undertaken Trust-wide every 6 months and the results are used to review staffing requirements and to adjust establishment budgets to meet the need of patients. Some wards within the Trust use this information on a daily basis to manage their variable acuity and staffing to best effect.

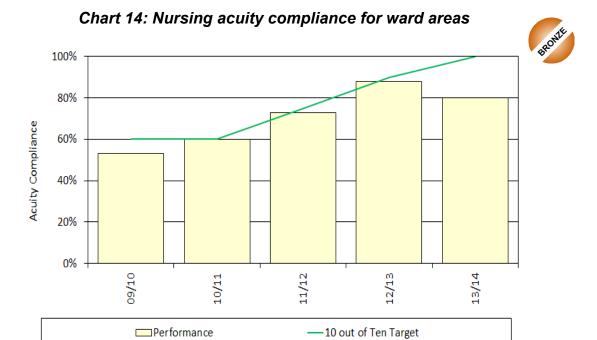
The acuity data is the closest indicator we have of the staffing needs of our patients at a point in time. The data over the past three years has demonstrated a continual increase in the level of acuity/dependency of patients across the wards. The results of the SNCT from January 2014 show an incremental improvement in staffing levels across all areas and a continued rise in the level of acuity/dependency. This continual rise in acuity/dependency is to a number of factors:

- Increasing complexity of patients' medical and nursing requirements
- Reduction in length of stay
- Increasing older population
- Increasing number of patients with dementia
- Increasing numbers of patients with long term conditions.

During 2013/14, the Trust invested approximately £980,000 in additional ward based nursing staff within the emergency care division which led to the recruitment of an additional 26 whole time equivalent nursing staff. Despite continual investment and robust recruitment plans, the acuity and dependency of patients continues to increase.

Information collated during 2013/14 has been reviewed by the Trust's Acuity group and escalated to the Divisional Boards, Workforce Assurance Committee and Board of Directors.

The aim for 2013/14 was that 100% of adult inpatient wards would be within range of their required establishment. Chart 14 shows that the Trust achieved 80% against the target of 100%.



Actions to address this shortfall have been taken which include the redeployment of staff from over established areas, robust and active recruitment plans including overseas recruitment and close working with the University of Chester to recruit the newly qualified nurses. The Trust also makes daily use of its trained and unqualified bank staff to ensure that the required staffing levels are met.

Planning for longer term recruitment has seen the Trust resume the secondment process for healthcare assistants to undertake their nurse training at the University of Chester. In March 2014, two Healthcare Assistants commenced their training and the Trust has been provided with five places for March 2015 (four general nurse training positions and one for a mental health post). In addition, the Trust held a joint recruitment event with the University of Chester to provide on-site information about the facilities both organisations have to offer prospective students. The event was extremely well attended and feedback was very positive. A further event will take place later in 2014.

Doctors

The ratio of doctors has, in the previous three years, been an element of the 10 out of Ten strategy. The data previously used to report this indicator is no longer available to the Trust. There has been extensive work undertaken to look at other information available to the Trust such as the 2011 census and consultant episodes of care. Unfortunately, this has proven not to be able to provide the information the Trust needs in a robust way to support this indicator. Therefore it is no longer possible to report against this metric.

The Trust strives to provide safe, effective and compassionate care to all its patients and is committed to ensuring appropriate staffing levels for all healthcare professionals, including doctors.

Consequently, during 2013/14, the Trust has appointed additional Consultants in Cardiology, Sexual Health, Acute Medicine, Colorectal Surgery, Paediatrics and Ear, Nose and Throat (ENT).

The Trust has also received support from the Mersey Deanery to appoint an additional training grade post in Breast Surgery and three Foundation Trainees (Junior Doctors).

The Trust's investment in additional Consultant posts will continue in 2014/15.



Experience

Priority 7: Environment

To monitor and eliminate mixed sex accommodation for all patients admitted to the Trust (unless based on clinical need)

On 1 April 2013, the Trust declared compliance in eliminating mixed-sex accommodation (EMSA). The declaration of compliance has been published on the Trust's website and reads as follows:

"Mid Cheshire Hospitals NHS Foundation Trust is pleased to confirm that the Trust is compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice."

The Trust has the necessary facilities, resources and culture to ensure that patients who are admitted to its hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed area.

Over the past year the Trust has maintained the elimination of mixed sex accommodation on all wards and departments. The only area where patients might receive care in a mixed-sex environment was within the critical care areas of intensive care and high dependency.

Robust processes are in place to ensure the breaches in these areas are kept to an absolute minimum. The critical care staff work closely with the patient placement team to prioritise patients who could breach mixed-sex accommodation and plans are immediately put in place to move these patients into same-sex accommodation as a matter of priority.

The Trust has recently opened a purpose-built Critical Care Unit, and the elimination of mixed sex accommodation was a key consideration in its build. The newly opened unit will mean patients will



no longer breach mixed sex accommodation standards and from April 2014 the Trust will not have any further breaches.

Trust volunteers have continued to ask patients on a monthly basis about their experience of mixedsex accommodation and The Trust continues to report that there have been no patient concerns raised as a result of mixed sex accommodation and none of the patients surveyed reported either sharing accommodation or washing/toilet facilities with patients of the opposite sex.

Chart 15 highlights the significant progress that has been made since last year. The numbers of breaches are reported monthly to the Trust Board and Commissioners.

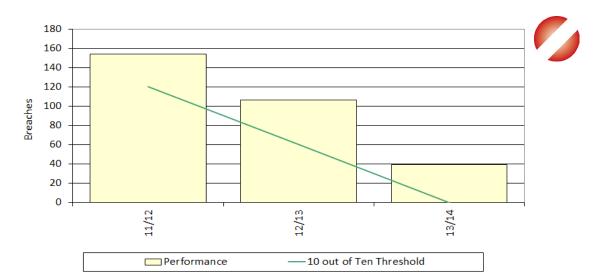


Chart 15: Reduction in breaches within mixed sex accommodation



Outcomes

Priority 8: Cardiovascular

To reduce the 30 day mortality rate in patients following Acute Myocardial Infarction (AMI)

There were approximately 600 patients admitted in 2013/14 with a diagnosis of Acute Myocardial Infarction (AMI). Many of these patients were either taken directly to tertiary hospitals for treatment and intervention, or transferred after initial treatment at the Trust for further intervention. Patients that were taken directly to tertiary centres were treated within the catheter laboratory via stent therapy. Patients were then either discharged home or transferred back to the Trust to continue their care.

For all patients who suffer an AMI, a return to an active and healthy lifestyle is positively encouraged with everyone being invited to join the cardiac rehabilitation programme. This programme is set out in four phases. Phase One is offered whilst the patient is still in hospital, Phases Two and Three are offered following discharge and Phase Four is offered in partnership with Cheshire East Council and Age Concern Cheshire who fund exercise instructors for sessions held in Winsford and Sandbach.

Cardiac rehabilitation has supported the reduction in patient mortality and morbidity and provides support for both the patient and carer to enhance their quality of life. The chance of death following an AMI is significantly reduced when lifestyle modifications are made.

The Trust uses data from CHKS to monitor mortality within 30 days following AMI and it can be seen from Chart 16 that the Trust has achieved the target to reduce further deaths following AMI during 2013/14. In addition, the Trust remains significantly below the peer average.

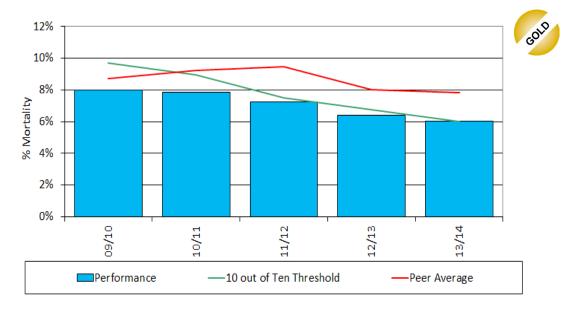


Chart 16: Reducing Acute Myocardial Infarction mortality within 30 days

Outcomes

Priority 9: Cancer

To reduce acute admissions and length of stay in hospital following early complications of diagnosis and / or treatment of cancer

The acute oncology team at the Trust was established in May 2012. The team consists of two clinical nurse specialists and a multi-disciplinary team coordinator.

The Trust was one of the first Trusts in the Cancer Network to establish an acute oncology service and therefore there is very little peer data available with which to compare the Trust. The intention of the implementation of the acute oncology team is reduce the length of stay for patients admitted with complications of their cancer treatment or the cancer itself.

The introduction of the rapid alert system highlighting that a patient with a known cancer diagnosis has been admitted to the Emergency Department or into hospital has meant that the acute oncology team can rapidly intervene resulting in an improved patient experience and a reduction in length of stay.

The acute oncology team have worked in collaboration with the emergency department physicians during 2013 /14 to educate front line staff about the one-hour "door to needle time" for patients undergoing chemotherapy who present with signs and symptoms of neutropenic sepsis. Treating these patients with intravenous antibiotics within one-hour of presentation at the emergency department can significantly improve mortality rates and also reduce any subsequent length of stay in hospital.

It can be seen in the data provided in Chart 17 that the length of stay has decreased since the implementation of the acute oncology team in 2012, so that the stretch 10 out of Ten target has been achieved. In addition, the number of patients staying 10 days or longer has decreased steadily during 2013/14.



45.0 40.0 35.0 30.0 25.0 20.0 15.0 10.0 5.0 0.0 12/13 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

■No of Patients

Target

Chart 17: The average length of stay and numbers of acute admissions

The acute oncology team saw a total of 373 patients in 2013/14, whilst an additional 113 patients avoided admission to hospital through appropriate intervention by the team.

Average LOS Monthly

The admitting medical teams report that they value the input of the acute oncology team to support the decision making process at ward level. The acute oncology team also ensure that up-to-date clinical information is available from the tertiary cancer centres so that patients benefit from the right treatment at the right time.



Outcomes

Priority 10: Infections

To reduce the rates of Healthcare Associated Infections (HCAI)

Planned Target Outcomes

To demonstrate an annual reduction in HCAI rates

MRSA bacteraemia	Target: 0	Actual 4	Not Achieved
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Clostridium difficile Target: <15 Actual 26 Not Achieved

MRSA bacteraemia

The Trust has had four cases of MRSA bacteraemia (blood stream infection) over the past twelve months, which means that the target of zero cases has not been achieved this year. However, the Trust still achieved better than peer, hence its bronze rating in this report.

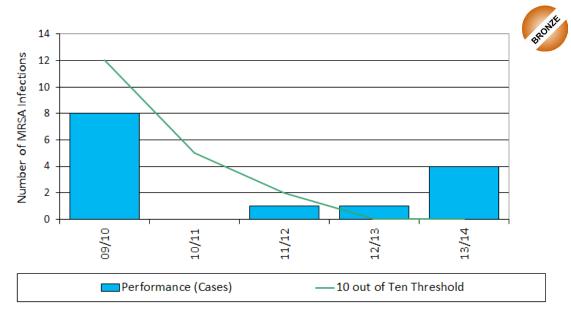
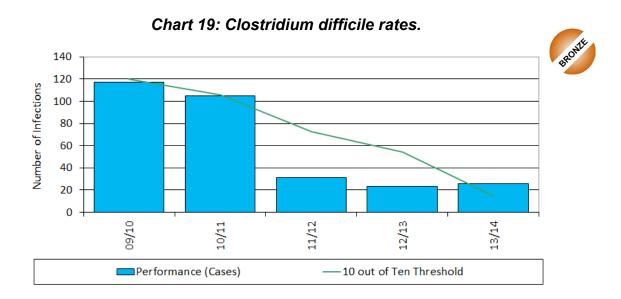


Chart 18: MRSA bacteraemia rates

Clostridium difficile

Rates of Clostridium *difficile* infection (CDI) have increased this year by three cases (23 last year against 26 this year) which means that the target of less than 15 cases has not been achieved this year. However, similarly to MRSA bacteraemia performance, the Trust still achieved better than peer, hence the bronze rating in this report.



Infection Prevention Strategies

Cases of CDI are allocated to either the hospital or the community in terms of infection source as determined by the sampling date. Out of the 26 cases reported in 2013/14, six of these could have been attributed to the community rather than the Trust due to the sampling date/time. Therefore, one of the prevention strategies to be employed in 2014/15 will focus on accurate sampling processes and staff education.

Additionally, the infection prevention and control team will implement the following infection prevention strategies:

- Increased frequency of the Strategic Infection Control Committee (SICC) to ensure corporate engagement and divisional ownership for HCAI prevention strategies
- A re-launch of basic infection prevention measures within wards and departments to ensure clinical staff understand the risks associated with HCAI's and continue to implement proactive preventative strategies
- Development of ward metrics for HCAI cases with the inclusion of an assurance framework to closely monitor infection rates and progress with remedial actions
- Increased frequency of Matron/Infection Control walkabouts (or ward rounds) to ensure the clinical environment remains optimal for the delivery of safe, clean care
- Development of training programmes and type of training delivered to ensure all relevant staff are equipped to safely manage patients with an infection or those at risk of developing an infection
- Review of environmental hygiene performance and campaigns for "clean-ups" and "declutters" within ward and department areas.

Governors' choice of indicator - reducing patient falls

The majority of hospital beds in the developed nations are occupied by older people, many of whom have been admitted because of mobility problems, falls, or injury from falls. With an aging population and projected increases in the number of people surviving with functional impairment, cognitive impairment, or multiple long-term conditions, these trends are likely to continue. This means fall prevention is an increasing risk management challenge for hospitals and a real threat to patient safety.

Falls are a considerable burden for patients, healthcare workers and hospitals. Preventing falls from happening must be a priority in healthcare organisations. While the risk of falling cannot be eliminated, it can be significantly reduced through the implementation of an effective falls prevention programme.

For people experiencing a fall, there may be many negative associations and perceptions, such as a sense of imminent loss of independence and risk of institutionalisation.

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects family members and the carers of people who fall.

Falls are estimated to cost the NHS more than £2.3 billion a year. Therefore, falling has potentially a significant impact on quality of life, health and healthcare costs.

Chart 20 shows the number of patient falls in the Trust over a 12 month period between April 2013 and March 2014. The red line on the graph indicates that the overall number of falls has decreased over the last 12 months. This represents a 15% reduction.



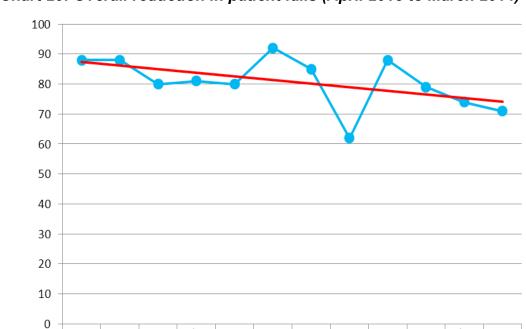


Chart 20: Overall reduction in patient falls (April 2013 to March 2014)

Work undertaken to reduce the number of patient falls and harm caused

Total

The Trust has a patient falls prevention group which meets on a six weekly basis. The group membership includes clinicians, nurses, pharmacists, therapists and divisional risk and governance managers. The group reviews all patients' falls at each meeting.

Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14

A successful link nurse programme has been rolled out across the Trust to deliver education for staff on falls prevention.

The Trust continues to be involved in a number of national projects including Safety Express and FallSafe, both of which aim to reduce the harm from patient falls. The Trust has also undertaken a thorough documentation review to ensure compliance with the latest NICE Guidelines (the assessment and prevention of falls in older people - CG161).

Statements from external agencies

NHS South Cheshire and Vale Royal Clinical Commissioning Groups

NHS South Cheshire CCG and NHS Vale Royal CCG welcome this opportunity to comment on Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) Quality Account for 2013/14.

NHS Vale Royal Clinical Commissioning Group

We have discussed the development of this Quality Account with MCHFT over the year and have been able to contribute our views on consultation and content.

South Cheshire Clinical Commissioning Group

We confirm that we have reviewed the information contained within the Quality Account and this reflects a fair, representative and balanced overview of the quality of care in MCHFT and includes the mandatory elements required.

We would particularly wish to commend MCHFT for the format of the Quality Account, which is clear and has a strong focus on patient engagement. It was excellent to see the outcome of the engagement programme based on the themes from the Francis Report driving and being included in the development of the Quality and Safety Improvement Strategy for 2014-2016.

Embedding what patients/public, staff and stakeholders have said as part of the engagement process during 2013/2014, demonstrates a clear focus on the patient, their experience and outcomes. This evidences the Trust's values and behaviours in using engagement as an integral part of ensuring quality and patient safety.

It is commendable that the Trust have demonstrated how patient's comments have been actioned through the 'you said, we did' poster. It is good to see what has changed as a result of patient's comments.

The Quality Account details very clearly those clinical issues MCHFT have addressed during 2013/14. There has been a specific focus on the three domains of quality; patient experience, clinical effectiveness and patient safety which are very clear and measurable. It is pleasing to see that the Trust has achieved a 10% reduction in hospital acquired pressure ulcers and reduced the number of unnecessary patient moves during a stay in hospital. It is apparent that there is also a commitment by the Trust to improve further in 2014/2015.

We welcome the honesty by the Trust about the challenges in achieving the targets around Health Care Associated Infections, the number of patient falls without harm, medication incidents and the 'higher than expected' mortality rates.

There are clear actions included about how the Trust is going to address these issues. However, it would have been useful to include more detail to aid understanding of how the Trust is addressing the higher than expected mortality rates.

As the 10 out of ten Strategy is being replaced by the Quality and Safety Improvement Strategy from 2014 it would have been beneficial to have an indication about the impact each of the ten outcomes have had on patient experience and quality of service.

It is particularly commendable to see the 'Healthcare for All' criteria for meeting the needs of people with Learning Disability not only included but most importantly describing in detail how the Trust are meeting the six criteria.

Overall we welcome the vision described within the Quality Account, agree with the priority

areas and will continue our strong commissioning relationship in an open and transparent way.

Healthwatch Cheshire East

The Trust offered Healthwatch Cheshire East the opportunity to comment on the contents of this document. However, at the time of finalising the document, no comment had been received.

Healthwatch Cheshire West

Robust relationships and strong engagement have been developed between Healthwatch Cheshire West as the new statutory, independent consumer champion for health and social care in Cheshire West and Chester and senior management and quality leads at Mid Cheshire Hospitals Foundation Trust during 2013/14.



Healthwatch Cheshire West has been invited to attend meetings of the Patient Experience Committee to develop intelligence sharing capability in relation to the patient experience/quality data that we collect and we also receive regular patient experience reports from the Trust on a quarterly basis.

A draft copy of the Quality Account for Mid Cheshire Hospitals NHS Foundation Trust was received by Healthwatch Cheshire West on the 30th April 2014 in line with the NHS Quality Account regulations 2010. Healthwatch Cheshire West was also invited to attend a Quality Account Presentation Day by the NHS England Area Team on 2nd May 2014, to receive the presentation of the draft Quality Account for Mid Cheshire Hospitals NHS Foundation Trust for 2013-2014.

The presentation day allowed the opportunity for Healthwatch Cheshire West to comment on the Quality Account in draft format and interact with Trust representatives in a positive way. Healthwatch Cheshire West was pleased to see that the Trust took on board the feedback that we and wider stakeholders provided at the presentation day in developing its Quality Account.

Based on the views of patients received by Healthwatch Cheshire West regarding Mid Cheshire Hospitals NHS Foundation Trust, and other information that we have access to, there are no surprises in the report which is a fair reflection of the full range of services offered.

Areas of concern for Healthwatch Cheshire West which resonate with patients and the public include the need to reduce mortality rates (a key priority for MCHFT), and the occurrence of '4 Never Events' in 2013/14. It is also important that efforts continue to address staffing levels to ensure a safe and high quality 7 day service for patients and the public.

The openness and transparency of Tracy Bullock, Chief Executive of Mid Cheshire Hospitals NHS Foundation Trust, and the level of engagement and regular updates received by Healthwatch Cheshire West, means that we are suitably assured in relation to the commitment to make improvements in these areas. We were delighted to see such positive results in the staff survey and particularly the high response rates and results of the Friends and Family test.

The presentation of the Quality Account is generally good however, Healthwatch Cheshire West feels that greater consideration and more effort could be made to explore alternative formats and more innovative ways to make the information contained within the Quality Account more accessible to patients and the public. To this end we happily offer our expertise in this area to the Trust for future publications.

Healthwatch Cheshire West looks forward to receiving regular updates from the Trust on progress with the implementation of the Quality Account and the impact on patient care throughout 2014/15.

Jonathan Taylor Service Manager 9 May 2014

Cheshire East Council Health and Wellbeing **Scrutiny Committee**

These are the Health and Wellbeing Scrutiny Committee's official comments on the Quality Accounts for 2013/14 of the Mid Cheshire Hospitals NHS Foundation Trust. (Note: these comments are based **Cheshire Eas** on the first consultation draft which was submitted to the Committee on 8 May 2014; it is understood that the comments below will be incorporated into the final version of the Quality Account)



The Committee welcomes the opportunity to comment on the Quality Account and would like to thank Jayne Hartley for attending the meeting on 8 May 2014.

The Committee:

- is generally pleased with the achievements of the Trust during 2013/14
- would like to see the Trust work with Public Health and the Council in partnership to tackle each organisation's respective responsibilities for reducing smoking during pregnancy and increasing breast feeding
- would like to see a reduction in time taken to discharge patients and better communication with patients to ensure they have realistic expectations about their discharge. This includes and emphasis on ensuring that prescriptions are issues and available from pharmacies in good time for discharge
- would like to encourage a more proactive and forward thinking approach to ensuring elderly or vulnerable patients have the appropriate care in place so that they can be discharged. Planning for discharge should take place during a person's treatment and before they are ready to be discharged
- is glad to hear that there has been a reduction in readmissions following a patient's recent admission to hospital. There needs to be more co-ordination between hospitals, care services and carers to ensure patients receive the appropriate care and are not readmitted unnecessarily
- is deeply concerned about mortality rates affecting the Trust's banding by the CQC. The Committee would welcome an in-depth report at its next meeting about the mortality rates, in private session if necessary, to understand the reasons behind them and whether anything can be done to address the issue. Councillors were very concerned by this and the Committee wishes to emphasize this serious point.

Yours Sincerely

James Morley Scrutiny Officer on behalf of the Health & Wellbeing Scrutiny Committee

Governors

Governors were invited to submit their comments on the Quality Account for 2013/14 and as Lead Governor I have been afforded the opportunity to respond on behalf of Council.

Our review of the document has highlighted the consistency between what Governors are being told by both the Board of Directors and patients. As a Council we are delighted that the Board has been proactive in their approach to listening to the patient voice and working to continually improve the quality of care and patient experience. This was evidenced through a number of forums, in particular the engagement sessions based on the themes from the Francis Inquiry into the failings at Mid Staffordshire NHS Foundation Trust. Council look forward to working with the staff and management of the Trust as they work to deliver the Quality & Safety Improvement Strategy 2014-16.

The Trust continues to ensure the Quality Account is a balanced document detailing not only where the Trust does well but also noting where the challenges lay.

John Lyons Lead Governor

Statement of Directors' responsibilities in respect of the Quality Report

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

Monitor has also issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support 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 2013/14
- The content of the quality report is not inconsistent with internal and external sources of information including:
 - Board minutes and papers for the period April 2013 to March 2014
 - Papers relating to quality reported to the Board over the period April 2013 to March 2014
 - Feedback from the Commissioners dated 16 May 2014
 - Feedback from Healthwatch Cheshire West dated 9 May 2014
 - Feedback from the Health and Wellbeing Scrutiny Committee dated 21 May 2014
 - Feedback from Governors dated 23 May 2014
 - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 25 April 2014
 - The 2013 national patient survey
 - The 2013 national staff survey
 - The Head of Internal Audit's annual opinion over the Trust's control environment dated 27 May 2014
 - Care Quality Commission (CQC) quality and risk profiles dated July 2013.

- The quality report presents a balanced picture of the Trust's performance over this period
- 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 and is subject to appropriate scrutiny and review
- The quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations published at www.monitor.gov.uk/ annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board, signed 27 May 2014

Dennis Dunn Interim Chairman

Tracy Bullock Chief Executive

Dr Paul Dodds Medical Director and Deputy Chief Executive Denise Frodsham Chief Operating Officer Julie Smith Director of Nursing and Quality

Mark Oldham
Director of Finance

David Pitt
Director of Service Transformation
and Workforce

Mike Davis
Non-Executive Director

Ruth McNeil Non-Executive Director David Hopewell
Non-Executive Director

Dame Patricia Bacon Non-Executive Director John Barnes
Non-Executive Director

Appendices

Appendix 1 - Glossary and Abbreviations

• •	Abbraviation				
Terms	Abbreviation	Description			
Acute Myocardial Infarction	AMI	AMI is commonly known as a "heart attack" which results from the partial interruption of the blood supply to a part of the heart which can cause damage or death to the heart muscle.			
Advancing Quality	AQ	A programme which rewards hospitals which improve care in a number of key areas such as heart attacks, pneumonia, hip and knee replacements and heart failure using research to determine the best care interventions.			
Advancing Quality Alliance	AQUA	A membership body which aims to improve the quality of healthcare in the North West.			
Angiotensin Converting Enzyme Inhibitor	ACE-I	A medication used for the treatment of hypertension (elevated blood pressure) and congestive heart failure.			
Anti-D (RHO) Immunoglobulin	ANTI-D	A medicine used in preventing antibody formation in rhesus negative people.			
Beta Blocker	B-Blocker	A medication used to treat angina, heart failure, high blood pressure or irregular heartbeats.			
Board (of Trust)		The role of Trust's board is to take corporate responsibility for the organisation's strategies and actions. The chair and non-executive directors are lay people drawn from the local community and are accountable to the Secretary of State. The chief executive is responsible for ensuring that the board is empowered to govern the organisation and to deliver its objectives.			
C.A.S.P.E Healthcare Knowledge Systems	CHKS	An independent company which provides clinical data/ intelligence to allow NHS and independent sector organisations to benchmark their performance against each other.			
Care Quality Commission	CQC	The independent regulator of health and social care in England.			
Child Health Reviews- UK	CHR-UK	UK-wide programme of work, systematically examining mortality and morbidity in children and young people between 1 and 18 year old.			
Chronic Obstructive Pulmonary Disease	COPD	A description for lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease.			
Clinical Commissioning Group	CCG	The GP led commissioning body who buy services from providers of care such as the hospital.			
Clinical Negligence Scheme for Trusts	CNST	A set of standards designed to improve quality and safety in maternity care.			
Clinical Nurse Specialist	CNS	Clinical specialist nurses work in a variety of acute and community settings, specialising in particular areas of practice.			

Terms	Abbreviation	Description
Clostridium <i>Difficile</i>	C-diff	A naturally occurring bacterium that does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C-diff bacteria can multiply and cause symptoms such as diarrhoea and fever.
College of Emergency Medicine	СЕМ	A medical college to advance education and research in emergency medicine
Commissioner		A person or body who buys services.
Commissioning for Quality and Innovations	CQUIN	CQUIN is a payment framework developed to ensure that a proportion of a providers' income is determined by their work towards quality and innovation.
Cost Improvement Plan	CIP	A cost improvement plan aims to save money but also, through long-term plans to transform clinical and non-clinical services, improves patient care, satisfaction and safety.
Data for Head and Neck Oncology	DAHNO	The audit collects data from hospitals within England and Wales which diagnose and treat patients with cancer of the larynx and oral cavity.
Delivering Same Sex Accommodation	DSSA	DSSA was a national initiative launched in 2009 to eliminate mixed sex accommodation (EMSA) in hospital. There may be members of the opposite sex on a ward but they will not share the same sleeping area with members of the opposite sex unless this is required for clinical need, such as in the Intensive Care Unit.
Duty of Candour		Candour is defined in the Francis' report as: 'The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made.'
Electronic patient record	EPR	Medical information stored on a computer instead of hand held notes.
Eliminating Mixed Sex Accommodation	EMSA	Please see description of Delivering Same Sex Accommodation.
Enhanced Recovery After Surgery	ERAS	The enhanced recovery programme is about improving patient outcomes using evidence based care at the right time and making sure patients are active participants in their own recovery process.
Falls and Fragility Fracture Audit Programme	FFFAP	A national clinical audit run by the Royal College of Physicians designed to audit the care that patients with fragility fractures and inpatient falls receive in hospital and to facilitate quality improvement initiatives.

Terms	Abbreviation	Description
Foundation Trust		An NHS Trust in England that has been created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people. NHS Foundation Trusts have members drawn from patients, the public and staff and are governed by a board of governors comprising people elected from and by the membership base.
Francis Report 2013		This report followed a public inquiry that examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005-2009. The report makes 290 recommendations.
Friends and Family Test	FFT or F and F Test	Introduced in 2013 patients are asked whether they would recommend hospital wards, A&E departments and maternity services to their friends and family if they needed similar care or treatment.
Gastro Intestinal	GI	The whole digestive tract (gut).
Gestation Related Optimal Weight	GROW Charts	These charts improve the antenatal detection of fetal growth problems, avoid unnecessary investigations and reduce anxiety by reassuring mothers when growth is normal.
Health and Social Care Information Centre	HSCIC	The national provider of information, data and IT systems for health and social care
Health Protection Agency	HPA	The HPA provides advice and information to protect the public in England from threats to health from infectious diseases and environmental hazards. In April 2013, the HPA became part of Public Health England.
Healthcare Associated Infections	HCAI	A generic name to cover infections like MRSA and C-diff.
Inflammatory bowel disease	IBD	Inflammatory bowel disease (IBD) encompasses ulcerative colitis and Crohn's disease. These are chronic diseases that involve inflammation of the gastrointestinal tract.
Integrated Care System	ICS	The system used by the Trust to record patient activity.
Intensive Care National Audit and Research Centre: Case Mix Programme	ICNARC CMP	A clinical database holding over 18 years data relating to patient outcomes from adult, general critical care units in England, Wales and Northern Ireland.
Intensive Therapy Unit	ITU	A specialised clinical area providing intensive care medicine.
Left ventricular function	LV Function	The left ventricle (lower chamber) of the heart is the main pumping chamber of the heart.

Terms	Abbreviation	Description
Methicillin-Resistant Staphylococcus Aureus	MRSA	Staphylococcus aureus is a bacterium which is often found on the skin and in the nose of about 3 in 10 healthy people. An infection occurs when the bacterium enters the body through a break in the skin. A strain of this bacterium has become resistant to antibiotic treatment and this is often referred to as MRSA.
Mid Cheshire Hospitals NHS Foundation Trust	MCHFT	The organisation which runs Leighton Hospital, Crewe, Victoria Infirmary, Northwich and Elmhurst Intermediate Care Facility, Winsford
Monitor		This is the regulator of NHS Foundation Trusts. It is an independent body detached from central government and directly accountable to Parliament.
Mothers and Babies: reducing Risk through Audits and Confidential Enquiries across the UK	MBRRACE- UK	An organisation which investigates maternal deaths, still births and infant deaths to support the delivery of safe, equitable, high quality, patient centred maternal, newborn and infant health services.
Multi Disciplinary Team	MDT	The team of professionals involved in a patient's care.
Myocardial Ischaemia National Audit Project	MINAP	A national audit to enable hospitals measure their performance against targets and improve the care of patients following a heart attack.
National Bowel Cancer Audit Programme	NBOCAP	An audit to measure care and clinical outcomes, enabling comparisons between hospitals and bringing about improvements where necessary
National Cardiac Arrest Audit	NCAA	National clinical audit of in-hospital cardiac arrests with the aim of improving resuscitation care and patient outcomes.
National Confidential Enquiry into Patient Outcomes and Death	NCEPOD	A review of the management of patients through confidential surveys and research. The results are used to improve the quality of patient care.
National Diabetes Audit	NDA	A national audit looking into the care of people with diabetes in primary and secondary care
National Emergency Laparotomy Audit	NELA	An audit of the quality of care received by patients undergoing emergency laparotomy.
National Inpatient Diabetes Audit	NaDIA	An audit of diabetes inpatient care in England and Wales.
National Institute for Health and Care Excellence	NICE	NICE provide independent, authoritative and evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation.
National Joint Registry	NJR	The NJR collects information on all hip, knee, ankle, elbow and shoulder replacement operations to monitor the performance of joint replacement implants.

Terms	Abbreviation	Description		
National Lung Cancer Audit	NLCA	An audit of the care delivered during referral, diagnosis, treatment and outcomes for people diagnosed with lung cancer and mesothelioma.		
National Neonatal Audit Programme	NNAP	An audit programme established to inform good clinical practice in aspects of neonatal care by auditing national standards.		
National Oesophago-Gastric Cancer Audit	NAOGC	An audit of care and the outcomes of treatment for all oesophageal gastro cancer patients, both curative and palliative.		
National Paediatric Diabetes Audit	NPDA	A national programme designed to improve care provided to children with diabetes and that of their families.		
National Patient Surveys		Co-ordinated by the CQC, they gather feedback from patients on different aspects of their experience of care they have recently received across a variety of services/ settings including: Inpatients, Outpatients, Emergency care and Maternity care.		
National Reporting and Learning System	NRLS	National database that allows learning from reported incidents. All Trusts upload their incident reporting data to this database on a weekly basis.		
Non alcoholic steato-hepatitis	NASH	A common liver disease that occurs in people who drink little or no alcohol.		
Non-Executive Director	NED	The non executive director holds the executive directors to account for the delivery of the trusts strategy ensuring that the Board acts in the best interests of its patients and the wider community.		
Parliamentary and Health Service Ombudsman	PHSO	The PHSO provides a service to the public by undertaking independent investigations into complaints where the NHS in England have not acted properly or fairly or have provided a poor service.		
Patient Reported Outcome Measures	PROMs	A programme in which patients complete a questionnaire on their health before and after their operation. The results of the two questionnaires can be compared to see if the operation has improved the health of the patient. Any improvement is measured from the patient's perspective as opposed to the clinicians.		
Payment by Results	PbR	The payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs.		
Primary percutaneous coronary intervention	Primary PCI	An emergency procedure used when a patient is having a heart attack. The procedure widens blocked or narrowed coronary arteries.		

Terms	Abbreviation	Description
Quality Account		This is a statutory annual report of quality which provides assurance to external bodies that the Trust Board has assessed quality across the totality of services and is driving continuous improvement.
Risk Adjusted Mortality Rates	RAMI	A measure to compare hospitals which looks at the actual number of deaths in a hospital compared to the expected number of deaths. The risk-adjustment is a method used to account for the impact of individual risk factors such as age, severity of illness (es) and other medical problems that can put some patients at greater risk of death than others.
Rockall Score		A risk assessment tool used to assess potential outcomes in a patient with a gastrointestinal bleed.
Saebo Splint		A rehabilitation product often used for patients with neurological injury.
Safer Nursing Care Tool	SNCT	A tool to measure patient dependency/acuity to help determine nurse staffing levels on the wards.
Safer Nursing Care Tool	SNCT	A tool used to judge the acuity and dependency of patients used to estimate what nursing establishment is required.
Scottish Intercollegiate Guidelines Network	SIGN	A network that develops evidence based clinical practice guidelines for the National Health Service (NHS) in Scotland
Sentinel Stroke National Audit Programme	SSNAP	SSNAP aims to improve the quality of stroke care by auditing stroke services against evidence based standards.
Speech and Language Therapy	SALT	A service designed to assess and treat speech, language and communication problems in people of all ages.
ST Elevation Myocardial infarction	STEMI	A type of heart attack determined by an electrocardiogram test
Standards Consulting Group	SCG	Part of the HSCIC, the SCG is a consultancy service within the Technology Office.
Summary Hospital level Mortality Indicator	SHMI	SHMI is a hospital level indicator which measures whether mortality associated with hospitalisation was in line with expectations. The SHMI value is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by that Trust
Systemic anti cancer therapy data set	SACT	The SACT collects clinical management information on patients undergoing chemotherapy in England.
Thrombolysis		A term used for the use of medication to dissolve blood clots.
Trauma Audit and Research Network	TARN	Provides accurate and relevant information to help Doctors, Nurses and Managers improve their services in trauma care.

Terms	Abbreviation	Description
University Hospital of North Staffordshire	UHNS	A tertiary referral centre who work closely with the Trust
Venous Thrombo- Embolism	VTE	A blood clot which can develop when a person may not be as mobile as they are usually or following surgery. The blood clot itself is not usually life threatening, but if it comes loose it can be carried in the blood to another part of the body where it can cause problems – this is called a Venous Thromboembolism (VTE).
10 out of Ten		The name of the Trust's strategic objective to improve quality by aiming for the Trust to be in the top 10 percent of hospitals nationally for the top ten indicators of Quality by 2014.

Appendix 2 - Feedback Form

We hope you have found this Quality Account useful.

To save costs, the report is available on our website and hard copies have been made available in waiting rooms or on request.

We would be grateful if you would take the time to complete this feedback form and return it to:

Clinical Quality and Outco Mid Cheshire Hospitals N	
Leighton Hospital	
Middlewich Road	
Crewe	
Cheshire	
CW1 4QJ	
Email: quality.accounts@	mcht.nhs.uk
How useful did you find	this report?
Very useful	
Quite useful 🛛	
Not very useful	
Not useful at all	
Did you find the conten	ts?
Too simplistic	
About right	
Too complicated	
Is the presentation of da	ata clearly labelled?
Yes, completely	
Yes, to some exter	nt □
No	
If no, what would have I	nelped?
le there anything in this	report you found particularly useful / not useful?
is there anything in this	report you found particularly useful? not useful?

Appendix 3 - 2013/14 limited assurance report on the content of the Quality Report and mandated performance indicators

Independent auditor's report to the Council of Governors of Mid Cheshire Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Mid Cheshire Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Mid Cheshire Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the "Quality Report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Mid Cheshire Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Mid Cheshire Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Mid Cheshire Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- · Patient treated within 62 days of GP urgent suspected cancer referral; and
- Incidence of Clostridium Difficile (C.diff) infections occurring 72 hours after admission.

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

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Requirements for Quality Reports 2013/14; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material

respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports 2013/14.

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

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with [either refer back to the specified documents in the guidance, or list those documents below:

- board minutes for the period April 2013 to March 2014;
- papers relating to Quality Reported to the board over the period April 2013 to March 2014:
- feedback from the Commissioners dated May 2014;
- feedback from local Healthwatch organisations dated 9 May 2014;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2013;
- the latest national patient survey dated 2013;
- the latest national staff survey dated 2013;
- Care Quality Commission quality and risk profiles dated 13 March 2014; and
- the Head of Internal Audit's annual opinion over the trust's control environment dated 14 April 2014.

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

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

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.

- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report.
- Reading the documents.

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

Limitations

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

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

The scope of our assurance work has not included governance over quality or nonmandated indicators which have been determined locally by Mid Cheshire Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in Detailed Requirements for Quality Reports 2013/14; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

Deloitte Ul

Deloitte LLP Chartered Accountants Manchester 28 May 2014

Chapter 9

Remuneration Report

Introduction

Section 234B and Schedule 7A of the Companies Act, as interpreted for the public sector, requires NHS bodies to prepare a Remuneration Report containing information about Directors' remuneration. In this report the information is in respect of the Senior Managers of the Trust. The definition of Senior Managers is those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments.

Remuneration Committee

The Committee is established to appoint Executive and Associate Directors, and to advise the Board on their employment packages and performance. The Committee comprises the Chairman of the Board, Non-Executive Directors and the Chief Executive. Meetings are held with the Chairman of the Board and at least two Non-Executive members in attendance.

The Chief Executive shall not be present at any meeting of the Committee where the Chief Executive's appointment or remuneration is under discussion.

The Remuneration Committee met on two dates during 2013/14 – 8 April 2013 and 3 March 2014. The meeting on 8 April 2013 saw discussion on the Chairman's Appraisal and Executive Pay whilst the meeting of 3 March 2014 was held to discuss Executive pay. In reviewing Executive Pay a benchmarking exercise of similar sized Foundation Trusts is completed. Consideration is also given to national guidance and pay deals for NHS and public sector staff.

The members and their attendance are shown opposite:

Member	Attendance				
Non-Executive Direc	tors				
Mr J Moran (Chair)	2				
Dame P Bacon	2				
Mr J Barnes	2				
Mr M Davis	2				
Mr D Dunn	2				
Mr D Hopewell	1				
Mrs R. McNeil	2				
Dr A Wood	1 (of 1)				
·					
Executive Director					
Mrs T Bullock	2				

Remuneration of Senior Managers Policy

Executive Directors receive a fixed salary which is established at the beginning of each year and determined using extensive benchmarking information from Foundation Trust Network surveys, Trust Annual Report & Accounts and knowledge of job descriptions, person specifications and market pay. The meeting of the Appointments and Remuneration Committee in April 2013 established the salary payments for 2013/14 whilst the meeting of March 2014 established the salary payments for 2014/15. Executive Directors did not receive a pay rise for the years 2011/12 and 2012/13; this was on top of a voluntary pay freeze during 2010/11.

In 2013/14, there was no policy on performancerelated pay and there is no proposal for any kind of performance-related pay for any future years for the current senior managers. Each Executive has agreed objectives and their performance is measured against these objectives in year. The performance management framework has been agreed by the Board.

In line with Monitor's Code of Governance for NHS Foundation Trusts, the Terms of Office of Members of the Board for the financial year end as at 31 March 2014 are set out overleaf:

Name	Position	Term of Contract	Date of Appointment / Reappointment	Unexpired Term	Notice Period	Liability for Early Termination
Moran J	Chairman	3 year Term	1 July 2012	1 years 3 months	None	None
Bacon P	Non-Executive Director	3 year Term	1 May 2012	1 years 1 month	None	None
Barnes, J	Non-Executive Director	3 year Term	1 February 2013	1 years 10 months	None	None
Davis M	Non-Executive Director	3 year Term	1 February 2013	1 years 10 months	None	None
Dunn D	Non-Executive Director	3 year Term	1 May 2012	1 years 1 month	None	None
Hopewell D	Non-Executive Director	3 year Term	1 December 2011	8 months	None	None
McNeil R	Non-Executive Director	3 year Term	1 November 2011	1 year 7 months	None	None

Name	Position	Term of Contract	Unexpired Term	Notice Period	Liability for Early Termination
Bullock T	Chief Executive	Permanent	N/A	6 months	6 months' salary
Dodds P	Deputy Chief Executive and Medical Director	Permanent	N/A	6 months	6 months' salary
Frodsham D	Chief Operating Officer	Permanent	N/A	6 months	6 months' salary
Oldham M	Director of Finance & Strategic Planning	Permanent	N/A	6 months	6 months' salary
Pitt D	Director of Service Transformation & Workforce	Permanent	N/A	6 months	6 months' salary
Smith J	Director of Nursing & Quality	Permanent	N/A	6 months	6 months' salary

Non-Executive Director appointments can be terminated by a 75% majority of Governors voting at a Council of Governors meeting.

Termination Policy

The Trust at present does not have a Termination Policy for Senior Managers, but each of the Executive Directors has a permanent contract and a notice period. At 31 March 2014, the termination period for all Executive Directors was six months. If a decision was required to terminate the contract of the individual then these terms would be adhered to, unless the member of staff was summarily dismissed for gross misconduct.

Senior Manager Remuneration and Benefits

Pension arrangements for the Chief Executive and all Directors are in accordance with the NHS Pension Scheme, the accounting Policies for Pensions and relevant benefits are set out in the Notes to the Accounts – Accounting Policies.

Full details of the remuneration can be found in Note 5.4 in the accounts on Page 183. Benefits in kind relate to the provision of lease cars.

Director Expenses & Remuneration

In line with the Health & Social Care Act, detailed below are non-audited Expenses which have been claimed by Directors during 2013/14. Details of remuneration and Benefits in Kind are provided in the audited accounts and in particular Notes 5.4(a) to 5.4(d). The Trust's Board of Directors comprises 13 members – seven Non-Executive Directors (including the Chairman) and six Executive Directors (including the Chief Executive).

Number of Directors who claimed	Total Amount
10	£18,896.07

Governor Expenses

Details of those Expenses which have been claimed by Governors during 2013/14 are also detailed below. In accordance with the Trust's Constitution, the Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust. Governors do not receive a salary. The Trust's Council of Governors comprises 30 Governors.

Number of Governors who claimed	Total Amount
4	£862.75

Review of Tax Arrangements of Public Sector Appointees

In line with the Foundation Trust reporting manual, the table below shows all off-payroll engagements for the financial year ending 31 March 2014.

For off–payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012.

	Number
Number in place on 31 March 2014	2
Number that have since come onto the Trust's payroll	0
Number that have since been renegotiated / re-engaged to include contractual clauses allowing the Trust to seek assurance as to their tax obligations	0
Number that have not successfully re-negotiated and therefore continue without contractual clauses allowing the Trust to seek assurance to their tax obligations	2
Number that have come to an end	0
Total	2



Tracy Bullock Chief Executive



Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Mid Cheshire Hospitals 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. am also responsible for ensuring that Mid Cheshire Hospitals NHS Foundation Trust (hereafter known as 'the 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 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 Trust for year ended 31 March 014 and up to the date of approval of the Annual Report & Accounts.

Capacity to handle risk

During 2013/14 through the Integrated Governance Framework and with support from the Trust's Medical Director and Deputy Chief Executive, I provided leadership in respect of risk management processes, as evidenced through the Integrated Governance and Risk Management Strategy and the Corporate Governance Handbook. These set out the responsibilities at all levels, including seniorlevel leadership, for the risk management process. The Integrated Governance and Risk Management Strategy provides a clear, structured and systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the organisation. The Strategy sets out the role of the Board of Directors and its Sub-Committees, together with the individual responsibilities of the Chief Executive, Executive Directors and all staff in managing risk. In particular, the Strategic Integrated Governance Committee provides the mechanism for managing and monitoring risk throughout the Trust and through to the Board of Directors. The Audit Committee oversees the systems of internal control and the overall assurance process associated with managing risk.

The Board of Directors receives assurance from the Strategic Integrated Governance Committee on all serious untoward incidents, as well as receiving reports on complaints claims and incidents, at each meeting. The Trust has mechanisms to act upon alerts and recommendations made by all relevant central bodies such as NHS England.

Appropriate and targeted risk management training is delivered as an integral part of the Trust's mandatory training schedule to ensure that staff are sufficiently aware and competent to identify hazards, and assess and manage risk within their working environment. Managers are responsible for ensuring that their staff are able to access and attend training appropriate to their needs, including statutory and mandatory requirements. This training is supplemented through the management development programmes, as risk and governance training is part of these programmes. New starters receive information on

risk management as part of the Trust's general induction arrangements. This includes the comprehensive induction of all junior doctors with regard to key policies, standards and practice prior to commencement in clinical areas. All Board members and senior managers attend, as a minimum, the Trust's mandatory training. Additional risk management training is included as appropriate in Board Development Away Days and focuses on key issues particularly changes in legislation.

The Trust aims to minimise adverse outcomes to the organisation, staff or estate, and particularly, the patients who use its services, through adequate supervision and training, appropriate delegation, continuous review of processes and the sharing of lessons learned and best practice via the Divisional governance systems.

The Risk and Control Framework

The risk control objective of the Trust is to reduce risks to a reasonable level consistent with its vision "To deliver excellence in healthcare through innovation and collaboration". Trust's Integrated Governance and Risk Management Strategy details how risk will be identified evaluated and managed. details of the monitoring arrangements and the authority for decision making through identified posts or committees. Risk Management requires participation, commitment and collaboration from all staff. The process starts with the systematic identification of risks throughout the organisation via structured risk assessments. Identified risks are documented on the Trust's Risk Register. These risks are then analysed in order to determine their relative importance using a risk scoring matrix. Achieving control of the higher scoring risks is given priority over lower scoring risks. Risk control measures are identified and implemented to reduce the Many control measures potential for harm. do not require extra funding and these are implemented as soon as practicably possible.

However, where risk control requires extra funding then a risk funding process determines how best to use the Trust's financial resources to control that risk. The Board of Directors is

kept fully informed of all significant risks and the plans to manage and mitigate them.

Awareness of, and responsibility for, risk issues are linked explicitly to key objectives, in order to build a sustainable risk management culture. There is delegated responsibility for risks at every level in the Trust. This is crucial to embedding risk management into the Trust and its culture, with risk management seen as an intrinsic part of the way the Trust works. The risk management objectives are inherently linked to the strategic objectives contained within the Board Assurance Framework. The Board Assurance Framework has been in place throughout the year. The Board of Directors undertakes a formal assessment of risks to its key objectives quarterly, and related action plans have been drawn up and considered by the Board.

In addition, a Significant Risk Register is maintained and updated quarterly. This Register contains Divisional and Corporate Service risks scored as 20 and above and, where appropriate, are cross referenced to either the Board Assurance Framework or Divisional Board Assurance Frameworks. These risks are reviewed at the Strategic Integrated Governance Committee quarterly to ensure the risks are being mitigated as promptly as possible.

At the beginning of 2013/14 the Trust identified its major risks as:

- Failure to deliver High Quality Clinical Care 24/7, investment in the clinical workforce remains a priority to ensure that patients see the right healthcare professional at the right time in the right location with access to the appropriate diagnostics
- Higher than expected Summary Hospital– Level Mortality Indicator (SHMI), there has been a continued focus on quality improvement throughout the year. AQuA (Advancing Quality Alliance) conducted an external review in January 2014 of the Trust's mortality position and the recommendations will be incorporated into the Trusts internal action plan which will form the basis of an overarching Local Health Economy Mortality Action Plan for 2014/15
- Failure to deliver all local and national targets

and standards. The Trust delivered the vast majority of national and local standards in 2013/14. Of particular note is delivery of all cancer targets. The Trust delivered the Referral to Treatment and 4 Hourly Target for the year although failed both in one quarter. Clostridium difficile performance was maintained compared to previous year but failed in year, partly due to a significantly reduced target. It was highlighted as a risk to Monitor in the Trust's annual plan for 2013/14. The Trust expects to continue to deliver its local and national targets during 2014/15.

During 2013/14 two additional major risks were identified:

- Failure to implement the Information Management & Technology Strategy. The timescales have been delayed due to financial constraints and are monitored by the Board Assurance Framework
- Following four Never Events (three related to the Theatre environment and one related to medicines management), failure to deliver safe patient care in a Theatre environment was identified as a risk.



Future Risks

Objective Risks	Mitigation
Failure in	24-hour senior medical staff cover
Delivering High	Increased Consultant on site presence at weekend
Quality Clinical	Separation of Consultant Anaesthetist rota in November 2013 to establish
Care 24/7	a specific Critical Care on call rota
	Critical Care Outreach Service 24/7
	Early Warning Scores in place and escalation plan for the detection and
	management of the deteriorating patient
	24-hour senior nursing staff cover including Night Nurse Practitioners
	Advanced Nurse Practitioners recruited to support non-elective
	emergency admissions
	High level Clinical Workforce Model for Medicine in progress
	Incremental investment in nursing staff related to acuity monitoring data
	Recruitment and Retention Strategy for Nurses and Midwives
	Successful international recruitment from Spain and Ireland
	Proactive recruitment of newly qualified nurses
	Urgent Centre Care pathway – integrated working in the Emergency
	Department
	Corporate Non – Elective Flow Group with three main areas of focus:-
	flow; admission avoidance and readmission avoidance
	Clinical NHS Services – Seven Days a Week Forum: Clinical Standards.
	Clinical Divisions undertaking a gap analysis as part of the contracting
	process for 2014/15
Higher than	A series of inter-related projects to reduce the Trust's mortality rates are
expected	currently in progress under the primary drivers of: Reliable clinical care;
Summary	Effective clinical care; Medical documentation, clinical coding and data
Hospital-Level	consistency; End of life care; Leadership
Mortality Indicator	Delivery of the Reducing Mortality Action Plan
(SHMI)	Revised senior medical leadership structure in place from November
(Or livil)	2013
	All in-patient deaths reviewed weekly
	All coding of in-patient deaths reviewed weekly
	Benchmark of Trust's medical staffing levels completed
	External AQUA Mortality Review undertaken in January 2014, jointly
	commissioned with the local Clinical Commissioning Group (CCG). Final
	report received April 2014.
	All frontline medical staff have attended a mortality workshop – a similar
	programme is being developed for nursing and allied health professional
	staff
	CCG review of out of hospital deaths included in SHMI in progress
	Foundation doctor project with coders around clinical documentation in
	progress and due for completion June 2014
	Emergency/Critical Care and Surgery and Cancer Divisions undertaking a
	piece of work relating to weekend mortality
	30 key frontline staff to undergo AQUA Quality Improvement training May/
	June 2014
	Julie 2014

Objective Risks	Mitigation
Failure in Delivering Safe Patient Care within a Theatre Environment	 External Safety Culture Survey led by Pascal Metrics, commenced March 2014. The results will lead to the development of a Quality and Safety Improvement Programme. Updated Standard Operating Procedure for 'Swab, Instrument and Needle Counts' introduced immediately Consistency of practice across all theatre environments introduced following Root Cause Analyses of Never Events All non-x-ray detectable swabs immediately removed from the theatre environment Monthly audits monitoring compliance with WHO Safety Checklist

Information governance risks are managed as part of the processes described above and assessed using the Information Governance Toolkit. The Risk Register contains the current information risks.

Data quality and data security risks are managed and controlled via the risk management system. Risks to data quality and data security are continuously assessed and added to the Risk The Information Commissioners Register. Office was invited by the Trust to conduct an audit on information governance and security during 2013/14 and its suggestions for continued improvement have been incorporated into an action plan. In addition, further independent assurance is provided by the annual internal audit of clinical coding by Mersey Coding Academy, the annual completeness and validity audit of Admitted Patient Care and Outpatient Commissioning Data Submissions and the Internal Audit review of data security.

Incident reporting is openly encouraged through staff training and further embedded by the Trust's adoption of a Just Safety culture. Incidents, claims and complaints are analysed and reviewed by the Board of Directors. Serious incidents undergo a detailed investigation and a root cause analysis chaired by an Executive Director. The results of the investigation are shared with the patient, relatives, and are reported to the Strategic Integrated Governance Lessons to be learned from Committee. incidents, claims and complaints, together with examples of good practice, are disseminated throughout the Trust. Action plans are followed through the Board sub-committees. Aggregation of incidents, claims, complaints and inquests are undertaken at the Complaints, Litigation, Incidents and PALS Committee and

shared throughout the Trust.

The Board of Directors formally assesses quality governance arrangements using Monitor's Quality Governance Framework for Foundation Trusts. Since 2011 the Trust initially conducted the self-assessment on a six monthly basis and since December 2013 the Board of Directors agreed to an annual self-assessment aligned to the annual self-certification process. An action plan was in place to address the identified gaps which was monitored by the Board of Directors. All items are now complete, however, following each self-assessment an action plan will be further developed should this be required. Key elements of the Integrated Governance and Risk Management Strategy clearly commit to the management of risk in order to:

- Monitor continuously, and seek to improve, the quality of care provided in partnership with patients, carers, staff and the public
- Provide a safe environment for the benefit of patients, staff and visitors by reducing and where possible, eliminating the risk of loss / harm
- Continually strive to move forward along the risk maturity spectrum
- · Protect its assets and reputation.

A Quality Strategy is in place which aims to improve the quality of care provided for patients and reduce avoidable harm to patients through the monitoring and measuring of quality and safety indicators. The Quality Account, within this Annual Report & Accounts, describe quality improvements and quality governance in more detail. In support of the Quality Strategy there is an Equality, Diversity and Human Rights Strategy in place to ensure that all of our services are inclusive and meet the needs of

the community. All Trust developments require an equality and diversity impact assessment. Equality impact assessments are required for all new and revised policies and for business cases and services. Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human legislation are complied with.

The Trust is unconditionally registered with the Care Quality Commission (CQC). The Trust underwent an unannounced inspection on 10 October 2013 in relation to Outcome 9 – Medicines Management. The Trust was compliant with drug security but received a minor concern in relation to drug omissions. The Trust received a follow up unannounced inspection on 5 March 2014 and successfully met the requirements for compliance.

On 4 and 5 February 2014 the CQC undertook an unannounced thematic inspection related to dementia care across the Trust and the Trust is awaiting the final report.

The Trust successfully achieved compliance at Level 3 in the Clinical Negligence Scheme for Trusts Maternity Clinical Risk Management Standards undertaken by the National Health Service Litigation Authority.

Governors and Members provide vital channels of communication with the general public and are encouraged to bring issues of concern swiftly to the attention of the Trust. Through the Chairman, serious concerns can be brought directly to the Board of Directors. Governor attends the monthly Board of Director Meetings and Governors also sit on a number of Board Committees where they have the opportunity to raise issues and inform the Risk Register. A Governor joins an Executive and Non-Executive Director on the monthly Patient Safety Walkabouts to selected clinical areas. In addition Governors provided valuable assistance in undertaking patient surveys and in the consultation exercise on the Trust's two year quality strategy approved in March 2014. This also gave the public and wider stakeholders the opportunity to comment on the Trust in regard to any other concerns or issues they wished to raise.

Executive Directors attend the meetings of the Local Authority Scrutiny Committees and Clinical Commissioning Groups, where any issues of risk can be highlighted. Clinical Commissioning Group representatives have a seat on key quality, safety and governance committees in the Trust and there are two stakeholder roles on the Council of Governors. The Clinical Commissioning Groups are also invited to contribute to the development of the Trust's strategy to ensure that the health economy commissioning intentions are incorporated into the strategy.

The Trust has undertaken risk assessments and Carbon Reduction Delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this Trust's obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

Compliance with the NHS Pension Scheme Regulation

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all major 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.

Review of economy, efficiency and effectiveness of the use of resources

The financial plan is approved by the Board of Directors and submitted to Monitor. The plan, including forward projections, is monitored in detail by the Performance and Finance Committee on a monthly basis, with key performance indicators and monitor metrics

reviewed by the Board of Directors. The Trust's resources are managed within the framework set by the Corporate Governance Handbook, which includes Standing Financial Instructions. Financial governance arrangements are supported by internal and external audit to ensure economic, efficient and effective use of resources.

Divisional and corporate departments are responsible for the delivery of financial and other performance targets via a performance management framework. This framework includes service reviews with the Executive Team

Annual Quality Account

The Board of Directors is required under the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 (as amended) to prepare a Quality Account for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of the Annual Quality Account which incorporates the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Trust has a Quality and Safety Improvement Strategy Group, chaired by the Director of Nursing and Quality, which is responsible for the development of the Quality Account and the operational monitoring of the delivery of the Quality Strategy. This Group has senior representation from the Patient Experience Team, integrated governance, performance, nursing, the Information Department and the Clinical Commissioning Groups. Controls are in place to ensure that all the Trust's staff have the appropriate skills and expertise to perform their duties. This includes the provision of relevant training and knowledge of the relevant policies and guidance. This ensures that the data used to assess the quality of the Trust's performance is reliably collected and prepared by staff. Each section of the Quality Strategy is reviewed quarterly in detail ensuring that data are robust and consistent in their presentation. Minutes from the group are reported to the Trust's Quality, Effectiveness and Safety Committee (QuESt) which is chaired by the Chief Executive and is a Board Committee. Progress against the Quality Strategy is reviewed by QuESt, presentations are given by the leads for each element of the Strategy and progress against the specific targets is discussed. Areas of concerns and recommendations are made to QuESt by the Quality and Safety Improvement Strategy Group. Data quality issues are addressed through the Trust's information governance systems in line with its Data Quality Policy.

The Quality Account is used to update the public about the Trust's achievements in respect of the Trust's Quality Strategy and other quality initiatives. During the year a public consultation exercise was undertaken to gather the views of the local population on the Quality Strategy. The consultation also enabled discussion to take place in relation to progress being made and any changing priorities held by the public to ensure a balanced view is achieved within the Quality Account publication.

Key stakeholders are invited to reflect their views on the Quality Account these include Trust Council of Governors, Commissioners, Overview & Scrutiny Committee and the local Healthwatch group. Their responses are included in the final publication of the Quality Account. The Quality Account is assessed by the Readers Panel prior to publication and an easy read format is produced and published alongside the full version.

The Quality Account is also reviewed by the External Auditors who provide an opinion on the Quality Account as well as on data quality and governance in respect of three key performance indicators, two mandated and one selected by the Council of Governors.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, Clinical Audit and the Executive Directors and Clinical Leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Account included in this Annual Report and other performance information available to me. My review is also informed

by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Strategic Integrated Governance Committee and the Quality, Effectiveness and Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board Assurance Framework provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principle objectives have been reviewed. Internal audit provides me with an opinion about the effectiveness of the assurance framework and the internal controls reviewed as part of the internal audit plan. Work undertaken by internal audit is reviewed by the Board subcommittees and the Audit Committee. Board Assurance Framework and Significant Risk Register are reviewed at least four times a year and provide me and the Board of Directors with evidence of the effectiveness of controls in place to manage risks to achieve the Trust's principal objectives.

My review is also informed by the:

- Trust's assurance process for monitoring levels of compliance with the Care Quality Commission's Essential Standards of Quality and Safety, including review of feedback from CQC inspections
- Programme of work undertaken by Internal Audit
- Clinical audit annual programme, including relevant national audits
- Annual Assessment Visit by the Deanery
- National Reporting and Learning System Incident Report – NHS England.

In assessing and managing risk, the Board of Directors and its sub-committees have a substantial role to play in reviewing the effectiveness of the system of internal control as follows:

Board of Directors

Through the review and approval of the Board Assurance Framework and key performance indicators.

Audit Committee

Through the review of the Internal Audit programme of work, receipt of their reports, receipt of reports from external audit, and assurances gained through management reviews requested by the Audit Committee. The Audit Committee specifically commissioned the Internal Auditors, during the 2013/14 Internal Audit programme to review the level of assurance in relation to adherence to the WHO Safety Checklist and access and security of clinical records. They identified internal control weaknesses and action plans were developed to resolve the issues identified. These were monitored by the Trust's Quality, Effectiveness Safety Committee and Information Governance Committee respectively. Improvements were confirmed in the follow up audits.

Strategic Integrated Governance CommitteeThrough the review and management of the Trust's Board Assurance Framework and Risk Register.

Conclusion

The Head of Internal Audit has indicated that based on the work undertaken in 2013/14, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. Where weaknesses were identified, appropriate action plans delivered the necessary improvements.

The Trust has considered the principal risks to compliance with the NHS Foundation Trust Condition 4 (FT Governance) as part of the risk management process and the Board of Directors is able to assure itself of the validity of its Corporate Governance Statement, required under NHS Foundation Trust Conditions 4(8) (b).

From the systems and mechanisms outlined above the Board of Directors is able to take assurance that the governance systems in place are robust and functional.



Tracy Bullock
Chief Executive Officer/Accountable Officer

Chapter 11

Annual Accounts

Foreword to the accounts

These accounts for the year ended 31 March 2014 have been prepared by Mid Cheshire Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 in the form which Monitor, the Independent Regulator of NHS Foundation Trusts has, with the approval of the Treasury, directed.

Bullon

Tracy Bullock Chief Executive

Statement of the Chief Executive's responsibilities as the Accounting Officer of Mid Cheshire Hospitals NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

Under the NHS Act 2006, Monitor has directed Mid Cheshire Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Mid Cheshire Hospitals NHS Foundation Trust and 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 Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
 - Ensure that the use of public funds complies with the relevant legislation, delegated

- authorities and guidance
- 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 her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer's Memorandum.



Tracy Bullock Chief Executive

27 May 2014

Independent Auditor's Report to the Board of Governors and Board of Directors of Mid Cheshire Hospitals NHS Foundation Trust

We have audited the financial statements of Mid Cheshire Hospitals NHS Foundation Trust for the year ended 31 March 2014 which comprise the Group and Foundation Trust Statements of Comprehensive Income, the Group and Foundation Trust Statement of Financial Position, the Group and Foundation Trust Statement of Cash Flows, the Group and Foundation Trust Statements of Changes in Taxpayers' Equity and the related Notes 1 to 35. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

This report is made solely to the Council of Governors and Board of Directors ("the Boards") of Mid Cheshire Hospitals NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland).

Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the group's and the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the group's and the Trust's affairs as at 31 March 2014 and of the group's and the Trust's income and expenditure for the year then ended
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts, and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Opinion on other matter prescribed by the National Health Service Act 2006

In our opinion:

 the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls
- proper practices have not been observed in the compilation of the financial statements, or
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.

Paul Thomson ACA (Senior Statutory Auditor) for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor

Chartered Accountants and Statutory Auditor Leeds, UK

27 May 2014

Statement of Comprehensive Income for the Year ended 31 March 2014

		Grou	in	Foundation Trust		
		2013/14	2012/13	2013/14	2012/13	
	Note	£000	£000	£000	£000	
Operating Income from patient care activities	3	163,954	157,524	163,954	157,524	
NHS Charitable Funds: Incoming Resources excluding investment income	4	295	2,428	-	-	
Other operating income	4	19,265	19,640	19,380	19,671	
Operating expenses	5-7	*(196,135)	*(181,917)	*(195,854)	*(181,549)	
OPERATING DEFICIT		(12,621)	(2,325)	(12,520)	(4,354)	
Finance Costs:						
Finance Income	8	103	104	67	75	
Finance expense – financial liabilities	9.1	(113)	(104)	(113)	(104)	
Finance expense – unwinding of	22	(30)	(29)	(30)	(29)	
discount on provisions PDC Dividends paid	28	(2,048)	(2,170)	(2,048)	(2,170)	
·						
NET FINANCE COSTS		(2,088)	(2,199)	(2,124)	(2,228)	
DEFICIT FOR THE YEAR		(14,709)	(4,524)	(14,644)	(6,582)	
Other comprehensive income						
Gain from transfer by absorption from demising bodies	34	90	-	90	-	
Impairments on property, plant and equipment	23	(20,880)	(16,163)	(20,880)	(16,163)	
Revaluations gains on property, plant and equipment	23	19,117	10,412	19,117	10,412	
Fair Value gains/(losses) on Available- for-sale financial investments	35	(19)	71	-	-	
TOTAL COMPREHENSIVE EXPENSE FOR THE PERIOD		(16,401)	(10,204)	(16,317)	(12,333)	

The notes on pages 165 to 217 form part of these accounts.

All income and expenditure is derived from continuing operations.

^{*}Impact of Property Plant and Equipment valuations

	Group		Foundatio	n Trust
	2013/14	2012/13	2013/14	2012/13
	£'000	£'000	£'000	£'000
Operating Surplus before adjustments for valuation	3,337	5,676	3,438	3,647
Impairment of Property Plant and Equipment	(16,001)	(8,001)	(16,001)	(8,001)
Reversal of previous impairments charged to the Statement of Comprehensive Income	43	_	43	
Net Operating deficit	(12,621)	(2,325)	(12,520)	(4,354)

Operating Expenses include a non-cash adjustments £16,001K and operating income includes Reversal of previous impairments charged to the Statement of Comprehensive Income of £43K. The adjustments reflect the changes in the value of the Trusts' property, plant and equipment. Accounting standards require that these adjustments are recognised in operating income and expenditure. The underlying operating surplus was £3,337K for the Group and £3,438K for the Foundation Trust which would leave a net surplus of £1,249K for the Group and £1,314K for the Foundation Trust after interest and dividend charges.

Group Statement of Financial Position as at 31 March 2014

		31 March 2014	31 March 2013	1 April 2012
	Note	£000	£000	£000
Non-current assets				
Intangible assets	10	1,033	815	850
Property, plant and equipment	11	67,893	66,683	73,410
Other Investments	12	925	922	828
Trade and other receivables	14	304	438	513
Total non-current assets		70,155	68,858	75,601
Current assets				
Inventories	14	3,107	3,337	3,234
Trade and other receivables	15	8,772	7,214	7,083
Cash and cash equivalents	24	12,202	12,432	9,011
Non-current assets held for sale	13	31	31	31
Total current assets		24,112	23,014	19,359
Current liabilities				
Trade and other payables	18	(14,871)	(14,579)	(14,040)
Borrowings	20	(882)	(1,064)	(1,071)
Provisions	22	(211)	(277)	(428)
Other liabilities	19	(1,070)	(131)	(320)
Total current liabilities		(17,034)	(16,051)	(15,859)
Total assets less current liabilities		77,233	75,821	79,101
Non-current liabilities				
Trade and other payables	18	-	-	(4)
Borrowings	20	(1,770)	(1,176)	(1,524)
Provisions	22	(1,527)	(1,408)	(1,332)
Total non-current liabilities		(3,297)	(2,584)	(2,860)
Total assets employed		73,936	73,237	76,241
Financed by taxpayers' equity				
Public dividend capital		75,146	58,046	50,846
Revaluation reserve	23	9,743	11,605	17,718
Income and expenditure reserve		(13,864)	591	6,811
Others' equity				
Charitable Fund Reserve		2,911	2,995	866
Total taxpayers' and others' equity		73,936	73,237	76,241

The financial statements on pages 159 to 217 were approved by the Board and signed on its behalf on 27 May 2014.



Foundation Trust Statement of Financial Position as at 31 March 2014

		31 March 2014	31 March 2013	1 April 2012
	Note	£000	£000	£000
Non-current assets				
Intangible assets	10	1,033	815	850
Property, plant and equipment	11	67,893	66,683	73,410
Other Investments	12	-	-	-
Trade and other receivables	14	304	438	513
Total non-current assets		69,230	67,936	74,773
Current assets				
Inventories	14	3,107	3,337	3,234
Trade and other receivables	15	8,767	7,269	7,080
Cash and cash equivalents	24	11,149	10,304	8,956
Non-current assets held for sale	13	31	31	31
Total current assets		23,054	20,941	19,301
Current liabilities				
Trade and other payables	18	(14,799)	(14,579)	(14,020)
Borrowings	20	(882)	(1,064)	(1,071)
Provisions	22	(211)	(277)	(428)
Other liabilities	19	(2,070)	(131)	(320)
Total current liabilities		(17,962)	(16,051)	(15,839)
Total assets less current liabilities		74,322	72,826	78,235
Non-current liabilities				
Trade and other payables	18	-	-	(4)
Borrowings	20	(1,770)	(1,176)	(1,524)
Provisions	22	(1,527)	(1,408)	(1,332)
Total non-current liabilities		(3,297)	(2,584)	(2,860)
Total assets employed		71,025	70,242	75,375
Financed by taxpayers' equity				
Public dividend capital		75,146	58,046	50,846
Revaluation reserve	23	9,743	11,605	17,718
Income and expenditure reserve		(13,864)	591	6,811
Total taxpayers' and others' equity		71,025	70,242	75,375

Statement of Changes in Taxpayers' Equity as at 31 March 2014 - Group

		Public dividend capital (PDC)	Retained Earnings	Revaluation Reserve	Foundation Trust Total	NHS Charitable Fund Reserve	Group Total
	Note	£000	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2013		58,046	591	11,605	70,242	2,995	73,237
Retained deficit for the year		-	(14,759)	-	(14,759)	50	(14,709)
Transfers by MODIFIED absorption: Gains on 1 April transfers from demising bodies.	34	-	90	-	90	-	90
Transfer between reserves	23	-	99	(99)	-	-	-
Fair value loss on Available for sale financial investments	35	-	-	-	-	(19)	(19)
Impairments	23	-	-	(20,880)	(20,880)	-	(20,880)
Revaluations	23	-	-	19,117	19,117	-	19,117
Public Dividend Received		17,100	-	-	17,100	-	17,100
Other reserve movement – charitable funds consolidation adjustment		-	115	-	115	(115)	-
Taxpayers' equity at 31 March 2014		75,146	(13,864)	9,743	71,025	2,911	73,936

Statement of Changes in Taxpayers' Equity as at 31 March 2014 - Foundation Trust

		Public dividend capital (PDC)	Retained Earnings	Revaluation Reserve	Foundation Trust Total
	Note	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2013		58,046	591	11,605	70,242
Retained deficit for the year		-	(14,644)	-	(14,644)
Transfers by MODIFIED absorption: Gains on 1 April transfers from demising bodies.	34	-	90	-	90
Transfer between reserves	23	-	99	(99)	-
Fair value loss on Available for sale financial investments		-	-	-	-
Impairments	23	-	-	(20,880)	(20,880)
Revaluations	23	-	-	19,117	19,117
Public Dividend Received		17,100	-	-	17,100
Taxpayers' equity at 31 March 2014		75,146	(13,864)	9,743	71,025

Statement of Changes in Taxpayers' Equity as at 31 March 2013 - Group

		Public dividend capital (PDC)	Retained Earnings	Revaluation Reserve	Foundation Trust Total	NHS Charitable Fund Reserve	Group Total
	Note	£000	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2012 - as previously stated		50,846	6,811	17,718	75,375	-	75,375
Prior period adjustment					-	866	866
Taxpayers' Equity at 1 April 2012 - restated		50,846	6,811	17,718	75,375	866	76,241
Retained deficit for the year	34	-	(6,613)	-	(6,613)	2,089	(4,524)
Transfer between reserves	23	-	362	(362)	-	-	-
Revaluations and impairments - charitable funds	35	-	-	-	-	71	71
Impairments	23	-	-	(16,163)	(16,163)	-	(16,163)
Revaluations	23	-	-	10,412	10,412	-	10,412
Public Dividend Received		7,200	-	-	7,200	-	7,200
Other reserve movement – charitable funds consolidation adjustment		-	31	-	31	(31)	-
Taxpayers' equity at 31 March 2013		58,046	591	11,605	70,242	2,995	73,237

Statement of Changes in Taxpayers' Equity as at 31 March 2013 - Foundation Trust

		Public dividend capital (PDC)	Retained Earnings	Revaluation Reserve	Foundation Trust Total
	Note	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2012 - as previously stated		50,846	6,811	17,718	75,375
Prior period adjustment		-	-	-	-
Taxpayers' Equity at 1 April 2012 - restated		50,846	6,811	17,718	75,375
Retained deficit for the year		-	(6,582)	-	(6,582)
Transfer between reserves	23	-	362	(362)	-
Revaluations and impairments - charitable funds		-	-	-	-
Impairments	23	-	-	(16,163)	(16,163)
Revaluations	23	-	-	10,412	10,412
Public Dividend Received		7,200	-	-	7,200
Taxpayers' equity at 31 March 2013		58,046	591	11,605	70,242

Statement of Cash Flows for the Year ended 31 March 2014

	Group		Foundation Trust	
	2013/14	2012/13	2013/14	2012/13
	£000	£000	£000	£000
Cash flows from operating activites				
Operating deficit	(12,621)	(2,325)	(12,520)	(4,354)
Non-Cash income and expense				
Depreciation and amortisation	4,314	4,859	4,314	4,859
Impairments	16,001	8,001	16,001	8,001
Reversal of impairments	(43)	-	(43)	-
(Increase) in trade and other receivables	(1,084)	(285)	(1,044)	(327)
Increase in Inventories	230	(103)	230	(103)
(Decrease) / Increase in trade and other payables	581	(158)	581	(158)
Decrease in other current liabilities	939	(189)	1,939	(189)
(Decrease) / Increase in provisions	23	(75)	23	(75)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	52	(4)	-	-
Other movements in operating cash flows	5	(91)	5	(91)
Net cash generated from operations	8,397	9,630	9,486	7,563
Cash flows from investing activities				
Interest received	67	75	67	75
Payments for intangible assets	(469)	(199)	(469)	(199)
Payments for property, plant and equipment	(21,519)	(10,138)	(21,519)	(10,138)
Sales of plant property and equipment	-	-	-	-
NHS Charitable funds - net cash flows from investing activities	14	6	-	_
Net cash used in investing activities	(21,907)	(10,256)	(21,921)	(10,262)
Cash flows from financing activities				
Public dividend capital received	17,100	7,200	17,100	7,200
Capital element of finance lease rental payments	(1,299)	(1,132)	(1,299)	(1,132)
Interest element of finance lease	(113)	(104)	(113)	(104)
Public Dividend Capital paid	(2,408)	(1,917)	(2,408)	(1,917)
Net cash used in financing activities	13,280	4,047	13,280	4,047
Increase in cash and cash equivalents	(230)	3,421	845	1,348
Cash and Cash equivalents at 1 April	12,432	9,011	10,304	8,956
Cash and Cash equivalents at 31 March	12,202	12,432	11,149	10,304

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 2013/14 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual 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.

1.1 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 and inventories.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Consolidation Charitable Funds

The NHS Foundation Trust is the corporate trustee to Mid Cheshire Hospital Charity. The Foundation Trust has assessed its relationship to the Charity and determined it to be a subsidiary because the Foundation Trust has the power to govern the financial and operating policies of the Charity so as to obtain benefits from its activities for itself, its patients or its staff.

Prior to 2013/14, the FT ARM permitted the NHS Foundation Trust not to consolidate the Charitable Fund. From 2013/14, the Foundation Trust has consolidated the Charitable Fund and

has applied this as a change in accounting policy.

The Charity's statutory accounts are prepared to 31 March 2014 in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles (UK GAAP). On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the foundation trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

Please see Note 35 for a summary of the Charitable Funds Statement of Financial Activities and Balance Sheet for the Year Ending 31 March 2014.

Charity accounting policies

Incoming Resources

The policies followed, which deal with income, voluntary assistance and donations, are:

- a) Cash donations, gifts, investment income and cash collected from fundraising events are included in full in the Statement of Financial Activities as soon as the Charity's rights become legally enforceable and there is a reasonable assurance of receipt. This point is determined as confirmation of receipt into the nominated bank account.
- b) Legacies are accounted for as incoming resources either upon receipt or where the receipt and value of the legacy is virtually certain; this will be once confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made once all conditions attached to the legacy have been fulfilled.

Resources Expended

The financial statements are prepared in accordance with the accruals concept. A liability (and consequently, expenditure) is recognised in the accounts when there is a legal or constructive obligation, capable of reliable measurement, arising from a past event.

Resources expended are split into two main categories being the costs of generating funds and the actual costs of charitable activities. The costs of generating funds are the costs associated with generating income for the Charity including the cost of Investment Manager's fees and fundraising activities. A grant is any payment which is made voluntarily to any institution or to an individual in order to further the Charity's objectives, without receiving goods or services in return.

Costs of activities in the furtherance of charitable activities are expenditure incurred on the provision of services or goods. Support costs are an integral and material part of the costs of activities in the furtherance of charitable activities and/or expenditure incurred in paying grants. Where VAT is irrecoverable on purchases, the gross cost is charged to the funds.

Investment Fixed Assets

Stocks and shares quoted on the London Stock Exchange and unit trusts are included on the Statement of Financial Position at mid-market price, ex dividend on the Statement of Financial Position date. Realised and unrealised gains and losses are included on the Statement of Financial Activities and are calculated against the carrying value at the previous Statement of Financial Position date or cost if the asset was acquired during the year. Investment in the manufacture/processing of tobacco products is not permitted under the Investment Policy.

Structure of Funds

Where there is a legal restriction on the purposes to which a fund may be put, the fund is classified in the accounts as a restricted fund

Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds. Mid Cheshire Hospitals Charity holds no endowment funds. Other funds are classified as unrestricted funds. Unrestricted funds comprise those funds which the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include designated funds where the donor has made known their non-binding wishes or where the Trustee

at its discretion has created a fund for a specific purpose.

The Trustee involves each division, ward, department, and where appropriate staff representatives, in fundraising and decisions regarding expenditure of charitable monies. A Committee of the Board of Directors meets regularly and approves all expenditure.

Pooling Scheme

Any official pooling scheme is operated for investments relating to all Mid Cheshire Hospitals NHS Foundation Trust Charitable Funds. This was registered with the Charity Commission on 8 April 1998.

Joint Ventures

Joint ventures are separate entities over which the Trust has joint control with one or more other parties. Control is defined as having the power to exercise control or as having a dominant influence so as to gain economic or other benefits.

The Trust, since 27 March 2009, had been part of the Central Cheshire Urgent Primary Care Consortium providing urgent care facilities at the Leighton Hospital site. The joint venture was controlled in equal shares with Shropdoc, Central and Eastern Primary Care Trust and Mid Cheshire Hospitals NHS Foundation Trust through a limited liability partnership. On 1 April 2011 the control of the Central Cheshire Urgent Primary Care Consortium was changed to a joint venture between Shropdoc and Mid Cheshire Hospitals NHS Foundation Trust. However, on 1 April 2012 the joint venture ceased to exist and the Trust took over the control of the Urgent Care Centre. In prior years the joint venture has been accounted for by consolidating the Trust's share of the transactions, asset, liabilities, equity and reserves of the entity.

1.4 Pooled budgets

The Trust has not entered into a pooled budget arrangement.

1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make

judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

1.5.1 Critical judgements in applying accounting policies

There are no critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the entity's accounting policies.

1.5.2 Key sources of estimation uncertainty The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the Statement of Financial Position date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Incomplete Spells until activity is fully coded on discharge the level of income calculation is described under Note 3.1 Income from Activities. In addition Ante-natal pathway income has had an adjustment to reflect incomplete pathways as at 31 March 2014, where the Trust has been paid in full for the complete pathway up front. The calculation is described under Note 3.1

Provisions The Trust is party to a number of employer and public liability claims which are detailed in Note 22. These are based upon probabilities of successful claims. However this is limited to a maximum excess of £10,000 in respect of employers' liability and £3,000 for public liability. The total provision as at 31 March 2014 is £96,787.

Employees' Expenses At 31 March 2014 the accrual for outstanding holidays is £316,704. Staff other than Medical Staff are expected to take all annual leave by 31 March. The figure for

Medical Staff has been based on a percentage of 94% and increased pro rata.

Valuation of Property, Plant and Equipment Management has estimated the asset values and useful economic lives of land and buildings using guidance given by the District Valuation Office. The values are determined using a Modern Equivalent Asset (MEA) alternative site and/or accommodation basis. This considers the likely position and design of the hospitals if they were constructed now. The Valuer considered the differing internal space requirements taking into account; space, efficiencies and changes in technology, as opposed to what is currently physically occupied. The valuation assumed that the sites should have the same service potential as the existing assets. In addition, the site of the MEA may not be necessarily in the same location as the existing assets and therefore alternative sites have been considered.

In determining the fair value for non-specialised operational assets Existing Use Value has been used and for specialised operational assets as there is no market based evidence, Depreciated Replacement Cost has been used. The District Valuer has taken into account such factors as deterioration and technical obsolescence when determining the Modern Equivalent Asset valuation. Any deviation in these estimations could significantly impact on depreciation, impairments and the Public Dividend Capital Dividend.

1.6 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 health care services.

Income relating to patient care spells that are part-completed at the year-end are apportioned across the financial years on the basis of length of stay at the Statement of Financial Position date compared to expected total length of stay/costs incurred to date compared to total expected costs.

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.

Interest income is accrued on a time basis, by reference to the principal outstanding and interest rate applicable.

1.7 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 staff. The cost of annual leave entitlement which is earned but not taken by staff at the end of the period is recognised in the financial statements to the extent that staff are permitted to carry-forward leave into the following period.

Pension Costs

NHS Pension Scheme

Past and present members of staff are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying Scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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.

1.8 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is 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.

1.9 Property, plant and equipment *Capitalisation*

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- individually have a cost of at least £5,000; or
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are and its under single managerial control; or
- form part of the initial equipping and settingup cost of a new building, ward or unit irrespective of their individual or collective cost;
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; and
- The cost of the item can be measured reliably.

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.

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.

Land and buildings are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the Statement of Financial Position date. Fair values are determined as follows:

- Land and non-specialised buildings Market based evidence
- Specialised buildings depreciated replacement cost.

The Trust has had its last full revaluation of the buildings as at 31 March 2014. The Trust, in the valuation of 31 March 2014, used an MEA alternative site and/or accommodation basis. This considers the likely position and design of the hospitals if they were constructed now. The Valuer considered the differing internal space requirements taking into account; space, efficiencies and changes in technology, as opposed to what is currently physically occupied. The valuation assumed that the sites should have the same service potential as the existing assets. In addition, the site of the MEA may not be necessarily in the same location as the existing assets and therefore alternative sites have been considered.

It is the opinion of the qualified external Valuer that the market value for existing use of the property has been primarily derived using the depreciated replacement cost approach because of the specialised nature of the asset means that there are no market transactions of this type of asset except as part of the business or entity.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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'.

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 derecognised. 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.

1.10 Intangible fixed assets

Intangible assets are non-monetary assets without physical substance which are capable of being separately identified 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 secure potential be provided to, the Trust and where the cost of an asset can be measured reliably.

Intangible assets are capitalised when they have a cost of at least £5,000. Intangible assets acquired separately are initially recognised at cost.

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.

There was no such expenditure requiring capitalisation at the Statement of Financial Position date. Expenditure which does meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. NHS Foundation Trusts disclose the total amount of research and development expenditure

charged in the Statement of Comprehensive Income separately.

However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

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. Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Following initial recognition at cost, intangible assets are carried at depreciated historic cost as this is not considered to be materially different from fair value. Internally-developed software is held at historic cost to reflect the opposite effects of development costs and technological advances. Purchased computer software licences are held at cost less any amortisation and impairment.

1.11 Depreciation, amortisation and impairments

Land and assets under construction are not depreciated.

Otherwise, depreciation and amortisation are charged on a straight line basis to write off the costs or valuation of tangible and intangible non-current assets, less any residual value, over their estimated useful lives. The estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives or, where shorter, the lease term.

At each Statement of Financial Position date, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss

and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

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 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 when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Buildings and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by the NHS Foundation Trust's Professional Valuers.

The estimated life of buildings ranges between 11 to 82 years.

Plant and Equipment are depreciated evenly over the estimated life of the asset, as follows:

- Plant and Equipment 1 to 15 years
- Information Technology –1 to 5 years
- Furniture & Fittings 1 to 8 years.

1.12 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 ie:
 - 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.

1.13 Borrowing costs

Borrowing costs are recognised as expenses as they are incurred.

1.14 Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the donation/grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial

years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.15 Revenue government and other grants

Government grants are grants from other Government bodies other than income from Clinical Commissioning Groups or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match expenditure.

1.16 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Amounts held under finance leases are initially recognised as an asset at the inception of the lease at fair value or, if lower, at the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The asset is recorded as property, plant and equipment with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are charged directly to the Statement of Comprehensive Income.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

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.

The Trust as lessor

Amounts due from Lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

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.

1.17 Private Finance Initiative (PFI) transactions

The Trust has not entered into any PFI transactions.

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in firstout cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.19 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within creditors. Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, "interest receivable" and "interest payable" in the periods to which they relate. Bank charges are recorded as

operating expenditure in the periods to which they relate.

1.20 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 the discount rates published and mandated by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.21 Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation 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 22 but is not recognised in the Trust's accounts.

Since financial responsibility for clinical negligence cases transferred to the NHSLA at 1 April 2002, the only charge to operating expenditure in relation to clinical negligence in 2013/14 relates to the Trust's contribution to the Clinical Negligence Scheme for Trusts.

1.22 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 as and when the liability arises.

1.23 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 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 27, 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.

1.24 Financial assets

Financial assets are recognised on the Statement of Financial Position when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets 'at fair value through income and expenditure'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through income and expenditure.

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through income and expenditure. They are held at fair value, with any resultant gain or loss recognised in the statement of comprehensive income. The net gain or loss incorporates any interest earned on the financial asset.

Available for sale financial assets

Available for sale financial assets are nonderivative financial assets that are designated as available for sale or that does not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the statement of comprehensive income on de-recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised

cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of ore or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows 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 a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Statement of Comprehensive Income to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.25 Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised

when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

Financial liabilities are classified as either financial liabilities 'at fair value through profit and loss' or other financial liabilities.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.26 Value Added Tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.27 Corporation Tax

Mid Cheshire Hospitals NHS Foundation Trust is a Health Service body within the meaning of s519A 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 disapply the 17 exemption in relation to the specified activities of a Foundation Trust (s519A (3) to (8) ICTA 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 there from exceed £50,000pa. Her Majesty's Revenue and Customs have for some time been considering how best to implement the requirement for foundation trust's to pay corporation tax on the profits of certain nonhealthcare related activities. A consultation document was issued in August 2008 which put forward the suggestion that the profits from all non-healthcare activities should be aggregated and corporation tax paid thereon. The payment of corporation tax has now been deferred and thus there is no tax liability arising in respect of the current financial year.

1.28 Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the statement of comprehensive income. At the Statement of Financial Position date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the Statement of Financial Position date.

1.29 Third Party Assets

Assets belonging to third parties are not recognised in the accounts if, in the opinion of the directors,

- a) the Trust has no beneficial interest in them;
- b) they are of significant value and therefore justify the administrative costs of maintaining separate bank accounts. In all other cases, third party assets are incorporated within the Trust's other asset and a corresponding liability is included in Creditors.

Details of Third party assets are given in Note 31 to the accounts.

1.30 Public Dividend Capital (PDC) and PDC Dividend

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 original NHS trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, Her Majesty's Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32 it is not treated as an equity financial instrument.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by Her Majesty's Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation 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) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund Deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, (iii) for 2013/14 only, net assets and liabilities transferred from bodies which ceased to exist on 1 April 2013 (iv) 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.

1.31 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 each individual case is handled.

Losses and Special Payments are charged to the relevant functional headings on a cash 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, Note 33 is compiled directly from the Losses and Compensation Register which reports on an accrual basis with the exception of provisions for future losses.

1.32 Transfers of functions between NHS bodies / local government bodies

For functions that have been transferred to the Trust from another NHS / local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain/loss

corresponding to the net [assets/ liabilities] transferred is recognised within income/ expenses, but not within operating activities. The net gain corresponding to the net assets transferred from Central and Eastern Cheshire PCT is recognised within the income and expenditure reserve.

For property plant and equipment assets and intangible assets, the Cost and Accumulated Depreciation Amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS/local government body, the assets and liabilities transferred are derecognised from the accounts as at the date of transfer. The net loss/gain corresponding to the net assets/liabilities transferred is recognised within expenses/income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

1.33 Going Concern

The use of going concern basis of accounting is appropriate because there are no material uncertainties related to events or conditions that may cast significant doubt about the ability of the NHS Foundation Trust to continue as a going concern.

1.34 Accounting Standards that have been issued but have not yet been adopted

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted:

Effective for the next financial year ending 31 March:

IAS 27	Separate Financial Statements	Effective from 2014/15
IAS 28	Associates and Joint Ventures	Effective from 2014/15
IAS 32	Financial Instruments: Presentation amendment - Offsetting financial assets and liabilities	Effective from 2014/15
IFRS 9	Financial Instruments	Uncertain. Not likely to be adopted by the EU until the IASB has finished the rest of its financial instruments project
IFRS 10	Consolidated Financial Statements	Effective from 2014/15
IFRS 11	Joint Arrangements	Effective from 2014/15
IFRS 12	Disclosure of Interests in Other Entities	Effective from 2014/15
IFRS 13	Fair Value Measurement	Effective date of 2013/14 but not yet adopted by HM Treasury

The Trust has considered the above new standards, interpretations and amendments to published standards that are not yet effective and concluded that they are either not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures.

1.35 Accounting standards, amendments and interpretations issued that have been adopted early

The Trust has not early adopted any new accounting standards, amendments or interpretations.

2. SEGMENTAL REPORTING

The Trust considers the Board of Directors to be the Chief Operating Decision Maker. The Audit Committee has assessed the Trust's position against IFRS 8 and concluded that the Trust operates in a single healthcare segment. This recommendation was approved by the Board of Directors during its March 2014 meeting.

3. INCOME FROM ACTIVITIES

3.1 Income from patient care activities comprises:

Group and Foundation Trust	2013/14	2012/13	
	£000	£000	
Elective Income	29,267	26,383	
Non Elective Income	49,543	52,068	
Outpatient Income	31,358	34,374	
A & E Income	7,059	7,001	
Other NHS Clinical Income	43,992	34,992	
Income from activities (before private patient income)	161,219	154,818	
Other non-protected clinical income	1,146	1,130	
Private patient income	1,589	1,576	
Total Activity Income	163,954	157,524	

The elective and non-elective income includes the levels of incomplete spells as at 31 March 2014. The calculation is based on all patients who are in a bed at midnight on the 31 March by specialty and point of delivery. This activity is then multiplied by the average spell income for the relevant specialty/point of delivery for that year. The calculation also takes into account any Payment by Results rules with regard to marginal rates and thresholds for non-elective activity. The movement in year impacting on the recognised income is a decrease of £88,557. An increase of £2,576 is due to a change in price and a decrease of £91,133 is due to a change in volume.

The Ante-natal pathway income has had an adjustment to reflect incomplete pathways as at 31 March 2014, where the Trust has been paid in full for the complete pathway up front. This calculation is based on all patients who have started an ante-natal pathway before 31 March 2014 and have not delivered by this date, which is calculated on the basis of the pathway tariff paid at that point multiplied by the percentage of days left of the incomplete pathway based upon on the patient's expected due date. The movement in year impacting the recognised income is a decrease of £1,144.

Included in Other NHS Clinical Income is direct access income for Pathology and Radiology, Community Service

income, high cost drugs income and income for screening programmes.

Injury Cost Recovery income included in 'Other non-protected clinical income' is subject to a provision for doubtful debts of 15.8% (2012/13 12.6%) to reflect expected rates of collection.

All of the income from activities before private income shown above has arisen from Commissioner requested Services as set out in the foundation trusts provider licence.

4. OTHER OPERATING INCOME

	Group		Foundation Trust		
	2013/14	2012/13	2013/14	2012/13	
	£000	£000	£000	£000	
Education and training	5,321	5,258	5,321	5,258	
Received from NHS Charities: Receipt of grants/ donations for capital acquisitions - Donation	-	-	99	19	
Received from NHS charities: Other charitable and other contributions to expenditure	-	-	16	-	
Received from other bodies: Receipt of grants/ donations for capital acquisitions - Donation	39	-	39	12	
Received from other bodies: Other charitable and other contributions to expenditure	59	24	59	24	
Non-patient care services to other bodies	10,136	10,752	10,136	10,752	
Other	2,894	2,844	2,894	2,844	
Reversal of impairments of property, plant and equipment	43	-	43	-	
Staff Recharges	484	527	484	527	
Rental Revenue from operating leases	289	235	289	235	
NHS Charitable Funds: Incoming Resources excluding investment income	295	2,428	-	-	
Total other operating income	19,560	22,068	19,380	19,671	

4.1 Operating lease income

Group and Foundation Trust	2013/14	2012/13
Operating Lease Income	£000	£000
Rents recognised in the period	289	235
Total	289	235
Future minimum lease payments due	2013/14	2012/13
	£000	£000
On leases of Land expiring		
- Not later than one year	2	2
- Later than one year but not later than five years	8	8
- Later than five years	187	185
Sub Total	197	195
On Leases of Buildings expired		
- Not later than one year	301	318
- Later than one year but not later than five years	494	662
- Later than five years	114	201
Sub Total	909	1,181
Total	1,106	1,376

The Trust generates income from a small number of non-cancellable operating leases relating to the short term lease of accommodation and the lease of land to non-NHS bodies.

5. OPERATING EXPENSES

5.1 Group operating expenses comprise:

	Group		Foundation Trust	
	2013/14	2012/13	2013/14	2012/13
	£000	£000	£000	£000
Employee expenses - Staff	123,780	119,954	123,780	119,954
Employee expenses - Directors' costs	928	864	928	864
Employee expenses - Non-Executives' Costs	138	136	138	136
NHS Charitable funds - employee expenses	54	62	-	-
Supplies and services - clinical	14,278	13,000	14,278	13,000
Depreciation on property, plant and equipment	4,063	4,625	4,063	4,625
Amortisation of intangible assets	251	234	251	234
Impairments of property, plant and equipment	16,001	8,001	16,001	8,001
Premises	6,886	6,626	6,886	6,626
Inventories written down	35	44	35	44
Drug Costs (non-inventory costs)	307	289	307	289
Drug Costs (inventories consumed)	10,754	9,107	10,754	9,107
Clinical negligence	3,637	3,555	3,637	3,555
Other	1,492	1,442	1,492	1,442
NHS Charitable funds: Other resources expended	222	298	-	-
Consultancy services	906	989	906	989
Supplies and services – general	2,314	2,256	2,314	2,256
Printing, stationery, travel & recruitment advertising	1,412	1,335	1,412	1,335
Services from NHS bodies	4,998	5,751	4,998	5,751
Transport (business travel only)	351	389	351	389
Transport (other)	332	306	332	306
Rentals under operating lease	769	744	769	744
Auditor's remuneration	76	74	76	74
Other Auditor's remuneration	-	62	-	62
Audit services - charitable fund accounts	5	8	-	-
Purchase of healthcare from non-NHS bodies	792	681	792	681
Provision for impairment of receivables (including provision against Road Traffic income)	519	152	519	152
Legal Fees	92	193	92	193
Hospitality	14	33	14	33
Redundancies	-	192	-	192
Training Courses and Conferences	369	284	369	284
Patient Travel	27	26	27	26
Insurances	179	96	179	96
Other services	86	57	86	57
Change in provisions discount rate(s)	57	43	57	43
Losses, ex gratia and special payments	11	9	11	9
Total	196,135	181,917	195,854	181,549

5.2 Auditor's Remuneration

The analysis of auditor's remuneration is as follows:

	Group		Foundation	on Trust
	2013/14	2012/13	2013/14	2012/13
	£000	£000	£000	£000
Fees payable to the auditor for the audit of the Trust's annual accounts	76	74	76	74
Audit services - charitable fund accounts	5	8	-	-
Total audit fees	81	82	76	74
				_
Other services	-	62	-	62
Total Non-Audit fees	-	62	-	62

Auditor's Other Services relates to a service line review commissioned in respect of Elderly care, Maternity services, Non-elective General Surgery and Accident and Emergency.

5.3 Operating leases

5.3.1 Arrangements containing an operating lease

Group and Foundation Trust

	2013/14	2013/14	2013/14	2013/14
	Buildings	Plant and Machinery	Other	Total
	£000	£000	£000	£000
Lease payments	-	741	28	769
Total	0	741	28	769
	2012/13	2012/13	2012/13	2012/13
	Buildings	Plant and Machinery	Other	Total
	£000	£000	£000	£000
Lease payments	4	690	50	744
Total	4	690	50	744

There are no significant leasing arrangements included in the above.

5.3.2 Arrangements containing an operating lease

Group and Foundation Trust

•				
	2013/14	2013/14	2013/14	2013/14
Future non-cancellable minimum lease payments due:	Buildings	Plant and Machinery	Other	Total
	£000	£000	£000	£000
- Not later than one year;	-	558	29	587
 Later than one year and not later than five years; 	-	892	22	914
- Later than five years.	-	-	-	-
Total	0	1,450	51	1,501
	2012/13	2012/13	2012/13	2012/13
Future non-cancellable minimum lease payments due:	2012/13 Buildings	2012/13 Plant and Machinery	2012/13 Other	2012/13 Total
• •		Plant and		
• •	Buildings	Plant and Machinery	Other	Total
due:	Buildings	Plant and Machinery £000	Other £000	Total £000

1,345

57

1,402

Total

5.4 (A) Senior Manager remuneration and benefits - Emoluments

2013/14

2013/14 Name	Title	Gross	Expense	Performance Pay and	Long Term Performance Pay	All Pensions related	Total
Name	Title	Pay	Payments	Bonuses	and Bonuses	Benefits	IUlai
		£000s	£00s*	£000s	£000s	£000s	£000s
Moran J	Chairman	45	21	-	-	-	47
Godfrey V	Non-Executive (until 30/04/12)	-	-	-	-	-	-
Hopewell D	Non-Executive	18	11	-	-	-	19
Wood A	Senior Independent Director and Deputy Chairman (until 30/04/13)	1	-	-	-	-	1
Craig WD	Non-Executive (until 31/01/13)	-	-	-	-	-	-
Dunn D	Non-Executive	15	-	-	-	-	15
McNeil R	Non-Executive	12	2	-	-	-	12
Bacon P	Non-Executive (from 01/05/2012)	12	2	-	-	-	12
Barnes J	Non-Executive (from 01/02/13)	12	-	-	-	-	12
Davis M	Non-Executive (from 01/02/13)	12	-	-	-	-	12
Bullock T	Chief Executive	148	-	-	-	21	169
Oldham M	Director of Finance & Strategy	112	74	-	-	50	169
Shaw J	Interim Director of Workforce & Organisational Development (until 31/12/12)	-	-	-	-	-	-
Smith J	Director of Nursing & Quality	100	44	-	-	71	175
Frodsham D	Chief Operating Officer	105	58	-	-	73	184
Pitt D	Director of Service Transformation & Workforce(from 01/01/13)	100	-	-	-	29	129
Dodds P	Deputy Chief Executive Officer & Medical Director	187	-	-	-	49	236
Total		879	212			293	1,193

^{*} Benefits in Kind for the Executive Directors relate to lease cars provided by the Mid Cheshire Hospitals NHS Foundation Trust. The Benefits In Kind for the Non-Executives are payments for Travel. The figures are reported both in 'thousands' and 'hundreds' to comply with the Foundation Trust Annual Reporting Manual.

2012/13

Name	Title	Gross Pay	Expense Payments	Performance Pay and Bonuses	Long Term Performance Pay and Bonuses	All Pensions related Benefits	Total
		£000s	£00s*	£000s	£000s	£000s	£000s
Moran J	Chairman	45	40	-	-	-	49
Godfrey V	Non-Executive (until 30/04/12)	1	-	-	-	-	1
Hopewell D	Non-Executive	15	19	-	-	-	17
Wood A	Senior Independent Director and Deputy Chairman (until 30/04/13)	15	6	-	-	-	16
Craig WD	Non-Executive (until 31/01/13)	10	5	-	-	-	11
Dunn D	Non-Executive	12	-	-	-	-	12
McNeil R	Non-Executive	12	3	-	-	-	12
Bacon P	Non-Executive (from 01/05/2012)	11	-	-	-	-	11
Barnes J	Non-Executive (from 01/02/13)	2	-	-	-	-	2
Davis M	Non-Executive (from 01/02/13)	2	-	-	-	-	2
Bullock T	Chief Executive	145	-	-	-	(34)	111
Oldham M	Director of Finance & Strategy	105	97	-	-	(22)	93
Shaw J	Interim Director of Workforce & Organisational Development (until 31/12/12)	66	-	-	-	(7)	59
Smith J	Director of Nursing & Quality	90	41	-	-	(16)	78
Frodsham D	Chief Operating Officer	95	62	-	-	(15)	86
Pitt D	Director of Service Transformation & Workforce (from 01/01/13)	25	-	-	-	(17)	8
Dodds P	Deputy Chief Executive Officer & Medical Director	175	-	-	-	5	180
Total	- -	826	273	-	-	(106)	747

^{*} Benefits in Kind for the Executive Directors relate to lease cars provided by the Mid Cheshire Hospitals NHS Foundation Trust. The Benefits in Kind for the Non-Executives are payments for Travel. The figures are reported both in 'thousands' and 'hundreds' to comply with the Foundation Trust Annual Reporting Manual.

5.4 (B) Salary and Pension entitlements of senior managers - Pension Benefits

Name	Title	Real increase in pension at age 60	Real increase in lump sum at age 60	Total accrued pension at age 60 at 31 March 2014	Total accrued lump sum at age 60 at 31 March 2014	Cash Equivalent Transfer Value at 31 March 2014	Cash Equivalent Transfer Value at 31 March 2013	Real Increase in Cash Equivalent Transfer Value	Employers contribution to Stakeholder Pension
		£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Board Member	ers								
Bullock T	Chief Executive	2	5	55	165	930	856	28	-
Dodds P	Deputy Chief Executive & Medical Director	4	11	66	199	1,264	1,136	52	-
Oldham M	Director of Finance & Strategy	3	8	40	119	637	564	31	-
Frodsham D	Chief Operating Officer	3	11	33	100	645	543	47	-
Smith J	Director of Nursing & Quality	4	11	31	93	568	386	92	-
Pitt D	Director of Service Transformation & Workforce	2	5	33	98	574	516	25	-

As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.

The Trust has made no Employers' contribution to any stakeholder pension.

The normal retirement age for all senior management is 60 years of age.

5.4 (C) Notes to Senior Managers remuneration and Pension benefits

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, 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. CETV's 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 member of staff (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.

5.4 (D) Multiple Statement

Group and Foundation Trust

	2014	2013	Change
	£000	£000	%
Highest Paid Director gross cost	187	175	7.13
Median Total earnings	25	25	0.06
Ratio	7.46	6.97	7.07

The median total earnings was calculated using the full-time equivalent gross cost of all staff paid through the Trust's payroll in March 2014 which is then annualised. Both the highest paid Director and other staff received a one per cent pay rise. However the in 2013/14 the highest paid Director went up one point on the Incremental Scale for Consultants.

6. STAFF COSTS AND NUMBERS

6.1 Staff Costs

	Gro	oup Foundation Trus		n Trust
	2013/14	2012/13	2013/14	2012/13
	£000	£000	£000	£000
Salaries and wages	102,679	97,828	102,679	97,828
Social Security Costs	6,946	6,718	6,946	6,718
Employer contributions to NHS Pensions Authority	11,075	10,588	11,075	10,588
Pension cost - other	6	-	6	-
Termination Benefits	-	192	-	192
Agency and contract staff	4,376	6,008	4,376	6,008
NHS Charitable funds staff	54	62	-	
Total Gross Staff Costs	125,136	121,396	125,082	121,334
Of which				
Costs capitalised as part of assets	(374)	(324)	(374)	(324)
Total Employee benefits excluding Capitalised Costs	124,762	121,072	124,708	121,010
Analysed into Operating Expenses (5.1 Op Ex)				
Employee Expenses - Staff	123,780	119,954	123,780	119,954
Employee Expenses - Executive directors	928	864	928	864
NHS Charitable funds: Employee expenses	54	62	-	-
Redundancy	0	192	0	192
Total Employee benefits excl. capitalised costs	124,762	121,072	124,708	121,010

Staff costs exclude Non-Executive Directors. A breakdown of Directors' costs can be found in Note 5.4A to the accounts.

6.2 Average number of persons employed (whole time equivalents)

	Total 2013/14	Other permanent employees	Directors	Other	Total 2012/13
	Number	Number	Number	Number	Number
Medical & Dental	300	300	-	-	290
Administration & estates	643	637	6	-	628
Healthcare Assistants & other support staff	487	487	-	-	463
Nursing, midwifery & health visiting staff	850	850	-	-	817
Scientific, therapeutic and technical staff	406	406	-	-	400
Agency & Contract Staff	43	-	-	43	73
Bank Staff	136	-	-	136	138
Other	292	292	-	-	295
Total average numbers	3,157	2,972	6	179	3,104
of which					
WTE engaged on capital projects	6	6	-	-	7

6.3 Employee Benefits

Other than those disclosed in Note 5.4(A), the Trust operates a number of schemes relating to the use of cars, all these schemes apportion costs in such a way to ensure that staff pay a fair rate for private mileage.

6.4 Retirements due to ill-health

During 2013/14 there were four (2012/13: 2) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £141,901 (2012/13: £317,944). The cost of these ill-health retirements will be borne by the NHS Business Services Authority – Pensions Division.

6.5 Pension costs

6.5.1 NHS Pension Scheme

Past and present staff are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS Employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the Scheme Actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with

updated membership and financial data for the current reporting period, and are accepted as providing suitable robust figures on valuation data as 31 March 2013, updated to 31 March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by Her Majesty's Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by Her Majesty's Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

However the national deficit of the scheme was £3.3 bn as per the last scheme valuation by the Government Actuary for the period 1 April 1999 to 31 March 2004. The conclusion of the valuation was that the scheme continues to operate on a sound financial basis.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of Her Majesty's Treasury, and consideration of the advice of the Scheme Actuary and appropriate

employee and employer representatives as deemed appropriate.

Employer contribution rates are reviewed every four years following the scheme valuation, on advice from the actuary. At the last valuation it was recommended that employer contribution rates should continue at 14% of pensionable pay. From 1 April 2008, staff pay contributions are on a tiered scale. In 2013/14 this ranged from 5% to 13.5% of their pensionable pay and will be 5% to 14.5% of their pensionable pay as from 1 April 2014.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and be used to inform contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under Her Majesty's Revenue and Customs rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

d) III-Health Retirement

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity.

e) Death Benefits

A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

f) Additional Voluntary Contributions (AVCs)

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVCs run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

g) Other Early Retirements

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

h) Transfer between Funds

Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

i) Preserved Benefits

Where a scheme member ceases NHS employment with more than two years' service they can preserve their accrued NHS pension for payment when they reach retirement age.

j) Compensation for Early Retirement

Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

6.5.2 National Employment Savings Trust

The Pensions Act 2008 requires every employer to automatically enrol eligible workers into a qualifying pension scheme and pay contributions. For those staff who do not wish to be enrolled into the NHS Pension scheme the National Employment Savings Trust (NEST) is offered as an alternative. NEST is a defined contribution pension scheme.

NEST Corporation is the Trustee body that has overall responsibility for running NEST, it's a non-departmental public body that operates at arm's length from government and is accountable to Parliament through the Department of Work and Pensions (DWP).

NEST levies a contribution charge of 1.8% and an annual management charge of 0.3% which is paid for from the staff contributions. There are no separate employer charges levied by NEST.

6.6 Staff exit packages

Group and Foundation Trust

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
< £10,000	- (-)	- (1)	- (1)
£10,000 - £25,000	- (-)	- (1)	- (1)
£25,001 - £50,000	- (-)	- (3)	- (3)
£50,001 - £100,000	- (-)	- (1)	- (1)
Total number of exit packages by type	- (-)	- (6)	- (6)

Exit package cost band	Cost of compulsory redundancies	Cost of other departures agreed	Total cost of exit packages by cost band
	£000	£000	£000
< £10,000	- (-)	- (6)	- (6)
£10,000 - £25,000	- (-)	- (13)	- (13)
£25,001 - £50,000	- (-)	- (118)	- (118)
£50,001 - £100,000	- (-)	- (56)	- (56)
Total cost of exit packages by type	- (-)	- (193)	- (193)

The Trust has offered staff a mutually agreed resignation scheme where the Trust may offer a financial package to a member of staff who wishes to leave their employment on voluntary terms. To be eligible the applicant must be permanently employed by the Trust and have a minimum of two years continuous service. The figures in brackets are those for 2012/13.

7. BETTER PAYMENT PRACTICE CODE

7.1 Better Payment Practice Code – measure of compliance

Group and Foundation Trust

	2013/14		2012/13	
	Number	£000	Number	£000
Total Trade bills paid in the year	48,131	131,294	48,214	117,170
Total Trade bills paid within target	44,769	123,507	44,586	110,480
Percentage of Trade bills paid within target	93%	94%	92%	94%

The target is to pay both non-NHS and NHS trade creditors within terms agreed with suppliers. In most cases the agreed terms are payment within 30 days of receipt of invoice.

7.2 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust had no interest payable for the year ended 31 March 2014 under the Late Payment of Commercial Debts (Interest) Act 1998.

8. FINANCE INCOME

Interest on bank accounts NHS Charitable funds: investment income
Total

Group		Foundation	Trust
2013/14	2012/13	2013/14	2012/13
£000	£000	£000	£000
67	75	67	75
36	29	-	_
103	104	67	75

9 FINANCE COSTS

9.1 Finance Cost – Interest Expense

Group and Foundation Trust

Interest on obligations under finance lease Total

2013/14	2012/13
£000	£000
113	104
113	104

9.2 Impairment of Assets

Group and Foundation Trust

	2013/14			
	Net Impairment	Impairment	Reversals	
	£000	£000	£000	
Changes in market price	15,958	16,001	(43)	
Total Impairments charged to operating surplus	15,958	16,001	(43)	
Impairments charged to the revaluation reserve	20,880	20,880	-	
Total Impairments	36,838	36,881	(43)	

	2012/13		
	Net Impairment	Net Impairment Impairment	
	£000	£000	£000
Loss or damage from normal operations	942	942	-
Changes in market price	7,059	7,059	_
Total Impairments charged to operating surplus	8,001	8,001	-
Impairments charged to the revaluation reserve	16,163	16,163	<u>-</u> _
Total Impairments	24,164	24,164	

Included in the above is the impact of the revaluation of the premises as at March 2014.

10. INTANGIBLE FIXED ASSETS

Group and Foundation Trust

	Software Licences 2013/14	Assets under construction 2013/14	Total 2013/14
	£000	£000	£000
Gross cost at 1 April 2013	1,640	124	1,764
Additions purchased	469	-	469
Reclassifications	124	(124)	
Gross cost at 31 March 2014	2,233	-	2,233
Amortisation at 1 April 2013	949	-	949
Provided during the year	251		251
Amortisation at 31 March 2014	1,200	-	1,200
Net book value			
- Total purchased at 1 April 2013	691	124	815
- Total purchased at 31 March 2014	1,200	0	1,033
	Software Licences 2012/13	Assets under construction 2012/13	Total 2012/13
			Total 2012/13 £000
Gross cost at 1 April 2012	2012/13	construction 2012/13	
Gross cost at 1 April 2012 Additions purchased	2012/13 £000	construction 2012/13 £000	£000
-	2012/13 £000 1,341	construction 2012/13 £000 224	£000 1,565
Additions purchased	2012/13 £000 1,341 75	construction 2012/13 £000 224 124	£000 1,565
Additions purchased Reclassifications	2012/13 £000 1,341 75 224	construction 2012/13 £000 224 124 (224)	£000 1,565 199
Additions purchased Reclassifications Gross cost at 31 March 2013	2012/13 £000 1,341 75 224 1,640	construction 2012/13 £000 224 124 (224)	£000 1,565 199 - 1,764
Additions purchased Reclassifications Gross cost at 31 March 2013 Amortisation at 1 April 2012	2012/13 £000 1,341 75 224 1,640	construction 2012/13 £000 224 124 (224)	£000 1,565 199 - 1,764 715
Additions purchased Reclassifications Gross cost at 31 March 2013 Amortisation at 1 April 2012 Provided during the year	2012/13 £000 1,341 75 224 1,640 715 234	construction 2012/13 £000 224 124 (224)	1,565 199 - 1,764 715 234
Additions purchased Reclassifications Gross cost at 31 March 2013 Amortisation at 1 April 2012 Provided during the year Amortisation at 31 March 2013	2012/13 £000 1,341 75 224 1,640 715 234	construction 2012/13 £000 224 124 (224)	1,565 199 - 1,764 715 234

The reclassification is the transfer from intangible assets under construction to intangibles. All intangible assets relate to purchased software licences.

10.1 Intangible assets financing

Group and Foundation Trust

	Software Licences 2013/14	Assets under construction 2013/14	Total 2013/14
	£000	£000	£000
NBV - Purchased at 31 March 2014	1,033	-	1,033
NBV - Finance leases at 31 March 2014	-	-	-
NBV - Donated and government grant funded at 31 March 2014	-	-	
NBV total at 31 March 2014	1,033	-	1,033
:			
	Software Licences 2012/13	Assets under construction 2012/13	Total 2012/13
			Total 2012/13 £000
NBV - Purchased at 31 March 2013	2012/13	construction 2012/13	
NBV - Purchased at 31 March 2013 NBV - Finance leases at 31 March 2013	2012/13 £000	construction 2012/13 £000	£000
	2012/13 £000	construction 2012/13 £000	£000

10.2 Economic life of Intangible Assets

The economic life of the intangible assets ranges from 3 to 5 years.

11. TANGIBLE FIXED ASSETS

11.1 Tangible fixed assets at the Statement of Financial Position date comprise the following elements:

Group and Foundation Trust

			Group and	Foundation Trust				
	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & Machinery	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2013	2,600	51,738	2,280	4,863	14,472	3,463	271	79,687
Transfer by absorption - Modified	-	-	-	-	-	-	90	90
Additions – purchased	-	17,598	146	1,865	198	1,381	-	21,188
Additions – leased	-	-	-	-	1,706	-	-	1,706
Additions – donated	-	-	-	-	10	-	-	10
Impairments	-	(20,283)	(597)	-	-	-	-	(20,880)
Reversal of Impairments#	-	-	-	-	-	-	-	-
Revaluations	-	1,165	-	-	-	-	-	1,165
Reclassifications	-	4,566	-	(4,675)	109	-	-	-
Disposals	-	-	-	-	(1,006)	-	(49)	(1,055)
Cost or valuation at 31 March 2014	2,600	54,784	1,829	2,053	15,489	4,844	312	81,911
Accumulated depreciation at 1 April 2013	-	-	-	-	10,232	2,621	151	13,004
Provided during the year	-	1,902	92	-	1,660	364	45	4,063
Impairments	_	15,688	313	_	-	_	_	16,001
Reversal of impairments	_	(43)	_	_	_	_	_	(43)
Revaluation	_	(17,547)	(405)	_	_	_	_	(17,952)
Disposals	_	-	-	_	(1,006)	_	(49)	(1,055)
Accumulated depreciation at 31 March 2014	0	0	0	0	10,886	2,985	147	14,018
Net Book Value								
NBV - Purchased at 31 March 2013	2,600	50,361	2,280	4,863	1,647	627	93	62,471
NBV – Finance Lease at 31 March 2013	-	-	-	-	2,322	215	27	2,564
NBV - Donated at 31 March 2013	-	1,377	-	-	271	-	-	1,648
NBV total at 31 March 2013	2,600	51,738	2,280	4,863	4,240	842	120	66,683
Net Book Value								
NBV - Purchased at 31 March 2014	2,600	53,642	1,829	2,053	1,329	1,694	156	63,303
NBV – Finance Lease at 31 March 2014	-	-	-	-	2,949	165	9	3,123
NBV - Donated at 31 March 2014		1,142	-	-	325	-	-	1,467
NBV total at 31 March 2014	2,600	54,784	1,829	2,053	4,603	1,859	165	67,893

In 2013/14 land and buildings were revalued using a Modern Equivalent Asset (MEA) alternative site and/or accommodation basis. The District valuer considered the likely position and design of the hospitals if they were constructed now. The valuer considered the differing internal space requirements taking into account; space efficiencies and changes in technology, as opposed to what is currently physically occupied. The valuation assumed that the sites should have the same service potential as the existing assets. The valuation reduced the value of land and buildings by £17,721K. A charge of £15,958K was made to the Operating Expenditure, reflecting the difference between the downward valuation and the balance in the revaluation reserve. The net charge to the revaluation reserve was £1,763K.

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & Machinery	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2012	2,600	61,673	2,715	723	17,108	3,151	265	88,235
Additions – purchased	-	5,156	-	4,854	622	179	-	10,811
Additions – leased	-	-	-	-	598	241	-	839
Additions – donated	-	-	-	-	-	-	-	-
Impairments	-	(15,728)	(435)	-	-	-	-	(16,163)
Revaluations	-	53	-	-	-	-	-	53
Reclassifications	-	584	-	(714)	(44)	168	6	-
Disposals		-	-	-	(3,812)	(276)	-	(4,088)
Cost or valuation at 31 March 2013	2,600	51,738	2,280	4,863	14,472	3,463	271	79,687
Accumulated depreciation at 1 April 2012	-	-	-		12,371	2,335	119	14,825
Provided during the year	-	2,248	110	-	1,673	562	32	4,625
Impairments	-	8,001	-	-	-	-	-	8,001
Reversal of impairments	-	-	-	-	-	-	-	-
Revaluation	-	(10,249)	(110)	-	-	-	-	(10,359)
Disposals	-	-	-	-	(3,812)	(276)	-	(4,088)
Accumulated depreciation at 31 March 2013	-	-	-	-	10,232	2,621	151	13,004
Net Book Value								
NBV - Purchased at 31 March 2012	2,600	60,007	2,715	723	1,430	797	101	68,373
NBV – Finance Lease at 31 March 2012	-	-	-	-	2,952	19	45	3,016
NBV - Donated at 31 March 2012	-	1,666	-	-	355	-	-	2,021
NBV total at 31 March 2012	2,600	61,673	2,715	723	4,737	816	146	73,410
Net Book Value								
NBV - Purchased at 31 March 2013	2,600	50,361	2,280	4,863	1,647	627	93	62,471
NBV – Finance Lease at 31 March 2013	-	-	-	-	2,322	215	27	2,564
NBV - Donated at 31 March 2013		1,377	-	-	271	-	-	1,648
NBV total at 31 March 2013	2,600	51,738	2,280	4,863	4,240	842	120	66,683

In 2012/13 land and buildings were revalued using a Modern Equivalent Asset (MEA) alternative site and/or accommodation basis. The District valuer considered the likely position and design of the hospitals if they were constructed now. The valuer considered the differing internal space requirements taking into account; space efficiencies and changes in technology, as opposed to what is currently physically occupied. The valuation assumed that the sites should have the same service potential as the existing assets. The valuation reduced the value of land and buildings by £13,752K. A charge of £8,001K was made to the Operating Expenditure, reflecting the difference between the downward valuation and the balance in the revaluation reserve. The net charge to the revaluation reserve was £5,571K.

11.4 Economic life of property, plant and equipment

Group and Foundation Trust

	Min. Life	Max. Life
Buildings excluding dwellings	11	82
Dwellings	20	50
Assets under construction	-	-
Plant & machinery	1	15
Information Technology	1	15
Furniture and Fittings	1	8

Land is treated as having an infinite life.

11.5 Assets held at open market value

At the Statement of Financial Position date there was no land, buildings or dwellings valued at open market value.

12. INVESTMENTS

	Group	Foundation Trust
	NHS Charitable Funds: Other investments	NHS Charitable Funds: Other investments
	2013/14	2013/14
	£000	£000£
Carrying Value 1 April 2013 (restated)	922	-
Acquisitions in year - other	22	-
Movement in fair value of Available-for-sale financial assets recognised in Other Comprehensive Income	(19)	-
Carrying Value 31 March 2014	925	-
	Group	Foundation Trust
	NHS Charitable Funds: Other investments	NHS Charitable Funds: Other investments
	2012/13	2012/13
	£000	£000
Carrying Value 1 April 2012	-	-
Prior Period Adjustment	822	-
Carrying Value 1 April 2012 (restated)	828	-
Acquisitions in year – other	23	-
Movement in fair value of Available-for-sale financial assets recognised in Other Comprehensive Income	71	-
Carrying Value 31 March 2013	922	-

13. NON-CURRENT ASSETS FOR SALE AND ASSETS IN DISPOSAL GROUPS

Group and Foundation Trust

Non-current assets for sale and assets in disposal groups 2013/14	Total	Property, plant and equipment
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2013	31	31
NBV of non-current assets for sale and assets in disposal groups at 31 March 2014	31	31

A number of washer dryers have been transferred to non-current assets held for sale in 2010/11. Management still has an intention to sell these.

14. INVENTORIES

14.1 Inventories

Inventory Movements 2013/14	Drugs	Consumables	Energy	Total
inventory movements 2013/14	£000	£000	£000	£000
Carrying value at 1 April	861	2,361	115	3,337
Additions	10,660	9,216	54	19,930
Inventories recognised in expense	(10,754)	(9,356)	(15)	(20,125)
Write down of inventories recognised in expense	(35)	-	-	(35)
Carrying value at 31 March	732	2,221	154	3,107

Inventory Movements 2012/13	Drugs	Consumables	Energy	Total
inventory movements 2012/13	£000	£000	£000	£000
Carrying value at 1 April	840	2,269	125	3,234
Additions	9,161	8,560	-	17,721
Inventories recognised in expense	(9,107)	(8,457)	(10)	(17,574)
Write down of inventories recognised in expense	(33)	(11)	-	(44)
Carrying value at 31 March	861	2,361	115	3,337

15. TRADE AND OTHER RECEIVABLES

Group	
-------	--

	2014	2013	2012
	£000	£000	£000
Current:			
NHS receivables	4,770	4,191	3,499
Provision for impaired receivables	(412)	(139)	(410)
Prepayments	1,444	1,157	1,574
PDC Receivable	320	-	213
VAT Receivable	188	253	109
Other receivables	2,435	1,745	2,095
NHS Charitable funds: Trade and other receivables	27	7	3
Total current trade and other receivables	8,772	7,214	7,083
Non-current:			
Other receivables	374	524	589
Provision for impaired receivables	(70)	(86)	(76)
Total non-current trade and other receivables	304	438	513
Total trade and other receivables	9,076	7,652	7,596

Foundation Trust

	2014	2013	2012
	£000	£000	£000
Current:			
NHS receivables	4,770	4,191	3,499
Provision for impaired receivables	(412)	(139)	(410)
Prepayments	1,444	1,157	1,574
PDC Receivable	320	-	213
VAT Receivable	188	253	109
Other receivables	2,457	1,807	2,095
Total current trade and other receivables	8,767	7,269	7,080
Non-current:			
Other receivables	374	524	589
Provision for impaired receivables	(70)	(86)	(76)
Total non-current trade and other receivables	304	438	513
Total trade and other receivables	9,071	7,707	7,593

15.1 Provision for impairment of receivables

Group and Foundation Trust

	2013/14	2012/13
	£000£	£000
At 1 April	225	486
Increase in provision	527	404
Amounts utilised	(262)	(413)
Unused amounts reversed	(8)	(252)
At 31 March	482	225

Included above is a provision of £234,240 which is based on 15.8% on the outstanding receivables from the Compensation Recovery Unit.

15.2 Ageing of receivables

90 to 180 days

Over 180 days

Total

Group and Foundation Trust

Ageing of impaired receivables	31 March 2014	31 March 2013	31 March 2012
Ageing of impaired receivables	£000	£000	£000
0 to 30 days	72	-	34
30 to 60 days	24	-	26
60 to 90 days	2	3	38
90 to 180 days	59	2	66
Over 180 days	325	220	322
Total	482	225	486
Ageing of non-impaired receivables past their due	31 March 2014	31 March 2013	31 March 2012
date	£000	£000	£000
0 to 30 days	602	386	191
30 to 60 days	558	232	430
60 to 90 days	141	89	23

228

85

1,614

91

13

811

16. OTHER FINANCIAL ASSETS

The Group and Foundation Trust have no other financial assets as at 31 March 2014 or 31 March 2013.

17. OTHER CURRENT ASSETS

The Group and Foundation Trust have no other current assets as at 31 March 2014 or 31 March 2013.

164

118

926

18. TRADE AND OTHER PAYABLES

18.1 Trade and other payables at the Statement of Financial Position date are made up of:

Group

	31 March 2014	31 March 2013	31 March 2012
	£000	£000	£000
Current:			
NHS payables	2,079	1,404	2,000
NHS pensions	1,539	1,380	1,291
Trade payables capital	1,651	1,972	1,300
Social Security costs	1,142	1,099	1,079
Other taxes payable	1,145	1,152	1,190
Other payables	100	116	148
Other trade payables	4,258	4,323	3,615
PDC dividend payables	-	40	-
Accruals	2,885	3,093	3,397
NHS Charitable funds: Trade and other payables	72	-	20
Total current trade and other payables	14,871	14,579	14,040
Non-current:			
Other payables			4
Total non-current trade and other payables	-	-	4
	14,871	14,579	14,044

Foundation Trust

	31 March 2014	31 March 2013	31 March 2012
	£000	£000	£000
Current:			
NHS payables	2,079	1,404	2,000
NHS pensions	1,539	1,380	1,291
Trade payables capital	1,651	1,972	1,300
Social Security costs	1,142	1,099	1,079
Other taxes payable	1,145	1,152	1,190
Other payables	100	116	148
Other trade payables	4,258	4,323	3,615
PDC dividend payables	-	40	-
Accruals	2,885	3,093	3,397
Total current trade and other payables	14,799	14,579	14,020
Non-current:			
Other payables			4
Total non-current trade and other payables		-	4
	14,799	14,579	14,024

19. OTHER LIABILITIES

Group

Current:
Deferred income
Total current liabilities

31 March 2014	31 March 2013	31 March 2012
£000	£000	£000
1,070	131	320
1,070	131	320

Foundation Trust

31 March 2014	31 March 2013	31 March 2012
£000	£000	£000
2,070	131	320
2,070	131	320

Included in the balance is £1,000,000 which has been donated from Mid Cheshire Hospital Charity for the refurbishment of the Neo-Natal Intensive care unit and £1,049,734 relating to Maternity income.

20. BORROWINGS

Current:

Deferred income

Total current liabilities

	31 March 2014	31 March 2013	31 March 2012
	£000	£000	£000
Current:			
Obligations under finance lease	882	1,064	1,071
Total current borrowings	882	1,064	1,071
Non-current			
Obligations under finance lease	1,770	1,176	1,524
Total non-current borrowings	1,770	1,176	1,524

21 FINANCE LEASE OBLIGATIONS

Minimum Logge Payments	31 March 2014	31 March 2013
Minimum Lease Payments	£000	£000
Gross liabilities	2,865	2,363
of which liabilities are due		
- not later than 1 year	956	1,128
- later than 1 year but not later than 5 years	1,583	1,161
- later than five years	326	74
Finance charges allocated to future periods	(213)	(123)
Net lease liabilities	2,652	2,240
- not later than 1 year	882	1,064
- later than 1 year but not later than 5 years	1,461	1,102
- later than 5 years	309	74
	2,652	2,240

22 PROVISIONS FOR LIABILITIES AND CHARGES

Group and Foundation Trust

Non-Current

31 March 2013

31 March 2014

Current

31 March 2014 31 March 2013

Legal Claims	97	81		-	-
Pensions	114	112	1,52	7	1,408
Other	-	84		-	-
Total	211	277	1,52	7	1,408
		Legal Claims	Pensions	Other	Total
		£000	£000	£000	£000
At 1 April 2013		81	1,520	84	1,685
Change in the discount rate		-	57	-	57
Arising during the year		71	182	-	253
Utilised during the year		(37)	(114)	(46)	(197)
Reversed unused		(18)	(34)	(38)	(90)
NHS Charitable funds: movemen	t in provision	-	-	-	-
Unwinding of discount		-	30	-	30
At 31 March 2014		97	1,641	0	1,738
Expected timing of cash flows:	:				
Not later than 1 year		97	114	-	211
Later than 1 year and not later th	an 5 years	-	435	-	435
Later than 5 years		-	1,092	-	1,092
At 31 March 2014		97	1,641	0	1,738
	-		· · · · · · · · · · · · · · · · · · ·		

Provisions for pension benefits are based on tables provided by the NHS Pensions Agency, reflecting years to normal retirement age and the additional pension costs associated with early retirement.

Legal claims consist of amounts due as a result of public and employee liability claims. The values are based on information provided by and the NHS Litigation Authority.

Clinical Negligence

The NHS Litigation Authority (NHSLA) took over the financial responsibility for unsettled clinical negligence Existing Liabilities Scheme (ELS) cases from 1 April 2000.

In respect of the ELS liabilities of the Trust, nothing has been included in the provision of the NHSLA at 31 March 2014 and 31 March 2013 (for which NHSLA is administratively responsible but the Trust has legal liability).

Financial responsibility for all other clinical negligence claims transferred to the NHS Litigation Authority (NHSLA) on 1 April 2002.

£27,356,404 (2012/13: £25,846,828) is included in the provision of the NHSLA at 31 March 2014 in respect of the CNST liabilities of the Trust (of which the NHSLA is administratively responsible but the Trust has legal liability).

In addition to the clinical negligence provision, contingent liabilities for clinical negligence are given in Note 27.

23. REVALUATION RESERVE

Movements on reserves in the year comprised the following :

	Revaluation Reserve Property, plant and equipment	Total 2014
	£000	£000
Revaluation reserve at 1 April 2013	11,605	11,605
Impairments	(20,880)	(20,880)
Revaluations	19,117	19,117
Transfers to other reserves	(99)	(99)
At 31 March 2014	9,743	9,743
	Revaluation Reserve Property, plant and equipment	Total 2013
Revaluation reserve at 1 April 2012	Property, plant and equipment	2013
Revaluation reserve at 1 April 2012 Impairments	Property, plant and equipment £000	2013 £000
•	Property, plant and equipment £000 17,718	2013 £000 17,718
Impairments	Property, plant and equipment £000 17,718 (16,163)	2013 £000 17,718 (16,163)

24. CASH AND CASH EQUIVALENTS

	Cash and Cash equivalents (excluding charitable funds) 31 March 2014	NHS Charitable Funds : cash and cash equivalents 31 March 2014	Cash and Cash equivalents (excluding charitable funds) 31 March 2014	NHS Charitable Funds : cash and cash equivalents 31 March 2014
	£000	£000	£000	£000
At 1 April	10,304	2,128	8,956	-
Prior period adjustment		_		55
At 1 April (restated)	10,304	2,128	8,956	55
Net change in year	845	(1,075)	1,348	2,073
At 31 March	11,149	1,053	10,304	2,128
Broken down into				
Cash at commercial bank and in hand	186	1,053	567	2,128
Cash with Government Banking Service	10,963	-	9,737	-
Cash and Cash equivalents as in SoFP and SoCF	11,149	1,053	10,304	2,128

25. **CAPITAL COMMITMENTS**

Commitments under capital expenditure contracts at the Statement of Financial Position date were £30,000 (2012/13: £413,000).The commitment is for IT Security software.

26. **EVENTS AFTER THE** REPORTING PERIOD

There are no events after the reporting period requiring disclosure.

27. **CONTINGENCIES**

The Trust has received claims to the value below for compensation for alleged clinical negligence and public or employer liability. These claims are disputed and the Trust's financial liability, if any, cannot be determined until these claims are received. Where the Trust feels it is unlikely that these claims will be successful the estimates are included in contingencies otherwise they are included in provisions. A prudent estimate of the amount involved, inclusive of legal cost is:

27.1 Contingent Liabilities

Foundation Trust		
Clinical Negligence	Other Legal	Total
31 March 2014	31 March 2014	31 March 2014
£000	£000	£000
15,024	419	15,443
(15,024)	(362)	(15,386)
-	57	57
Clinical Negligence	Other Legal	Total
	Other Legal 31 March 2013	Total 31 March 2013
Negligence		
Negligence 31 March 2013	31 March 2013	31 March 2013
Negligence 31 March 2013 £000	31 March 2013 £000	31 March 2013 £000
	Clinical Negligence 31 March 2014 £000 15,024	Clinical Negligence 31 March 2014

27.2 Contingent Asset

In 2013/14, the Mid Cheshire Hospital Charity was notified of a legacy entitling to the Charity to half of the residual estate but this has been subject to a claim of promissory estoppel by another beneficiary of the will. At the point of the completion of the accounts, this claim has not been withdrawn so the Group has made no provision for the receipt of it's entitlement within these statements. If no challenge had been made to the validity of the legacy, it is estimated that the share for Mid Cheshire Hospitals Charity would be £773,000.

28. PUBLIC DIVIDEND CAPITAL DIVIDEND

The Trust is required to pay a dividend to the Department of Health at a real rate of 3.5% of average relevant net assets less the average daily cleared Government Banking Service balances. The Trust's public dividend paid in year totals £2,408,000 which included a payable of £40,000 from 2012/13. However, based on actual average relevant net assets, this figure should be £2,048,000 and a receivable of £320,000 has been recognised.

29. RELATED PARTY TRANSACTIONS

Mid Cheshire Hospitals NHS Foundation Trust is a public interest body authorised by Monitor – the Independent Regulator of NHS Foundation Trusts.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Mid Cheshire Hospitals NHS Foundation Trust.

Other main NHS entities with which Mid Cheshire Hospitals NHS Foundation Trust are regarded as related parties. During the year Mid Cheshire Hospitals NHS Foundation Trust had a number of material transactions with other NHS entities which are listed below:

	Income	Expenditure
	£000	£000
Value of Transactions (other than salary) with board members 2013/14	-	-
Value of Transactions with key staff members 2013/14	-	-
Value of transactions with other related parties 2013/14	-	-
Department of Health		
Other NHS Bodies	175,206	9,727
Charitable Funds	-	-
Subsidiaries/Associates/Joint Ventures	-	-
Other	2,043	18,742
NHS Shared Business Services	-	-
Value of Transactions (other than salary) with board members 2012/13	-	-
Value of Transactions with key staff members 2012/13	-	-
Value of transactions with other related parties 2012/13		
Department of Health	-	-
Other NHS Bodies	170,962	11,045
Charitable Funds	386	-
Subsidiaries/Associates/Joint Ventures	-	-
Other	33	18,185
NHS Shared Business Services	-	-

	Receivables	Payables
	£000	£000
Value of balances (other than salary) with board members at 31 March 2014	-	-
Value of balances (other than salary) with key staff members at 31 March 2014	-	-
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2014	-	-
Value of balances (other than salary) with related parties in respect of doubtful debts written off in year at 31 March 2014	-	-
Value of balances with other related parties 31 March 2014		
Department of Health	320	-
Other NHS Bodies	4,771	3,124
Charitable Funds		
Subsidiaries/Associates/Joint Ventures	-	-
Other	603	3,830
Value of balances (other than salary) with board members at 31 March 2013	-	-
Value of balances (other than salary) with key staff members at 31 March 2013	-	-
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2013	-	-
Value of balances (other than salary) with related parties in respect of doubtful debts written off in year at 31 March 2013	-	-
Value of balances with other related parties 31 March 2013		
Department of Health	-	40
Other NHS Bodies	4,191	1,405
Charitable Funds	62	-
Subsidiaries/Associates/Joint Ventures	-	-
Other	253	2,251

Included in 'other' are a number of material transactions with other Government departments and other central and local Government bodies. Most of these transactions have been with Her Majesty's Revenue and Customs, NHS Pension Scheme, and Cheshire East Council.

The Trust has also received revenue and capital payments from a number of charitable funds, for which the Board of Directors acts as Trustee. There are separate audited accounts for charitable funds.

30. FINANCIAL INSTRUMENTS

FRS29, Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Mid Cheshire Hospitals NHS Foundation Trust actively seeks to minimise its financial risks. In line with this policy, the Trust neither buys nor sells financial instruments. 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.

30.1 Market Risk

30.1(i) Interest-Rate Risk

All of the Trust's financial liabilities carry nil or fixed rates of interest. In addition, the only element of the Trust's assets that are subject to a variable rate are short term cash investments. The Trust is not, therefore, exposed to significant interest-rate risk.

30.1(ii) Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

30.2 Credit Risk

The Trust operates primarily within the NHS market and receives the majority of its income from other NHS organisations, as disclosed in Note 3. There is therefore little risk that one party will fail to discharge its obligation with the other. Disputes can arise, however, around how the amounts owed are calculated, particularly due to the complex nature of the Payment by Results regime. For this reason the Trust makes a provision for irrecoverable amounts based on historic patterns and the best information available at the time the accounts are prepared. The Trust does not hold any collateral as security.

30.3 Liquidity risk

The Trust's net operating costs are incurred under annual service agreements contracts with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust receives such contract income in accordance with Payment by Results (PBR), which is intended to match the income received in year to the

activity delivered in that year by reference to the National Tariff procedure cost. The Trust receives cash each month based on an annually agreed level of contract activity and there are monthly payments made to adjust for the actual income due under PBR. This means that in periods of significant variance against contracts there can be a significant cash-flow impact. The Trust presently finances its capital expenditure from internally generated funds or funds made available from Government, in the form of additional Public Dividend Capital, under an agreed limit. In addition, the Trust can borrow, both from the Foundation Trust Financing Facility and commercially to finance capital schemes. Financing is drawn down to match the capital spend profile of the scheme concerned and the Trust is not, therefore, exposed to significant liquidity risks in this area.

30.4(i) Financial assets by category

group excluding non-financial assets

Group			
	Total	Loans and receivables	Available for sale
	31 March 2014	31 March 2014	31 March 2014
	£000	£000	£000
NHS Trade and other receivables excluding non-financial assets	7,312	7,312	-
Non-current assets held for sale and assets held in disposal group excluding non-financial assets	0	-	0
Cash and cash equivalents (at bank and in hand)	11,149	11,149	-
NHS Charitable funds: financial assets	1,978	1,053	925
Total	20,439	19,514	925
	Total	Loans and receivables	Available for sale
	31 March 2013	31 March 2013	31 March 2013
	£000	£000	£000
NHS Trade and other receivables excluding non-financial assets	6,495	6,495	-
Non-current assets held for sale and assets held in disposal	31	-	31

Cash and cash equivalents (at bank and in hand)	10,304	10,304	-
NHS Charitable funds: financial assets	3,050	2,128	922
Total	19,880	18,927	953
Foundation Tr	ust		
	Total	Loans and receivables	Available for sale
	31 March 2014	31 March 2014	31 March 2014
	£000	£000	£000
NHS Trade and other receivables excluding non-financial assets	7,307	7,307	-
Non-current assets held for sale and assets held in disposal group excluding non-financial assets	0	-	0
Cash and cash equivalents (at bank and in hand)	11,149	11,149	
Total	18,456	18,456	0
	Total	Loans and receivables	Available for sale
	31 March 2013	31 March 2013	31 March 2013
	£000	£000	£000
NHS Trade and other receivables excluding non-financial assets	6,550	6,550	-
Non-current assets held for sale and assets held in disposal group excluding non-financial assets	31	-	31
Cash and cash equivalents (at bank and in hand) NHS Charitable funds: financial assets	10,304	10,304	-
Total	16,885	16,854	31

All financial assets are denominated in Sterling.

30.4(ii) Financial liability by category

Group	0
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Group		
	Total	Other financial liabilities
	31 March 2014	31 March 2014
	£000	£000
Obligations under finance leases	2,652	2,652
Trade and other payables excluding non-financial liabilities	12,584	12,584
Provisions under contract	1,738	1,738
Total	16,974	16,974
	Total	Other financial liabilities
	31 March 2013	31 March 2013
	£000	£000
Obligations under finance leases	2,240	2,240
Trade and other payables excluding non-financial liabilities	12,288	12,288
Provisions under contract	1,685	1,685
Total	16,213	16,213
Foundation Trust		
Foundation Trust	Total	Other financial
Foundation Trust	Total 31 March 2014	liabilities
Foundation Trust		liabilities 31 March 2014
	31 March 2014 £000	liabilities 31 March 2014 £000
Obligations under finance leases	31 March 2014	liabilities 31 March 2014
	31 March 2014 £000 2,652	liabilities 31 March 2014 £000 2,652
Obligations under finance leases Trade and other payables excluding non-financial liabilities	31 March 2014 £000 2,652 12,512	liabilities 31 March 2014 £000 2,652 12,512
Obligations under finance leases Trade and other payables excluding non-financial liabilities Provisions under contract	31 March 2014 £000 2,652 12,512 1,738	liabilities 31 March 2014 £000 2,652 12,512 1,738 16,902
Obligations under finance leases Trade and other payables excluding non-financial liabilities Provisions under contract	31 March 2014 £000 2,652 12,512 1,738	liabilities 31 March 2014 £000 2,652 12,512 1,738
Obligations under finance leases Trade and other payables excluding non-financial liabilities Provisions under contract	31 March 2014 £000 2,652 12,512 1,738 16,902	liabilities 31 March 2014 £000 2,652 12,512 1,738 16,902 Other financial
Obligations under finance leases Trade and other payables excluding non-financial liabilities Provisions under contract	31 March 2014 £000 2,652 12,512 1,738 16,902 Total 31 March 2013 £000	Iiabilities 31 March 2014 £000 2,652 12,512 1,738 16,902 Other financial liabilities 31 March 2013 £000
Obligations under finance leases Trade and other payables excluding non-financial liabilities Provisions under contract	31 March 2014 £000 2,652 12,512 1,738 16,902 Total 31 March 2013 £000 2,240	Ilabilities 31 March 2014 £000 2,652 12,512 1,738 16,902 Other financial liabilities 31 March 2013 £000 2,240
Obligations under finance leases Trade and other payables excluding non-financial liabilities Provisions under contract Total Obligations under finance leases Trade and other payables excluding non-financial liabilities	31 March 2014 £000 2,652 12,512 1,738 16,902 Total 31 March 2013 £000	Iiabilities 31 March 2014 £000 2,652 12,512 1,738 16,902 Other financial liabilities 31 March 2013 £000 2,240 12,288
Obligations under finance leases Trade and other payables excluding non-financial liabilities Provisions under contract Total Obligations under finance leases	31 March 2014 £000 2,652 12,512 1,738 16,902 Total 31 March 2013 £000 2,240	Ilabilities 31 March 2014 £000 2,652 12,512 1,738 16,902 Other financial liabilities 31 March 2013 £000 2,240

30.4(iii) Maturity of Financial liabilities

	31 March 2014	31 March 2013
	£000	£000
In one year or less	13,605	12,572
In more than one year but not more than two years	580	1,173
In more than two years but not more than five years	1,316	1,415
In more than five years	1,401	1,053
Total	16,902	16,213

All financial liabilities are denominated in Sterling.

30.5 Fair Values

There is no significant difference between book values and fair values of the Trust's financial assets and liabilities as at 31 March 2014.

31. THIRD PARTY ASSETS

	2013/14 Money on deposit	2012/13 Money on deposit
	£000	£000
At 1 April	2	7
Gross inflows	14	21
Gross outflows	(15)	(26)
At 31 March	1	2

The Trust held £929 cash at bank and in hand at 31 March 2013 (£2,340 at 31 March 2013) which relates to monies held by the Trust on behalf of patients. This is not included in cash at bank and in hand figure reported in the accounts.

32. LIMITATION ON AUDITOR'S LIABILITY

The Trust's external auditor has no liability cap as at 31 March 2014.

33. LOSSES AND SPECIAL PAYMENTS

Group and Foundation Trust

	2013/14	2013/14	2012/13	2012/13
	Total number of Cases	Total value of Cases	Total number of Cases	Total value of Cases
	Number	£000	Number	£000
Losses:				
Cash Losses	-	-	-	-
Fruitless payments and constructive losses	10	4	7	4
Bad debts and claims abandoned	122	25	141	19
Damage to buildings, property and stores losses	21	35	22	48
Total Losses	153	64	170	71
Special payments:				
special severance payments				
ex gratia payments	21	7	23	49
Total special payments	21	7	23	49
Total Losses and special payments	174	71	193	120

During 2013/14 there have been no individual cases of fraud, personal injury, compensation under legal obligation and fruitless payment cases, where the net payment exceeds £250,000.

The amounts reported are shown on an accruals basis but excluding provisions for future losses.

34. TRANSFER BY ABSORPTION

The Group has received on the dissolution of Central and Eastern Cheshire PCT £90,000 of fixture and fittings for the service at Elmhurst. This was through modified absorption accounting on 1 April 2013.

35. Mid Cheshire Charity Summary Statements

Statement of Financial Activities for the Year Ended 31 March 2014

	Unrestricted	Restricted	2013/14	2012/13
INCOMING RESOURCES	£000	£000	£000	£000
Incoming resources from generated funds				
Voluntary Income	213	37	250	1,920
Legacies	32	10	42	504
Investment income	34	2	36	29
Income from charitable activities	3	-	3	4
TOTAL INCOMING RESOURCES	282	49	331	2,457
RESOURCES EXPENDED				
Charitable activities:				
Staff welfare & amenities	48	13	61	72
Patients' welfare & amenities	143	13	156	201
Contributions to hospital capital expenditure	65	34	99	39
	256	60	316	312
Costs of generating funds				
Cost of generating voluntary income	52	2	54	62
Investment Manager's fees	5	-	5	5
	57	2	59	67
Governance Costs				
Audit fees	4	1	5	8
Other administrative costs -				
Services provided by Mid Cheshire Hospitals NHS Foundation Trust	16	-	16	12
	20	1	21	20
TOTAL RESOURCES EXPENDED	333	63	396	399
NET INCOMING/(OUTGOING) RESOURCES	(51)	(14)	(65)	2,058
GAINS ON INVESTMENT ASSETS				
Realised gains	8	-	8	2
Unrealised (loss)/gain	(25)	(2)	(27)	69
NET MOVEMENT OF FUNDS	(68)	(16)	(84)	2,129
Fund balances brought forward at 1 April 2012	2,878	117	2,995	866
Fund balances carried forward at 31 March 2013	2,810	101	2,911	2,995

Balance Sheet as at 31 March 2014

	Unrestricted Funds 31 March 2014 £000	Restricted Funds 31 March 2014 £000	Total at 31 March 2014 £000	Total at 31 March 2013 £000	Total at 1 April 2012 £000
FIXED ASSETS					
Investments at market value	878	47	925	922	828
CURRENT ASSETS					
Debtors	1,027	-	1,027	7	3
Cash at bank and in hand	999	54	1,053	2,128	55
TOTAL CURRENT ASSETS	2,026	54	2,080	2,135	58
CREDITORS					
Amounts falling due within one year - NHS	(94)	-	(94)	(62)	(20)
NET CURRENT ASSETS	1,932	54	1,986	2,073	38
TOTAL NET ASSETS	2,810	101	2,911	2,995	866
FUNDS OF THE CHARITY					
Unrestricted income funds	2,810	-	2,810	2,878	735
Restricted income funds	_	101	101	117	131
TOTAL FUNDS	2,810	101	2,911	2,995	866

The charity consists of six funds which are split between restricted and unrestricted as follows:

Unrestricted

- Leighton Hospital General Fund
- Victoria Hospital General Fund

Restricted

- · Mighty Magnet Appeal Fund
- Cancer Fund
- Diabetes Fund
- Arthritis Fund



Mid Cheshire Hospitals NHS Foundation Trust Leighton Hospital Middlewich Road Crewe, Cheshire CW1 4QJ