

NHS Foundation Trust









Annual Report and Accounts 2012-2013



Mid Cheshire Hospitals NHS Foundation Trust Annual Report and Accounts 2012-2013

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Chapter 1

Chairman's and Chief Executive's Foreword

This report marks the end of another successful year for Mid Cheshire Hospitals NHS Foundation Trust and the beginning of a new year that will see major developments completed and ongoing improvements to the services we deliver.

In line with the March 2013 update of the NHS Constitution our key focus will continue to be a drive for improvements in the quality and safety of services that we deliver. We will make intelligent use of patient feedback and continue to ensure the patient is at the heart of decision making. We are continuing our sustained focus on reducing mortality rates and at the same time seeking to improve patient experience. So far, our endeavours have resulted in the Trust being named as 'The Most Improved Trust in the Country' and one of the 'Top 40 Hospitals' in May 2012. We have also had Care Quality Commission (CQC) unannounced inspections where patients praised the compassion and quality of care they received.

Our performance against operational standards and finance has remained strong. We continue to deliver core national targets and standards and indeed, we are one of only a handful of Trusts who sustained delivery against the 4 hourly performance standard of patients waiting no longer than 4 hours in the A&E department following a decision to admit to hospital or to be seen for treatment. This achievement underlines our relentless focus on quality and safety by ensuring the flow of patients through our departments is as efficient and effective as possible. To cope with increasing pressures from emergency admissions and Accident & Emergency Department attendances the Board of Directors agreed to invest further monies in this area





and this has seen, amongst other things, the opening of the Primary and Surgical Assessment Areas.

The Trust ended last year with a surplus and a financial position which allowed major infrastructure redevelopments to continue. We are continuing our ward refurbishment programme and the hospital corridors are coming to the end of an extensive upgrade which will be completed by the end of 2013. Added to that, the Critical Care and Theatre rebuild is progressing at pace and on track to open in early 2014. This £22m investment will provide new state of the art facilities for the immediate benefit of our local population. We will also be embarking on the complete refurbishment of our Neo-Natal Intensive Care Unit this year having secured the funding to do so from a very successful Charitable Appeal. We would like to thank all our many donors who helped us reach our fundraising total of £1.8m, for your support and generosity.

All of these works unfortunately mean some disruption around the hospital site and we would like to sincerely apologise for the inconvenience our estate developments have caused to our patients, staff and visitors. However, we are sure you will join us in acknowledging that these developments are significant improvements for the long term benefit of the local population. We could not deliver all of these improvements and achievements without the drive and determination of our dedicated staff, the selflessness of our volunteers and the

commitment of our Governing Council. We also have many partners who we continue to work with effectively across the health and social care sectors who play an important part in our success.

The main body of the report details a number of changes both to our Board of Directors and Council of Governors over the year. We would like to thank those Board and Council members who have retired and left the Trust for their support and commitment to the Trust over their terms of office whilst also welcoming those who have recently joined us.

Once again, we would like to thank you all for your contribution and your enthusiastic support for the work of the Trust.

John Moran Chairman Tracy Bullock Chief Executive

Chapter 2

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 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 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 3,400 staff and the principle site is at Leighton Hospital, Middlewich Road, 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 and procurement
- 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 PALS – Patient Advice and Liaison Service, 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"

Chapter 3

Director's Report and Business Review

Introduction

In 2011 the Board of Directors developed a Ten Year Vision 2011–2021 and Five Year Strategy 2011–2015. However, in light of the introduction of the Health and Social Care Act and the significant transformational changes required to meet the economic challenges that face the NHS, the strategy is reviewed and revised at least annually. It is vital that the strategy remains current as this underpins business priorities and financial decision making.

Central and Eastern Cheshire Primary Care Trust commissioned 95% of the Trust's work in 2012/13. From 1 April 2013, the Trust's services will be commissioned by the Clinical Commissioning Groups, NHS England (including Specialist Commissioning) and Local Authorities.

Approximately 85% of funding will come from the NHS South Cheshire Clinical Commissioning Group and NHS Vale Royal Clinical Commissioning Group who have been operating in shadow form over the past two years. Both Clinical Commissioning Groups have been engaged in the Trust's Strategy reviews ensuring that priorities are aligned for the population of Cheshire.

Business Review

2012/13 has been a challenging year for the Trust with a number of significant achievements, challenges and ongoing service transformation programmes, a number of which are highlighted below.

Service Development & Improvement

The Trust has undertaken significant change and improvement to a number of services over the last year, such as additional investment in staffing within the Emergency Department and continued upgrades to the physical environment. To enable greater pace of change and to continue service improvement, we have committed to strengthening our project management approach. This will be used across service transformation projects and in particular for the three improvement priorities identified for 2013/14 - continued reduction in length of stay; improving theatre productivity; and improving outpatient productivity. The project approach is being led by the new Director of Service Transformation & Workforce who joined the Trust in January 2013.

Effective Management of Emergency Demand

Along with many Trusts in the country we have experienced consistent emergency pressures since December 2011, with a large increase in the number of patients referred for an urgent medical or surgical opinion. This resulted in the Trust not meeting the 95% minimum standard of seeing patients within 4 hours during the first three months of 2012/13. In July 2012, to alleviate the pressure of this increase in activity within the Emergency Department and to ensure patients receive timely and effective assessment, a new unit called the Primary Assessment Area (PAA) was established. The PAA assesses patients referred by their General Practitioner for an urgent medical opinion.

The PAA consists of male and female trolley and seated areas. Patients are referred directly to the unit avoiding the need to attend the Emergency Department. The patients are assessed by a team of doctors and nurses within a 4 hour time period. Following assessment, patients are discharged, admitted to a speciality bed, or admitted to

the Acute Medical Unit for further diagnostics or observation. The benefits for the patients have been evident in that they are managed in a dedicated unit receiving timely care or discharged as appropriate. Reducing the number of patients attending the Emergency Department has supported delivery of the Trust's 4 hour 95% target. This is a significant achievement as many Trusts in the country continue to struggle to achieve this target. We are particularly proud that our patients continue to receive this essential service in a timely and effective way.

In January 2013, due to the success of the PAA, we also opened a Surgical Assessment Area at the Leighton Hospital site to improve access for patients referred by their GP for urgent surgical review.

The Surgical Assessment Area has provided the following benefits for our patients:

- An area where patients who present as a surgical emergency can receive an initial clinical assessment and provisional management plan within one hour of attendance to the assessment area;
- A reduction in patients' anxiety by providing a designated clinical location for assessment, which in turn improves privacy and dignity; and,
- A reduction in the number of unnecessary patient admissions to surgical wards, facilitating the development of an abdominal pain pathway in conjunction with the Urgent Care Centre.

The Surgical Assessment Area currently accommodates general surgical patients, however there are plans in 2013 to extend this to other surgical specialties.

Urgent Care Centre

The Urgent Care Centre was commissioned in 2009 to provide a Primary Care resource adjacent to the Emergency Department at Leighton Hospital. Since opening it has provided a high quality service to those

patients whose needs are best met by a General Practitioner or Primary Care nurse practitioner rather than in the Accident & Emergency Department. The Urgent Care Centre also provides a Community Deep Vein Thrombosis pathway service which successfully manages up to 1,000 patients per year, patients who previously would have been admitted to hospital. Pathway development has been expanded during 2012 to include treatment of patients with:

- Cellulitis
- Acute Urinary Retention
- Renal Colic Pathway
- · Gynaecological Bleeding
- Ophthalmology

Both Chest Pain & Pulmonary Embolus Pathways are under development.

Stroke Thrombolysis

From July 2012 we commenced a phased approach to the delivery of a Stroke Thrombolysis service. Initially a five day service, from 0900hrs to 1700hrs, was introduced and will be followed by a twenty four hours a day, seven days a week service in the near future.

The Stroke Thrombolysis service has been developed through an alliance with the University Hospital of North Staffordshire NHS Trust using telemedicine and the development of a regional network to ensure service cover for the full 24 hours a day for our patients.

Alongside this development the Trust also relocated the Stroke Unit to a ward specifically refurbished to care for stroke patients. This ensures the environment for stroke patients is optimal to meet their acute and rehabilitation needs.

eHandover

In 2012 Health Education England commenced a programme of Better Training Better Care pilots. Our submission focusing on e-handover

was one of only 15 pilots selected nationally. The aim of the pilot is to introduce a structured handover process for ward-based tasks that will be implemented as part of a consultant-led medical service.

The pilot will include training for doctors to develop key handover skills such as leadership, task prioritisation and time management. This will be supported by the introduction of an e-handover IT solution. The goals of the pilot are to:

- Establish a structured handover process for ward-based patients
- Integrate e-solution to support this into routine care
- Measure patient outcomes in terms of:
 - Handover task completion
 - Analysis of critical incidents related to clinical handover
 - Out-of-hours/weekend mortality data
- Measure trainee outcomes in terms of:
 - Knowledge and attitudes towards handover
 - Trainee perspective on learning from handover

Effective handover has been identified as a key area of improving quality and safety of care by both the World Health Organisation and by the Department of Health at a national level. It is an essential process at all levels of inpatient care and numerous studies have illustrated that any breakdown in the handover process can lead to serious adverse events and poorer patient outcomes. The change to shift-work patterns has created a greater emphasis on the continuity of information which this handover project will provide.

New Midwifery led Unit

A Midwifery Led Unit was opened in October 2012 as part of the full refurbishment of the delivery unit at Leighton Hospital. The Midwifery Led Unit enables midwives to promote normality and provide a service for women, assessed as low risk in labour, who do not choose to have a home birth. This

is a dedicated area which includes en-suite single rooms, birthing pools and birthing balls and aims to allow the midwives to work autonomously with women in a stress-free environment. The delivery unit also includes delivery rooms with Consultant Obstetrician cover should this be required for any part of the delivery or for women whose births are considered high risk.

Strategic Alliances and Collaborations

The Trust has been successful in pursuing strategic alliances with key partners to ensure the sustainability, quality and safety of clinical services is enhanced. For example, following a vacancy within the Consultant Cardiologists and several unsuccessful recruitment attempts it was agreed to progress a joint appointment with the University Hospital of North Staffordshire NHS Trust for a Consultant Cardiologist. The Consultant commenced in post in Spring 2012 and this alliance further strengthened the partnership between the two Trusts for Cardiology services, streamlining the referral processes and patient pathways for the benefit of patients.

Also, on 1 December 2012, the provision of vascular surgical services to our local population changed as the Trust formed a partnership with the University Hospital of North Staffordshire NHS Trust and Mid Staffordshire NHS Foundation Trust to form the Staffordshire, South Cheshire and Vale Royal Strategic Vascular Alliance. This means the majority of outpatients, simple day case surgery and diagnostic services for vascular patients continue to be provided at their local hospital and for the few highly specialist and complex surgical cases, patients would be treated at the hub site which is the University Hospital of North Staffordshire by a combined specialist team of medical and nursing professionals. This is in line with national recommendations which aim to improve access and patient outcomes.

A further significant development is the pathology collaborative between our Trust and East Cheshire NHS Trust which has continued to work towards the development of a larger alliance with three Trusts in Staffordshire; the University Hospital North Staffordshire NHS Trust, Burton Hospital NHS Foundation Trust and Mid Staffordshire NHS Foundation Trust. This initiative supported the development of a pathology network which meets the requirements of the Department of Health's Quality, Innovation, Productivity and Prevention (QIPP) Programme.

Progress has recently been slowed due to a tendering decision for GP direct access work in the West Midlands and until this is complete, or the outcomes understood, the full alliance cannot be progressed further. Therefore, alternative options to deliver a high quality, sustainable service, are being explored to ensure that the national agenda is met at a local level through greater integration between Mid Cheshire Hospitals NHS Foundation Trust and East Cheshire NHS Trust. However, Mid Cheshire Hospitals NHS Foundation Trust remains committed to the longer term strategic alliance as outlined above and as such, where possible, progress with some pathology services has continued. For example, the Gynae Cytology Screening Program was centralised at University Hospital North Staffordshire NHS Trust. The service transfer was completed in March 2013 with a site coordinator remaining at Leighton Hospital to ensure quality systems and processes are in place to support service users locally.

Strategic alliances and collaborative developments have been developed beyond the traditional boundaries of acute hospitals and in 2012, in conjunction with Nantwich Health Centre, the Cardio Respiratory Department introduced a community based Echocardiogram service to offer a more local service to patients and to improve overall access to diagnostic testing. A review of this service was undertaken in April 2013 which included patient feedback to determine the

level of satisfaction from service users. The Department has also extended services at Victoria Infirmary, bringing services closer to the Northwich population. For example, as well as providing high quality contraception and sexual health service from its dedicated, purpose built unit at Leighton Hospital, this service is now offered twice weekly from Victoria Infirmary. The Sexual Health Team are also working collaboratively with Body Positive to provide education, screening, support and HIV testing services on an outreach basis for hard to reach groups within the population.

Trauma Unit

Across England and Wales a network of Trauma Centres has been established, providing 24/7 lifesaving treatment for seriously injured patients. The Trauma Centres work alongside Trauma Units, which are geographically spread to ensure a high quality trauma service nationally. Consultant-led specialist teams with access to state of the art diagnostic and treatment facilities provide care and rehabilitation to these seriously injured patients. We are very proud that following external scrutiny and assessment the Trust was deemed to be meeting the requirements to become a Major Trauma Unit and were accredited as such in March 2012. This ensures our population receives a full trauma service through working in partnership with the University Hospital of North Staffordshire NHS Trust as the Trauma Centre

Critical Care and Theatres Rebuild

Building work on the new multi-million pound operating theatres and critical care facilities has begun at Leighton Hospital. The exciting £22.8m project, which is being supported by Government funding of £21.7m, will enable the Trust to further improve the quality and safety of patient care, the efficiency of service provision and secure future sustainability. The new building will replace the current theatres, Intensive Care and High Dependency units, with state of the art services.

The building will be adjacent to, and integrated with, Leighton Hospital's existing Treatment Centre, and is expected to be completed in early 2014.

New Neo-Natal Unit

Another exciting estate development is the planned Neo-Natal Unit rebuild. The "One in Eleven" charitable fund set up to provide a new Neo-natal Intensive Care Unit at Leighton Hospital reached its £1.8m target through the fund raising efforts of the local communities and a £1.5m donation from a local benefactor. These funds will allow the Trust to provide increased space and facilities for pre-mature babies and their families and will match the high level of care already provided by the staff in the current unit. The project will aim to be completed in 2013/14.

Medical Imaging

Due to increased demand for diagnostic services in 2012, the Medical Imaging Department received significant investment for the introduction of a second CT (computerised tomography) scanner which was installed in December 2012. The scanner provides the Trust with additional scanning capacity that improves access to imaging for cancer patients and reduce overall wait times for patients requiring routine tests.

The recent investment also allowed the Department to increase its staffing levels in all staff groups. All non-medical staff posts have been recruited to. However, as there is a national shortage of Consultant Radiologists, which continues to be a cause of concern, an overseas recruitment campaign was undertaken to improve the opportunities of appointing to the outstanding posts which to date has had some success.

Pharmacy

A ward based pharmacy service was fully implemented in 2012. This change in service has delivered a number of positive outcomes.

• 55% of medications are now dispensed at

- ward level. This reduces the time taken to dispense medications on discharge.
- Pharmacy is currently achieving the
 Trust's standard of providing a medicines
 reconciliation service to 70% of patients
 within 48 hours of admission. This service
 ensures the detail of medicines a patient
 may have been prescribed prior to their
 admission is accurately documented, which
 in turn provides excellent continuity of
 care following admission from home or a
 community setting and supports on going
 care to the point of discharge
- Pharmacy is also contributing to reducing avoidable expenditure on medicines across the Trust. This has been achieved by reducing the level of drug wastage and increased use of patients' own medication.

In March 2012, to further support the Trust's quality and safety agenda, Pharmacy introduced a new competency based safe medicines management training package. 2012/13 saw a 10% reduction in medication associated harm. Staff feedback has been very positive, comments include "very useful", "excellent", "thoroughly enjoyed" and "will utilise in practice".

Ward 21B

In December 2012, the Trust opened Ward 21B, a newly refurbished rehabilitation unit in the previous mental health facilities based on the Leighton site. The ward has 24 beds together with a dedicated area for therapy support and assessment. The Rehabilitation Pathway supports patients in achieving patient-centred goals with the objective of achieving independent living. A recent Care Quality Commission report advised that all patients they had spoken to on Ward 21B were very complimentary about the care they had been given. One patient had said "Service is good, nurses are good and they can't do enough for vou."

2012/13 has seen the Trust face a number of challenges and whilst the Trust has responded

to these effectively in terms of performance and financial achievements, there are a number of risks and uncertainties that remain for 2013/14.

Workforce Development

Recruitment to some consultants and nursing posts has been difficult. There is a recognised national shortage of some professional groups which has impacted on the Trust's ability to increase its workforce. However, the Trust has conducted a number of very successful national and international recruitment campaigns with a significant number of nurses from Ireland and Spain being recruited along with a number of doctors.

The Board of Directors recognises our staff are key to the success of our Trust and further information on staff can be found in Chapter 5.

Continued growth in nonelective admissions

Continued growth in the number of emergency attendances at Leighton Hospital in 2012/13 resulted in increased utilisation of bed capacity across the medical and surgical wards. Further increases during the next financial year will have an impact on the Trust's ability to provide timely elective surgery, due to the increased likelihood of short term cancellations of elective activity. This would result in an adverse impact on patient waiting and experience as well as the Trust's financial position.

The increasing demand for emergency services is aligned to the increasing elderly population, many of whom have complex conditions or needs which require an alternative approach to delivery that ensures they receive treatment and care in the most appropriate setting. Therefore, we are currently reviewing and developing a Care of the Elderly Strategy to understand and develop services to meet the needs of these patients. This will be done in conjunction with our local stakeholders.

Quality Governance

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 twice yearly. 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.

Financial Position

The Trust has achieved a Financial Risk Rating of 3 against a plan of 3. The increased number of emergency attendances at Leighton Hospital has, however, led to the need for additional resources which has put the Trust under some financial pressure. Further detail on the Trust's current financial position and concerns for 2013/14 are detailed under the Financial Review.

Also detailed is additional information in relation to our operational delivery and financial position.

I confirm there have been no important events since the end of the financial year which affects Mid Cheshire Hospital NHS Foundation Trust.



Tracy Bullock
Chief Executive Officer

Operational Review

	2012/13	2011/12	2010/11	2009/10	2008/09
Emergency episodes of care requiring the use of a bed	31,270	29,934*	32,766	31,347	30,894
Attendances at Accident and Emergency and Minor Injuries	83,320	79,579	77,416	75,461	76,590
Elective episodes requiring a procedure to be performed	28,345	28,659	27,419	28,644	27,725
Total attendances at outpatient clinics	239,210	239,977	242,322	246,760	244,371
Births	2,827	2,879	3,004	2,991	2,947
Requests for medical imaging	192,574	181,457	172,764	164,784	154,877
Average number of beds open in the year	585	569	584	605	574
	2012/13	2011/12	2010/11	2009/10	2008/09
Average % Occupancy					
Overall	87.4%	84.1%	84.4%	87.1%	89.0%
General Medicine	91.8%	89.1%	89.6%	91.9%	94.0%
General Surgery	89.5%	84.6%	89.4%	88.7%	91.0%
Orthopaedics	86.6%	82.9%	83.4%	90.8%	97.0%

^{*}Changing in coding has adjusted reported data. This figure needs to be considered with the number of assessments carried out for comparison to previous years.

Performance Standard	National Target	Trust Performance Year End 2012/13	Trust Position
Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from referral	95%	97%	Achieved
Percentage of admitted patients starting treatment within a maximum of 18 weeks from referral	90%	93%	Achieved
Percentage of patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	92%	95.8%	Achieved
Percentage of patient records	ACHIEVE >=85%	Outpatients 90.7%	
with recorded ethnic group information	UNDERACHIEVE >=70%	Finished Consultant Episodes 91.4%	Achieved
	ACHIEVE >95%		
Maximum time of waiting of four hours in A & E from arrival to admission, transfer or discharge	UNDERACHIEVE <95% BUT >94%	95.04%	Achieved
	FAIL <94%		
Percentage of patients referred urgently with suspected cancer by a GP, waiting no more than two weeks for a first outpatient appointment	93%	95.1%	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%	94.8%	Achieved
Percentage of patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	96%	99.3%	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

Performance Standard	National Target	Trust Performance Year End 2012/13	Trust Position
Percentage of patients waiting no more than 31 days for subsequent treatment what that treatment is surgery	94%	100%	Achieved
Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	85%	91.4%	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%	95.1%	Achieved
MRSA hospital acquired Bacteraemia	Target <= 0MRSA	1*	Achieved
Clostridium <i>difficile</i> hospital acquired	<= 54 Clostridium <i>difficile</i> cases in year	28	Achieved

*The Trust achieved the MRSA hospital acquired Bacteraemia target having recorded only one case for 2012/13 against a Monitor deminimus target of 6 per annum.

The tables above detail the activity undertaken by the Trust during 2012/13.

Non-elective activity in both Accident & Emergency attendances and emergency admissions continued to rise. This had a significant impact on the bed occupancy rates which rose overall to 87.46% but within General Medicine specialties was on average 91.8%.

The Outpatients elective and Maternity activity remained relatively stable overall, although within certain specialties such as Endoscopy and Urology higher referral rates were seen, partly due to publicity campaigns around cancer awareness.

In line with continued use of diagnostic technology, the activity in Medical Imaging also increased by a further 11,000 requests compared to 2011/12. In response to this

increased demand and partly due to a number of initiatives including better cancer management, improved cardiac diagnostics, and increased non-elective activity for which patients require rapid diagnostics, the Trust procured a second CT scanner which was available for use from December 2012. The second scanner has supported improved access times for patients and enabled the Trust to continue to achieve the 99% standard of patients receiving diagnostic tests within 6 weeks of referral.

In relation to the Trust's performance in other national targets and standards, the Trust has seen significant improvements compared to previous years.

Only for Quarter 1 did the Trust not return a green governance rating to Monitor and this was due to not achieving the 4 hour standard of 95% of patients being seen and treated or admitted within 4 hours of attending the Accident & Emergency Department.

Urgent intervention through the opening of a Primary Assessment Area enabled the Trust to regain performance and go on to deliver 3 further consecutive quarters of green for all Targets and Standards and an overall annual achievement of 95.04% for the four hourly target.

Continued improvements to cancer pathways both internally and with specialist cancer provider hospitals, as well as improved tracking of patients who are being investigated for cancer, enabled the Trust to perform well against all of the cancer standards. This will continue to remain a key focus for 2013/14.

Research and Development

The Research and Development Department has continued to work closely with partners at the Cheshire and Merseyside Comprehensive Local Research Network to deliver the high level objectives set by the National Institute of Health Research. A key objective highlighted for 2012/13 was to increase the number of industry-sponsored studies and to increase the total number of patients recruited to such studies. Research and development at the Trust has substantially contributed to both of these aims in the last year.

The research collaboration with local GP practices has been strengthened by the signing of a Memorandum of Understanding between the Trust and its GP research partners.

Further detailed information on the Trust's Research and Development activities are included in the Quality Account in Chapter 8 of this Report.

Health and Safety

In 2012/13 there were 22 reportable incidents to the Health and Safety Executive (HSE) as required by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR), this compares to 28 in 2011/12. 2012/13 also saw a decrease in the number of health and safety incidents reported by

approximately 19.5%. Of those incidents reported, there was approximately a 32.5% reduction in the number of incidents resulting in harm, however this figure was mainly due to changes in the categorisation of Violence & Aggression incidents. The percentage reduction without these was 4.7. There was also a 13.5% reduction in the number of no harm incidents reported.

During the year the Trust has continued with its Asbestos Removal Programme and fire infrastructure improvements, namely:

- The upgrading of the structural fire integrity of the hospital streets (corridors). This will be completed later in 2013;
- The upgrading of the fire compartmentation on the wards at a rate of two wards per year is due to complete in 2019.

The Trust has also undertaken a scheme of work to improve Infrastructure defects identified in the Treatment Centre building during 2012.

Sustainability

Sustainable development is concerned with meeting society's needs today without compromising the ability of future generations to meet their needs - often referred to as good corporate citizenship or corporate social responsibility. The NHS is the largest employer in Europe and as a provider of healthcare is viewed as a socially responsible organisation, but it has the highest rate of carbon emissions in the public sector in England. The challenge has been set for the NHS to lead on all aspects of sustainable development, particularly carbon reduction, and promote the good corporate citizenship model. The model has been updated for 2012. The NHS Sustainability Unit provides leadership and support for NHS organisations to meet the challenge set.

The Trust continues its commitment to sustainability and sets out the general aims and principles of what is an extensive agenda for continuous development. The strategy will apply to all stakeholders in the Trust's

business and needs to become embedded in all activities of the organisation. The expansive and long-term nature of the sustainability agenda means that implementing sustainability issues will be an incremental process.

Objectives

The Trust is committed to minimising the impact of its activities on the environment and becoming a good corporate citizen. The objectives are set out below:

- · Comply with all relevant legislation;
- Achieve the carbon emission reductions target established by the NHS National Carbon Reduction Strategy of 10% by 2015 and 80% by 2050 and where possible exceed these targets;
- Establish baselines for all relevant activities, set measurable objectives and targets

- using national measurement systems where available, and measure performance against these targets;
- Establish a carbon/sustainability weighting to all investment and procurement options;
- Include climate change in the organisation's risk register including financial risk;
- Reduce/minimise environmental impact whilst maintaining continuous improvement;
- Integrate the principles of sustainability into all areas of Trust business;
- Follow the Good Corporate Citizenship assessment model to measure and access the Trust's performance;
- Measurement of performance against pre-determined targets and from these performance measures identify how improvements can be made.

Waste Management

Definition	Tonne 2011/12	Tonne 2012/13	Disposal Cost 2011/12	Disposal Cost 2012/13
Total amount of waste produced by the Trust	1,046	1,089	£273,521	£308,467
Method of disposal (Landfill)	364	385	£54,604	£56,980
Method of disposal (Heat treated then deep land fill)	404	429	£154,398	£169,828
Method of disposal (Incinerated then deep landfill)	69	70	£39,904	£43,775
Method of disposal (Recycled) *	184	202	£24,714	£43,516

Summary Position – Waste Management

- Waste produced has increased by 4%, due to additional activity;
- Waste going to Landfill has increased by 5.5%:
- Heat treated waste has increased by 6.1%;
- Incinerated waste has increased by 1.9%;
- Recycling has increased by 9.7%.

*In previous years there has been no cost to the Trust for the disposal of mixed recycled waste. During 2012/13 this free service was removed and the Trust now pays for the service.

Hygiene waste has not been included in the previous year's figures. A new service and disposal contractor has been appointed who recycles the end waste product - therefore Hygiene waste has also now been included in the figures for recycled waste.

Finite Resources

Definition	Consumption 2011/12	Consumption 2012/13	Cost 2011/12	Cost 2012/13
Water	103,770M ³	101,490 M ³	£263,294	£299,261
Electricity	8,561,961kWh	9,309,770 kWh	£663,847	£843,895
Gas	23,461,666kWh	23,362,142 kWh	£624,009	£806,490
Oil	341,667kWh	100,639 kWh	£21,354	£6,897

Summary Position – Finite Resources

- Water usage has reduced by 2.2%
- Electricity consumption has increased by 8.73%
- Gas consumption has reduced by 0.42%
- Oil consumption has reduced by 239.5%
 mainly due to a change in the method of standby generator testing

sincerely. In addition, there are a number of policies in place which cover staff matters which are monitored appropriately through the governance structure. Further detail information on engaging with staff can be found in Chapter 5.

Good Corporate Citizenship

The NHS Good Corporate Citizenship Assessment Model has been changed during 2012. The new model still features the original six sections:

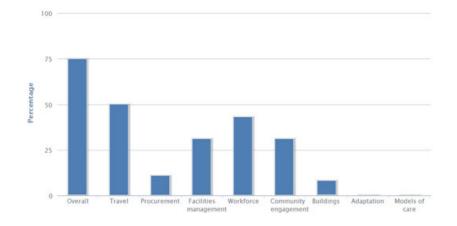
- Travel
- Procurement
- · Facilities Management
- Workforce
- Community Engagement
- Buildings

However the performance parameters have been strengthened and a further two sections have been added:

- Adaptation
- Models of Care

To date the Trust has not progressed the latter two sections but plans to include these from 2013/14 onwards.

The above detail highlights, the Trust is very much aware of its impact on the environment, local community and workforce, taking its commitment to Good Corporate Citizenship and sustainability



Financial Review

Overview

The statement of comprehensive income for the year ended 31 March 2013 shows a deficit for the year of £6.6m. However, this position has been affected by the revaluation of the Trust's land and buildings which has created an impairment charge of £8.0m. Adjusting for this exceptional non-cash entry gives an adjusted surplus of £1.4m against an initial planned surplus of £1.7m, demonstrating the Trust's continued strong financial stewardship.

This represents a reduction in the adjusted surplus delivered in 2011/12 (£3.4m). Whilst this financial performance gives the Trust a financial risk rating of 3 and within the Terms of Authorisation expected by Monitor, it demonstrates the increasing challenge described in last year's Annual Report of delivering increasing levels of efficiency year on

year.

Looking forward the efficiency challenge facing the Trust is expected to continue through an anticipated real terms deflator in the tariff paid for activity by 4.5% - 5.0% per annum. This represents a significant challenge and requires all health providers to develop innovative solutions to improve financial efficiency whilst remaining focused on delivering and improving the quality standards.

The Trust's full accounts can be found starting on page 151.

Analysis of Income

The total income received by the Trust in 2012/13 was £177.2m. This represents an increase on 2011/12 of £3.4m or 2.0%. An analysis of the key income streams can be seen below:

2012/13 £000s	2011/12 £000s	Change £000s	%
157,524	152,871	4,653	3.0
5,258	5,315	(57)	(0.0)
10,752	10,765	(13)	(0.0)
3,661	4,156	(495)	(11.9)
-	724	(724)	-
177,195	173,831	3,364	2.0
	£000s 157,524 5,258 10,752 3,661	£000s £000s 157,524 152,871 5,258 5,315 10,752 10,765 3,661 4,156 - 724	£000s £000s £000s 157,524 152,871 4,653 5,258 5,315 (57) 10,752 10,765 (13) 3,661 4,156 (495) - 724 (724)

The reduction in other non-clinical income is in the main due to grants and donations received in 2011/12 which were in respect of non-recurrent capital spend and therefore not replicated in 2012/13.

The increased income received from patient care activity is primarily due to treatment of NHS patients, where a significant driver has been the growth in emergency medical

admissions.

During the year the Trust also took on the contract for the provision of the urgent care centre, which was previously provided under a Limited Liability Partnership (LLP) which the Trust was a partner. This new contract accounts for £1m of the increase and is offset by increases in expenditure.

Operating Expenses

The total operating expenditure incurred in 2012/13 was £181.5m. The key areas and comparison with 2011/12 can be seen below:

Expenditure	2012/13 £000s	2011/12 £000s	Change £000s	%
Employee expenses – staff	119,954	115,219	4,735	4.1
Supplies and Services – Clinical	13,000	13,134	(134)	(0.0)
Drugs costs	9,440	8,639	801	9.3
Premises costs	6,626	6,443	183	2.8
Clinical Negligence Insurance	3,555	3,464	91	2.6
Services from NHS bodies	5,751	5,688	63	1.1
Other	15,222	13,995	1,227	8.8
Total costs excluding impairment	173,548	166,582	6,966	4.2
Impairments	8,001	12,296		
Total Operating Costs	181,549	178,878		

During the year the Trust employed an average of 3,104 full time equivalent staff, an increase of 102 on the previous year. The average staff cost rose from £38,300 to £38,600, an increase of 0.8% which is largely due to staff progressing through salary scales with only the lowest paid staff receiving national wage awards.

Tight cost controls and improvements in procurement deals have held clinical supply costs stable. However, drug costs have seen considerable increases primarily driven by increases in emergency admissions which have increased by 4.5%. In addition, the introduction of NICE guidance on drug usage has been another significant driver, particularly in Clinical Haematology.

It is encouraging to see the clinical negligence scheme insurance costs reducing from the historic 10% per annum increase to 2.6% reflecting the progress made in improving the Trust's risk profile.

Increases in other costs are as a result of a number of factors including increases due to the Trust now being the main contractor for the Urgent Care Centre and, therefore holding contracts for provision of GP services in the unit, which were previously provided through an LLP.

In addition, the Trust has incurred introduction fees to recruit overseas nurses from Spain and Ireland, as well as incurring new costs associated with registration fees with the Care Quality Commission, introduced for the first time in 2012/13.

Increase in the cost of premises has been driven by the increased energy costs which are being experienced nationally.

Capital Investments

2012/13 has been an exciting year for the Trust in respect of capital investments, taking advantage of the Department of Health allocation of £25.2m, as notified in 2011/12. The Trust utilised a further £7.2m in 2012/13 primarily to progress the Theatres and Critical Care build, giving a total utilised to date of £8.1m. The remainder will be drawn down in 2013/14 to complete the project by early 2014.

In total the Trust has seen capital additions in year of £11.0m with a further £0.8m funded through new finance leases. Key additions include:

- Second CT Scanner;
- · New Blood Tracking System;
- Continued programme of corridor refurbishment;
- Redesign of ward to create new Stroke Unit:
- Refurbished and redesigned the Labour Ward;
- Refurbished Ward 21b to meet needs of rehabilitation patients;
- Upgraded radiology equipment at Northwich to digital.

Prudential Borrowing Requirements

As an NHS Foundation Trust, the Trust was required to comply with and remain within a prudential borrowing limit, which consists of two elements:

- The maximum cumulative amount of long term borrowing, which is set by reference to a five ratio test set out by Monitor's prudential borrowing code. A copy of the code is available on the Monitor website (www.monitor-nhsft.gov.uk)
- 2. The amount of any working capital facility approved by Monitor.

The Trust's prudential borrowing for 2012/13 limit was:

Long term borrowing facility: £24.7m
 Working Capital facility: £11.0m

In the financial year ended 31 March 2013, the Trust reported accumulated borrowings against the long term facility of £2.2m associated with finance leases. The Trust has not utilised its working capital facility and maintained positive cash balances throughout the financial year.

From 1 April 2013 these prudential borrowing limits will no longer form part of the Trust's compliance requirements.

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 2012/13 is at level 3, against a plan of 3, as shown overleaf:

Metric 2012/13	Achieved Rating	Plan Rating
Earnings before interest, tax, depreciation and amortisation (EBITDA)	3	3
EBITDA % of plan achieved	4	5
Return on Assets	3	5
Income and Expenditure surplus margin	2	3
Liquidity ratio	4	3
Overall Rating	3	3

The Compliance Framework covers a risk rating from "1" (very high risk) through to "5" (minimal risk) with "3" representing the minimum expected level defined in the Trust's Terms of Authorisation. All financial monitoring returns were submitted on time and were complete and correct.

The tables below details the governance ratings for 2012/13.

Table of Analysis – 2012/13 Governance Ratings

	Annual Plan 2012/13	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
Governance Risk Rating	AG	AR	G	G	G
Mandatory Services	G	G	G	G	G

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

The Monitor Governance Risk Rating is dependent upon achievement of a range of targets as specified within the Compliance Framework. Each target is weighted either 0.5 or 1.0. A score of less than 1 is required to maintain a green rating. A score of >1 but <2 is amber/green, a score of >2 but <4 is amber/red and a score greater than 4 is red.

In 2012/13 the Trust declared a risk rating against the delivery of the 4 hourly target in its annual planning document.

The Trust has overall performed well against targets and standards with the exception of the Quarter 1 target of 95% of patients being seen and treated within 4 hours of attending at the Emergency Department. Significant pathway work in the management of patents with cancer has resulted in the successful delivery of 3 quarters against the 62 day cancer standard against a previous quarter failure.

Additional work has been very successful in reducing waiting lists in the most challenged specialities and this continues to be progressed to improve patient access further.

Non-NHS Income

The Trust is assured 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 2013, the Trust paid 94% by value (2011/12:94%) 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. Prior to this date the Trust was obliged not to exceed its pre-determined private patient cap. This is the proportion of income generated from treating private patients to total patient related income, compared with the proportion generated at the end of the 2002/03 financial year. In year the Trust's cap under the rules applied prior to 1 October was 1.5%, with actual income within this level at 1.0%.

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.

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 anti-fraud culture across the Trust.

External Auditors

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

During the year Deloitte LLP were appointed to undertake consultancy to carry out service line reviews of a number of specialties. There are no known conflicts of interest that need to be addressed by the Auditor or the Audit Committee.

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.

Going Concern

After making enquiries, the Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts. This conclusion has been reached after reviewing the 2013/14 plan which gives a surplus of £0.6m and a positive

cashflow throughout the year and maintaining reasonable cash balance moving into 2014/15.

Cost Allocation and Charging Requirements

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

Data Loss

The Trust had two serious untoward incidents in 2012/13, both incidents involved handover sheets which contained a small amount of patients' details. The Trust reported the incidents to the Information Commissioners Office (ICO) and where appropriate informed the patients involved. Following an investigation the ICO welcomed the remedial steps taken by the Trust, and agreed that the staff responsible for these losses were in direct breach of the Trust's procedures. As a result the ICO took no enforcement action against the Trust. The Trust took a number of steps to raise staff awareness of these risks and continues to provide Information Governance Training to all staff in order to ensure that patient information is kept secure.

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 2012/13, 4.95% of total income was incurred on management costs.

This represents a decrease on the previous year (2011/12:5.0%), 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.

Chapter 4

Board of Directors

Introduction

As at 1 April 2013, the Board of Directors was comprised of eight 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 David Pitt	Director of Service Transformation & Workforce (Appointed 1 January 2013)
Mrs J Shaw	Interim Director of Workforce & Organisational Development (to 31 December 2012)
Mrs J Smith	Director of Nursing & Quality
Mr J Moran	Chairman
Dr A Wood*	Senior Independent Director & Deputy Chairman
Dame P Bacon	Non-Executive Director (Appointed 1 May 2012)
Mr J Barnes	Non-Executive Director (Appointed 1 February 2013)
Mr M Davis	Non-Executive Director (Appointed 1 February 2013)
Mr D Dunn	Non-Executive Director (Reappointed 1 May 2012)
Mr W Craig	Non-Executive Director (Retired 31 January 2013)
Mrs V Godfrey	Non-Executive Director (Retired 30 April 2012)
Mr D Hopewell	Non-Executive Director
Mrs R McNeil	Non-Executive Director

*Dr Wood's tenure was extended, under special circumstances, to 30 April 2013 and, therefore, as at 1 May 2013 there were seven Non-Executive Directors.

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 meeting with individual items raised by exception. The Chair 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 member and none of the Executive Directors serve elsewhere as a Non-Executive Director. There is full disclosure of all Directors 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. All Non-Executive Directors, including the Chairman, have confirmed in writing they are able to honour the necessary time commitments to undertake their

various roles and responsibilities at 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. A review of the skills during 2012/13 saw the reappointment of Mr Dennis Dunn in May 2012 and the appointment of Dame Pat Bacon, following the retirement of Mrs Val Godfrey. The year also saw the appointment of Mr John Barnes and Mr Mike Davis (effective 1 February 2013) following the expiration of tenure and retirement of Mr Bill Craig. The tenure of Dr Wood also expired during 2012/13, however, it was agreed by the Board of Directors and Council of Governors to extend Dr Wood's tenure to 30 April 2013. Dr Wood was the Deputy Chairman and Senior Independent Director and the extension allowed for the appointment of other Non-Executive Directors on the Board to these roles and to ensure a seamless transfer of duties.

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.

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.

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 2013 are set out below:

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	2 years 3 months	None	None
Bacon P	Non-Executive Director	3 year Term	1 May 2012	2 years 1 month	None	None
Barnes J	Non-Executive Director	3 year Term	1 February 2013	2 years 10 months	None	None
Davis M	Non-Executive Director	3 year Term	1 February 2013	2 years 10 months	None	None
Dunn D	Non-Executive Director	3 year Term	1 May 2012	2 years 1 month	None	None
Hopewell D	Non-Executive Director	3 year Term	1 December 2011	1 year 8 months	None	None
McNeil R	Non-Executive Director	3 year Term	1 November 2011	1 year 7 months	None	None
Wood A	Senior Independent Director/Deputy Chair	3 year Term (extended to 30 April 2013)	1 October 2009	1 month	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 month's salary
Dodds P	Deputy Chief Executive and Medical Director	Permanent	N/A	6 months	6 month's salary
Frodsham D	Chief Operating Officer	Permanent	N/A	6 months	6 month's salary
Oldham M	Director of Finance & Strategic Planning	Permanent	N/A	6 months	6 month's salary
Pitt D	Director of Service Transformation & Workforce	Permanent	N/A	6 months	6 month's salary
Smith J	Director of Nursing & Quality	Permanent	N/A	6 months	6 month's salary

Non Executive Director appointments can be terminated by a 75% majority of Governors voting at a Council of Governors meeting.

Board Member Profiles

Non-Executive Directors



Mr John Moran, Chairman

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.

Dr Alan Wood, Senior Independent Director (to 30 April 2013)

Alan studied chemistry at university and spent some time in pharmaceutical research before converting to a commercial career with ICI, spending nearly thirty years at various management levels in marketing and export sales. Alan also gained experience in business process design, career planning and general business and company management. Since retiring in 1999, Alan has done some business consultancy in the education and skills area for the North West Development Agency, but has now discontinued this.



Dame Patricia Bacon (from 1 May 2012)

Prior to joining the Trust, Patricia worked for 21 years with St Helens College, where she was Deputy Principal for 12 years before becoming Principal in 2002. Alongside this role, Patricia undertook Non-Executive Director roles at a number of organisations, including seven years at University Hospital North Staffordshire NHS Trust, where she was Chair of the HR Committee, member of Audit and Clinical Governance, and lead for the Frameworks for Care of the Elderly and Improving Working Lives.

Mr John Barnes (from 1 February 2013)

John joined the Trust as a Non-Executive Director on 1 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 areas of sustainability, the utility sector, change management and leadership. He is a member of a number of business groups, and is Chair of Sustainable Communities Working Group for zero-carbon homes for the UK Business Council for Sustainable Energy.





Mr Bill Craig (to 31 January 2013)

Bill held a number of personnel, training and industrial relations roles before joining the senior management team of a major US computer company to head up their Human Resources function for their North UK business operations. Since 1994, he has worked as an independent human resources consultant providing strategic and operational HR support to SMEs and business performance improvement consultancy. Bill is a Member of the Chartered Institute of Personnel & Development.

Mr Mike Davis (from 1 February 2013)

Mike joined the Trust on 1 February 2013. Mike has had a long and successful career in the business services, facilities management and project finance industries, with 25 years as Managing Director or CEO.



Mr Dennis Dunn (reappointed 1 May 2012)

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.



Val served for 20 years as a Councillor for Vale Royal Borough Council. Val is a member of Cuddington Parish Council and is active in several voluntary and community organisations in the Winsford and Northwich areas.





Mr David Hopewell

David is a chartered accountant by profession. He spent several years working with Shell, both overseas and in the UK, subsequently 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 the UK charity, Retrak, which supports street children in Africa and is currently involved with Guinness Northern Counties Housing Association.



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 joined Cheshire Police Authority as an independent Board Member in October 2008 and is 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 2 years periodically seconded to the Commission for Health Improvement/Healthcare Commission to conduct investigations and governance reviews across the country. Tracy subsequently spent 4 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, until being appointed to the Chief Executive role in October 2010.





Dr Paul Dodds, Medical Director and Deputy Chief Execuitve
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 26 years, including 8 years at the Trust developing and implementing modernisation programmes to improve quality, efficiency and capacity, as well as reducing cost and increasing income. Immediately before joining the Board of Directors, Denise was the Trust's Associate Divisional Director for Diagnostic and Clinical Support Services. She 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 noticeable 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 (Appointed 1 January 2013)

David joined the NHS through the General Management Training Scheme over 26 years ago and has experience of working in acute Trusts, community & mental health Trusts, Primary Care Trusts and with a Strategic Health Authority. He has over 10 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.





Jayne Shaw, Interim Director of Workforce & Organisational Development (to 31 December 2012)

Jayne is a qualified HR practitioner and has worked in the NHS for over 25 years. She has gained experience working in a variety of roles within HR, across a range of services including mental health, community and primary care and specialist services. Before joining the Trust as the Interim Director of Workforce and Organisational Development, Jayne was Director of Human Resources and Organisational Development at Alder Hey Children's NHS Foundation Trust where she worked for nearly 8 years.

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 undertook the positions of Deputy Director of Nursing at a large acute teaching hospital and as 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 2012/13	14	4	12	12	7	6	
Mr J Moran	11/14	4/4	-	-	-	4/6	
Dr A Wood	14/14	4/4	10/12	-	5/7	n/a	
Dame P Bacon*	11/13	3/3	-	-	-	4/4	
Mr J Barnes**	2/2	n/a	1/1	-	-	-	
Mr W Craig***	10/14	1/4	-	8/10	-	-	
Mr M Davis**	2/2	n/a	-	-	1/1	-	
Mr D Dunn	11/14	2/4	-	-	3/7	-	
Mrs V Godfrey****	1/1	1/1	-	-	-	-	
Mr D Hopewell	12/14	3/4	11/12	-	-	-	
Mrs R McNeil	14/14	2/4	-	11/12	-	-	
Mrs T Bullock	14/14	4/4	-	-	-	5/6	
Dr P Dodds	14/14	3/4	-	11/12	5/7	5/6	
Mrs D Frodsham	14/14	3/4	10/12	-	6/7	-	
Mr M Oldham	13/14	3/4	11/12	-	6/7	-	
Mr D Pitt****	3/3	1/1	3/3	2/3	-	-	
Mrs J Shaw*****	9/11	1/3	4/9	7/9	-	-	
Mrs J Smith	13/14	2/4	-	9/12	-	5/6	

Notes:

- Dame Patricia Bacon commenced 1 May 2012
- ** Mr John Barnes & Mr Mike Davis commenced 1 February 2013
- *** Mr Bill Craig retired 31 January 2013
- **** Mrs Val Godfrey retired 30 April 2012
- ***** Mr David Pitt commenced 1 January 2013
- ****** Mrs Jayne Shaw's contract expired 31 December 2012

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 2012/13.

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 2012/13:

Director	Interest	Seeking to do business with health authorities	Has business dealings with the Trust
Mr J Barnes	Director of Practiq Consulting LimitedASC Renewables Limited	*	
Mr M Davis	 Director of Alpraham Hall Barns Management Company Limited Chairman of the Board of Central Nottinghamshire Hospitals Plc. Chairman of the Board Derby Healthcare Plc. 	*	
Mr D Dunn	 Pro Vice Chancellor of Manchester Metropolitan University Director of Marketing Cheshire Magistrate 	*	

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

In addition, the Chair has confirmed to the Trust that he has no other significant interests that adversely impact on the time he has 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 2012/13 the Trust continued to work with the Clinical Commissioning Group Chairs and Chief Officer, whilst in shadow form, to

develop a Partnership Board. The remit of the Board was to develop a number of strategic priorities to ensure sustainable healthcare for the population of Cheshire.

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 web sites 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 2012/13 the Committee met on the following occasions and attendance is as below:

Attendance at Audit Committee Meetings

Name	16 April 2012	28 May 2012	18 June 2012	13 August 2012	15 October 2012	10 December 2012	11 February 2013
David Hopewell (Chair)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pat Bacon	n/a	Yes	Yes	Yes	Yes	Yes	Yes
John Barnes	n/a	n/a	n/a	n/a	n/a	n/a	Yes
Bill Craig	Yes	Yes	No	Yes	No	Yes	n/a
Mike Davis	n/a	n/a	n/a	n/a	n/a	n/a	No
Dennis Dunn	Yes	Yes	No	Yes	No	Yes	Yes
Val Godfrey	Yes	n/a	n/a	n/a	n/a	n/a	n/a
Ruth McNeil	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Alan Wood	Yes	Yes	Yes	Yes	Yes	Yes	Yes

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 2012/13 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 3,400 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.

An important piece of work in 2012/13 was the focus on the Health, Work and Wellbeing agenda. Ensuring a healthy workforce is vital to maintaining and improving quality across the Trust. Evidence shows there are clear links between the health and wellbeing of staff and improved patient outcomes. During the past twelve months the Trust has worked to raise the profile of Wellbeing amongst staff and to build on the inspiration and legacy of both Olympic and Paralympic games ensuring compliance with NICE guidance. Key activities to highlight include:

- 1km walking route on Trust premises for staff use during breaks;
- Zumba classes:

- Yoga classes;
- · Staff Choir;
- 5km Fun run and walk;
- · Complimentary therapies;
- · Charity football match;
- Participation in NHS Northwest Inter Trust Games;
- · Healthy Eating Advice;
- Health Checks for staff.

2013/14 will see the Trust's Health & Wellbeing Group continue to focus on the following key stands:

- Emotional Wellbeing;
- Physical Wellbeing;
- Nutrition:
- Workplace Design;
- Health Partnerships;
- Communications.

Celebration of Achievement Evening

The Trust held its fifth annual Celebration of Achievement Evening in March 2013 with over 200 attendees celebrating the achievement and dedication of their colleagues and peers across the Trust. Staff are encouraged to nominate their colleagues across the Trust in ten categories.

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 2012 annual national staff survey increased from 64% in 2011 to 65%, putting the Trust in the top 20% of the Trust's peer group.

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

A review of the findings show the Trust's score for Staff Engagement for 2012 was

3.70 out of 5 (1 indicating that staff are poorly engaged and 5 indicating that staff are highly engaged), demonstrating an increase for the fifth consecutive year. The Trust also saw an improvement in the number of staff who would recommend the Trust as a place to work and receive treatment.

Other areas of significant improvement include; staff feeling confident in how to handle confidential information, staff feeling more motivated at work, communication between senior managers and staff is effective and more staff saying they would know how to voice any concerns at work.

Divisional action plans will be developed based on the 2012 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 2012 survey results and which will be a focus within the Divisional action plans are the number of incidents involving violence

against staff, the quality of appraisals and teamworking. These plans will also contain actions from the Investors in People review for the Division.

Progress against Action Plans will be monitored through forums including Executive Workforce Committee, Divisional Quarterly Performance Reviews (DQPR) and Divisional Workforce meetings.

The Trust also holds focus groups with staff in June and October across the Divisions to gain further indepth 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 four ranking and bottom four ranking scores are noted below:

Top Four Ranking scores

Question	Trust Score	National Average for Acute Trusts
KF15. Fairness and effectiveness of incident reporting procedures	3.64	3.50
KF14. Percentage of Staff reporting errors, near misses or incidents witnessed in the last month	94%	90%
KF28. Percentage of Staff experiencing discrimination at work in last 12 months	7%	11%
KF2. Percentage of Staff agreeing that their role makes a difference to patients	92%	89%

Bottom Four Ranking scores

Question	Trust Score	National Average for Acute Trusts
KF17. Percentage of staff experiencing physical violence from staff in last 12 months	4%	3%
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	46%	55%
KF4. Effective Team Working	3.68	3.72

Investors in People

The Trust maintains the Bronze Status of the Investors in People Standard that it achieved in



INVESTORS IN PEOPLE

January 2011. A full review will take place using both internal and external assessors during 2012/13. Annual internal reviews are undertaken in between the formal external assessments to provide a 'temperature check' and triangulate the information collected as part of the staff survey and also the 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.

Leadership Development

The Trust runs a number of in-house development programmes:

- Bands 1 5 NVQ in Management
- Bands 5 and 6 Becoming an MCHFT Manager
- Bands 7 and 8A Managers Moving On (This programme will be replaced with the master

- classes below in 2013 14)
- Master classes for senior leaders
- A programme for bands 3 and 4 will also begin in 2013.

Coaching

- The Trust continues to provide one to one coaching for senior staff from the team of twelve 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

A review of Mandatory training and Induction has been completed. From 1 April 2013 the Biennial Mandatory Update (BEMU) will also include sessions on Equality, Diversity

and Human Rights and Integrated Risk Management. A review of the appraisal and Key Skills Framework (KSF) process will be undertaken in autumn 2013 with a view to simplifying the process and aligning it with forthcoming changes to Agenda for Change.

Health Care Assistant (HCA) support

A three-day HCA training programme was 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 and learning disability awareness. Evaluations are positive and complementary. A recent analysis demonstrates a definite increase in the confidence of HCAs in performing key skills after their training. A new one day programme launches in September 2013 to provide "key messages" refresher training for experienced HCAs.

Communications

Following a thorough review of staff communications in 2011/12, the updated methods of employee interaction have continued throughout 2012/13.

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 briefs senior managers on a monthly basis around specific Trust issues, which are then cascaded down through the various teams in the organisation.

A number of newsletters are produced for the benefit of staff:

 Each employee 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 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 quarterly newsletter is also produced for staff, providing an overview of some of the major developments within the organisation, as well as regular articles focusing on specific teams and events.

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.

The Chief Executive holds weekly 'drop in' sessions whereby staff, at all levels across the Trust, can meet with the Chief Executive to share experiences of their work, details of achievements or concerns.

In April 2012, the Trust launched its updated external website, with the aim of making it easier for patients, carers and members of the public to navigate information about the Trust, whilst also making it easier for staff to update the content available.

A survey into the effectiveness of internal communications was undertaken in the summer of 2012, the results of which will be used to further enhance the methods of staff interaction.

Staff Engagement

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

Changing and improving how the Trust delivers services will be one of the main thrusts of the 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. To emphasise the Board's commitment to the effective engagement of staff, a number of Master Classes for Senior Leaders have been taking place since January 2013 and are led by a member of the Executive Team.

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 Occupational Health Service achieved national accreditation in 2012 and is a member of the NHS Health at Work network. The Service works to improve clinical standards by contributing to Management Of Health At Work Knowledge (MOHAWK) which is the NHS Occupational Health Clinical Governance system.

The continued use of a dedicated physiotherapy resource and an independent employee support and counselling service has proved a positive step in helping minimise musculoskeletal and psychologically related sickness absence.

2012/13 has been particularly challenging as a result of staff turnover, however the service continues to meet its key performance indicators whilst continuing to support individuals and managers in delivering the Trust's objectives.

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 2012/13 saw a turnover rate of 9.01% which was within the target range of 5-10%, and a sickness absence rate of 4.19%, 0.18% less than the 2012/13 year representing a 4% reduction in sickness absence. 2013/14 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 are 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 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.

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 '2 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.

The Trust's analysis of the 2011 Staff Survey results highlighted concerns relating to staff with disabilities or long term conditions. Work has been ongoing in 2012/13 to understand the difficulties and implement improvements and the Trust is delighted to report that respondents in the 2012 Staff Survey Results did not raise this as a concern.

Equality information, including that related to disabled staff, is available on the Trust's website and is monitored through the Trust's Equality, Diversity and Human Rights Committee.

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.

Partnering Patients

The Patient Experience

Each of the Board of Directors meetings starts with a patient story which is presented as a video clip, audio account or letter. The story relays the very real and personal experience of an individual who has been a patient or carer at the Trust. The stories are a combination of positive and negative experiences and are enormously beneficial to the Board of Directors in ensuring there is a genuine connection between patient experience and the decisions the Board of Directors are required to make.

Customer Care Team

The complaints and PALS (Patient Advice and Liaison Service) staff merged to form a central dedicated Customer Care Team which ensures a central point of contact for patients or relatives. The Customer Care Team's role is to provide on the spot advice and 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, providing advice and information about local health services. The Customer Care Team aims to respond to patients' concerns and issues promptly 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 straight away 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 may be able to help.

An information leaflet explaining the role of the Customer Care Team is available on all wards and department. The leaflet has been designed with patient input, and highlights that overall the feedback we receive from patients is very positive.

644 formal compliments were received by the Trust during 2012/13 which express thanks from patients and families about the care received. Compliments are shared with respective teams and highlighted as positive feedback.

As the Trust strives to continually improve complaints handling, the Team have participated in a project led by the Patient's Association Benchmarking to improve complainants' satisfaction with complaint handling and have also attended panel meetings to benchmark complaints anonymously with other Trusts.

Partnering Patients and 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.

Details of the Trust's Consultation on Quality can be found in the Quality Account, Chapter 8.

During 2012/13, the Trust was an active member of the Local Area Partnership which has resulted in links being developed with projects in schools. The year also saw the Trust continuing to work with its Youth Council to increase the involvement of young people across the Trust.

The Patient Experience Team also host quarterly meetings in local venues to share information and seek views of members of the public on a range of topics which included the Stroke Ward, Infection Prevention and Control, and Fracture Neck of Femur patient pathway.

Further detail on the Patient and Public Involvement Programme can also be found in the Quality Account, Chapter 8.

Partnering Volunteers

The Trust has 226 registered volunteers who are supervised and supported by the Voluntary Services Department. 2012 marked the 40th Anniversary of Leighton Hospital and incredibly several pioneer volunteers from 1972 are still volunteering on a regular basis within our Outpatients Department.

The Trust is also fortunate to have several voluntary organisations such as the League of Friends, WRVS, Hospital Broadcast Service, ABC Association, British Red Cross and the Ray of Hope Appeal that raise funds or provide services for the benefit of patients.



Chapter 6

Council of Governors

Welcome from the Lead Governor

As Lead Governor I am 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. This has become more apparent following the failures at Mid Staffordshire NHS Foundation Trust. The NHS is in a time of significant change and whilst the local health economy is seeing an increase in patient demand, resources continue to remain stretched.

The performance of the Trust has continued to improve over the last few years and management and staff must be congratulated for their efforts. This is confirmed through data collected not only on operational performance but also through staff and patient surveys and a number of national awards received. This improvement is also backed up by the positive remarks made to Governors by patients and their relatives about their care. However, we do take adverse comments seriously but these are far outweighed by unsolicited reports from satisfied patients. Governors communicate 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.

From a Governor perspective there is an effective working relationship with the Board of Directors, characterised by open, frank and honest behaviours. 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 "Patient Safety Walkabouts" 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 seven appointed Governors who represent a range

of lay partner organisations that were selected to enhance the Trust's ability to contribute more widely to the public and social benefit. There are currently five appointed Governors on Council, representing the following organisations:

- Central & Eastern Cheshire Primary Care Trust (Mandatory Appointment)
- Cheshire East Council (Mandatory Appointment)
- Cheshire West & Chester Council (Mandatory Appointment)
- Chamber of Commerce (Non Mandatory Appointment)
- Manchester Metropolitan University (MMU) (Non Mandatory Appointment)

As at 31 March 2013 there were three Governor vacancies, as follows:

- Central & Eastern Cheshire Primary Care Trust (Mandatory Appointment – second Governor appointment)
- Community and Voluntary Service
 Cheshire East and Cheshire Community
 Development Trust (Appointed Governor)
- Carer of a Patient aged 15 Years or less (Elected Governor)

From 1 April 2013, the Primary Care Trusts were abolished with the role of commissioning local non-specialised services now provided through the local Clinical Commissioning Groups. The Trust has a good working relationship with the two local Commissioning Groups - NHS South Cheshire Clinical Commissioning Group and NHS Vale Royal Clinical Commissioning Group – and believes it is important that the Trust continues to work in partnership with the Commissioning Groups. In this regard, both Commissioning Groups have been invited to appoint a Governor to the Trust's Council of Governors. These two appointments will seek to replace the representative appointments from Central and Eastern Cheshire Primary Care Trust.

The Trust has also been working with Community and Voluntary Service Cheshire East and Cheshire Community Development Trust during 2012/13 to seek an appointment to the Appointed Governor vacancy. In March 2013 Community and Voluntary Service Cheshire East confirmed they were not in a position to appointment a Governor to the Trust's Council of Governors. The Trust is now completing a review of local community organisations with the view to inviting a representative to join Council.

A term of office for Governors is three years.

The names of the Governors and details on the constituency they represent, as at 31 March 2013, are noted overleaf. Details of attendance at Council of Governor meetings are also noted. Since 1 April 2012 the Council of Governors has met formally on four occasions.

Constituency	Elected/ Appointed	Unexpired Term	Coun	Council Meeting Attendance		
			26 April	26 July	18 Oct	31 Jan
Public – Congleton Area						
Mawdsley, Harry	Elected	1 year	No	Yes	No	No
Bone, Donald	Elected	1 year	Yes	Yes	Yes	Yes
Public – Crewe & Nantw	rich Area					
Beadle, Barbara	Elected	1 year	n/a	n/a	n/a	n/a
Cooper, Christine	Elected	1 year	Yes	Yes	Yes	Yes
Hadfield, Mike	Elected	1 year	Yes	Yes	Yes	Yes
Park, Jerry	Elected	1 year	Yes	Yes	Yes	Yes
Public – Vale Royal Area	 1		,		,	
Creed, Jenny	Elected	2 years, 2 months	n/a	Yes	Yes	Yes
Fairhurst, Gill	Elected	1 year	Yes	Yes	No	Yes
Harris, Norman	Elected	1 year	Yes	Yes	No	Yes
Smart, Jane	Elected	1 year	Yes	No	Yes	Yest
Patient						
Dawson, Kevin	Elected	1 year	Yes	Yes	Yes	Yes
Dibben, Nigel	Elected	1 year	Yes	No	Yes	Yes
Lyons, John	Elected	1 year	Yes	Yes	Yes	Yes
Phillips, Gerry	Elected	2 years, 9 months	n/a	n/a	n/a	Yes
Carer of a Patient aged	16 years & over					
Stalker, Pat	Elected	3 months	Yes	Yes	Yes	Yes
Staff – Medical & Dental	Practitioner					
Hopkins, Colin	Elected	1 year	Yes	No	Yes	Yes
Staff – Qualified Nursing	& Midwifery Sta	nff				
Coombes, Sarah	Elected	1 year	n/a	n/a	Yes	Yes
Staff – Other Profession	ally Qualified Cli	 nical				
Ritchings, Andrew	Elected	1 year	No	Yes	Yes	Yes
Staff – Clinical Support Staff						
Cunningham, Angela	Elected	1 year	No	Yes	Yes	Yes
Staff – Non Clinical Supp	port Staff					
Walton, Brian	Elected	3 months	No	Yes	Yes	Yes
Staff – Recognised Staff	Organisations &	Trade Unions				
Nimmo, Peter	Elected	1 year	Yes	Yes	No	Yes
, 1 0.01		1 3001	100	100		100

Constituency	Elected/ Appointed	Unexpired Term	Council Meeting Attendance			lance
			26 April	26 July	18 Oct	31 Jan
Staff – Registered Volun	teers					
Williams, Heather	Elected	1 year	Yes	Yes	No	Yes
Appointed Governors	Appointed Governors					
Colman, Paul (Chambe	r of Commerce)	1 year	Yes	Yes	Yes	Yes
Flude, Dorothy (Cheshire East Council)		1 year	Yes	Yes	No	Yes
Griffiths , Jonathan (Primary Care Trust)		1 year	Yes	Yes	Yes	Yes
Moore Dutton, Eveleigh (Cheshire West & Chester Council)		1 year	No	No	No	No
West-Burnham, Joss (N	MMU)	1 year	Yes	Yes	No	Yes

Five Governors resigned during 2012/13 as follows:

Name	Constituency	Resignation Effective	Council Meeting Attendance		lance	
			26 April	26 July	18 Oct	31 Jan
Amson, Derek	Carer of a Patient aged 15 years or less	18 October 2012	Yes	Yes	n/a	n/a
Gray, Stuart	Public – Area of Crewe & Nantwich	7 February 2013	No	No	Yes	Yes
Falkland, Joanne	Staff - Qualified Nursing & Midwifery Staff	12 October 2012	Yes	Yes	n/a	n/a
Macaulay, Brenda	Patient	30 September 2012	Yes	Yes	n/a	n/a
Paul, Neil	Appointed – Primary Care Trust	31 January 2013	Yes	No	No	No

Roles & Responsibilities

The roles and responsibilities of the Governors are:

- Advisory, by communicating to the Board of Directors the wishes of Members and the wider community;
- Guardianship, by ensuring that the Trust is operating in accordance with its Principal Purpose and is compliant with its Authorisation. In this regard it acts

- in a trustee role for the welfare of the organisation;
- Strategic, by advising on a longer term direction to help the Board of Directors effectively determine its policies.

In particular, the Governors are to:

 engage with and develop the membership of the Trust, representing the interests of Members;

- communicate with their local Members on issues whilst feeding back to the Trust, via the Council of Governors, the views and ideas of Members;
- give the views of the Council of Governors to the Board of Directors for the purposes of the preparation by the Directors of the document containing information as to the Trust's forward planning in respect of each financial year to be given to Monitor;
- respond to any matter as appropriate when consulted by the Directors;
- appoint or remove the Chairman and the other Non-Executive Directors in accordance with the Constitution;
- decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and Non-Executive Directors in accordance with the Constitution;
- approve an appointment of the Chief Executive in accordance with the Constitution:
- consider the annual accounts, any report of the auditor on them, and the annual report;
- appoint or remove the Trust's external auditor:
- hold the Non-Executive Directors to account for the performance of the Board of Directors.

Following the enactment of the Health & Social Care Act 2012, Governors have a number of additional statutory duties and powers including holding the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and to represent the interests of the members of the Trust as a whole and the interests of the public. In 2013, the Trust commenced a Governor Development Programme presenting sessions on a number of key topics including the implications of the Health & Social Care Act for Governors, Governance in the NHS and Finance in the NHS. Council also received presentations from the Care Quality Commission and the Trust's External Auditors.

The Foundation Trust Network have also introduced a Governor Development Programme, Governwell, in which the Chairman and a number of Governors were involved in the development. The Governwell Programme is now live and Council have been advised of future sessions should they wish to attend.

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.

Governor Involvement

A number of Council of Governor committees are established and membership is shown opposite. 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 2013

Committee	Current Members	Meeting Dates
Membership & Communications Committee	Jane Smart (C) Sarah Coombes Kevin Dawson John Lyons Jerry Park	16 April 2012 14 May 2012 18 June 2012 16 July 2012 8 October 2012 12 November 2012 10 December 2012 14 January 2013 18 February 2013 11 March 2013
Nominations & Remuneration Committee	Sarah Coombes Michael Hadfield John Lyons Jerry Park	27 September 2012 30 January 2013
Strategy Committee	Donald Bone Christine Cooper Nigel Dibben Michael Hadfield John Lyons Eveleigh Moore-Dutton	11 June 2012 6 August 2012 1 October 2012 3 December 2012 4 February 2013

Governors are also invited to sit on Trust Committees and Governor representation, as at 31 March 2013, is detailed below:

Equality & Diversity Committee: Jane Smart

Patient Experience Committee: Kevin Dawson

Gill Fairhurst Dorothy Flude Norman Harris Andrew Ritchings

Pat Stalker

Infrastructure Committee: Brian Walton

QuESt Committee: Harry Mawdsley

Pat Stalker

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;
- Labour Ward Forum;
- Health Promotion Group;
- Patient Safety Walkrounds;
- Patient Representatives on Divisional Boards:
- Annual Plan Workshop;
- Member and Public Engagement Events;
- Patient Surveys;
- One in Eleven Appeal.

Lead Governor

Mr John Lyons was appointed as Lead Governor effective from 1 April 2012. 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.

General engagement with Governors and Members

In addition to the Council of Governor's meetings and the membership on various groups, there continues to be a targeted focus in gaining the views of Governors and Members as follows:

- The Trust carried out a Quality Accounts
 Consultation to obtain the views of
 Governors, Members and the Public on the
 key areas of focus of the Trust regarding
 quality;
- Work continues with the Youth Council to be a voice for young people;
- Meetings have taken place with local community groups;
- Governors have attended, at the invitation of members, local community groups to meet and discuss activity of the Trust.

A key focus for 2012/13 will continue to be membership engagement with the Engagement Plan being reviewed monthly by the Governor-led Membership & Communications Committee.

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. 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 Walkabouts. Board Members and Senior Managers from the Trust also attend other forums in which Governors became involved.

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 twice during 2012/13 and the dates of the meetings together with details of attendance are noted below:

	27 September 2012	30 January 2013
Mr J Moran (Chairman)	Yes	Yes
Ms S Coombes	n/a	Yes
Ms J Falkland	Yes	n/a
Mr S Gray	Yes	No
Mr M Hadfield	Yes	No
Mr J Lyons	Yes	No
Mr J Park	Yes	Yes

The September 2012 meeting was held to discuss the half year interim appraisal of the Chairman and Non-Executive Directors. The Committee were satisfied that a rigorous process was in place to conduct the review process and were assured that all Non-Executive Directors are continuing to operate effectively.

The Committee also discussed the expiration of tenures for Dr Wood and Mr Craig. It was agreed that the Trust should seek to advertise these roles on the open market, in line with the Trust's Constitution. The Committee considered the skills analysis of the Non-Executive Director team and whilst noting there was a good balance of necessary skills, it was agreed given the likely changes within the NHS in the future, the Trust should seek candidates that have senior experience of leading change and developing and implementing strategy.

It was specifically noted that the retirement of Dr Alan Wood would require a successor to be appointed to the role of Deputy Chairman and Senior Independent Director. It was agreed the two roles should be separated and the appointments made after the recruitment exercise has been concluded. In this regard, it was agreed the tenure of Dr Wood should be extended to 30 April 2013.

The Committee were involved in and directed the recruitment process culminating in the appointment of Mr John Barnes and Mr Mike Davis as Non-Executive Directors. GatenbySanderson 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 Barnes and Mr Davis was agreed by Council on 31 January 2013.



Chapter 7

Membership

Membership Commentary

The membership in total has grown by 2% over the year. The table below shows the membership size and movement with estimates for 2013/14.

Membership Size and Movements

Public constituency	Last year	Next year (estimated)
At year start (1 April)	4,145	4,265
New members	201	200
Members leaving	81	175
At year end (31 March)	4,265	4,340

Staff constituency	Last year	Next year (estimated)
At year start (1 April)	2,886	3,081
New members	405	100
Members leaving	210	75
At year end (31 March)	3,081	3,106

Patient constituency	Last year	Next year (estimated)
At year start (1 April)	1,309	1,409
New members	156	175
Members leaving	56	150
At year end (31 March)	1,409	1,434

The key focus for the coming year continues to be engagement with Members. However, the Trust is to undertake a data cleanse of the existing Membership database and it is anticipated this will reduce Membership figures through a number of Members having moved away or deceased. The Trust will, therefore, ensure the Membership target of 8,000 is retained whilst also ensuring proportional representation of Membership.

Analysis of Current Membership

Public constituency	Number of Members	Eligible Membership
Age (years):		
0 – 16	6	69,569
17 – 21	139	17,466
22+	3,934	236,720
Undisclosed	186	
Ethnicity:		
White	3,615	318,937
Mixed	10	1,684
Asian or Asian British	28	1,236
Black or Black British	18	609
Other	4	1,264
Undisclosed	590	
Socio-economic groupings		
ABC1	2,964	136,577
C2	1,017	39,241
D	150	42,195
E	114	36,695
Gender:		
Male	1,835	158,633
Female	2,251	165,052
Undisclosed	179	
Patient constituency	Number of Members	Eligible Members
Age:		
0 – 16	0	n/a
17 – 21	14	n/a
22+	1,327	n/a
Undisclosed		

Membership Engagement

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

- Health Information Events;
- Regular newsletters (IN);
- Website:
- Annual Members meeting;
- Governor meetings to which Members are invited;
- Trust consultation events:
- Recruitment drives:
- Attending staff induction events.

Governors are involved in out-reach to their Members, and run initiatives to engage with existing Members and recruit new Members at events held in the region. Events will continue throughout 2012/13 with a particular focus continuing to be attendance at Outpatient clinics across the Trust and also attendance at Community Events across the local community.

The Trust is to prepare a position response following the release of Robert Francis' report, in February 2013, on the system and regulatory failures which failed to prevent the events which occurred at Mid Staffordshire NHS Foundation Trust. Discussion has taken place as to the format of this response and the Board of Directors have agreed it should be a patient/public led response. In this regard, Members of the Trust who have expressed an interest in 'Patient Services' shall be invited to attend focus groups to have their say.

As part of its Governor Development
Programme, the Trust is to host a session
on Effective Membership Engagement.
This will provide Governors, particularly
newly appointed Governors, with the tools,
information and events to ensure effective
representative engagement with Members and
also the public.

Work is also ongoing with the Trust's Youth Committee to engage with young members. During the year the Committee worked with management from the Children's & Adolescent Ward to review the patient survey whilst the Committee has also commenced a programme of work with the local Clinical Commissioning Groups to engage with young people in the local health economy on service provision.

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 the affairs of the Trust 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 twice during 2012/13.

In May 2012, Members in the Public Constituency of Vale Royal and all other parts of Chester & Cheshire West were invited to stand for election, following the resignation of Mr David Speak (effective 31 March 2013). Mrs Jenny Creed was elected unopposed.

November 2012 saw Members in the Class of Patient being invited to stand for election following the resignation of Mrs Brenda Macaulay (effective 30 September 2012). Mrs Geraldine (Gerry) Phillips was appointed with effect from, January 2013, with the following voting report received.

Number of eligible voters	1,322
Total number of votes cast	311
Turnout	23.8%
Number of votes found to be invalid	3
Number of votes blank or spoilt	3
No declaration forms received	0
Total number of valid votes to be counted	308

Governors were also sought for the Class of Staff – Qualified Nursing & Midwifery, following the resignation of Ms Joanne Falkland (effective 12 October 2012) and Public Constituency of Crewe & Nantwich (and other surrounding areas) part of Cheshire East following the resignation of Mr Stuart Gray (effective 7 February 2013). Mrs Sarah Coombes and Mrs Barbara Beadle were appointed, respectively, as the candidate with the next highest number of votes in the previous election.

Chapter 8

Quality Account 2012/13

Part 1 - Statement on quality from the Chief Executive

I am pleased to present our fourth published Quality Account for the period of April 2012 to March 2013.

Mid Cheshire Hospitals NHS Foundation Trust is the organisation that runs Leighton Hospital, Crewe, Victoria Infirmary, Northwich and Elmhurst Intermediate Care Centre in Winsford.

2012 has continued to be a successful period for the Trust, with many significant achievements in quality, safety and experience. We are extremely proud to have continued our success within Infection Control having only one MRSA infection this year and seeing a further reduction in the number of cases of Clostridium difficile, placing us amongst the highest performers in the North West.

Another achievement has been the continued reduction in our mortality rates. We were awarded the CHKS national awards for the **Most Improved Hospital in 2012**, against 23 quality indicators (including mortality) and the CHKS **top 40 Trusts in the country**.

In December 2012, the Care Quality Commission (CQC) conducted an unannounced visit to a number of wards at Leighton Hospital to assess against 5 essential standards of care. The Trust received a very

positive report that reflected the direct experiences of patients on our wards on that day. Most notable were the patient comments in relation to being



treated with care and compassion.

There have been many areas where we have introduced new services/ new pathways to improve quality. One example is the introduction of an acute oncology service, being one of the first hospitals in the region to put this service in place. We have seen great benefits to patients who have been diagnosed with cancer and the care they receive when they have unplanned admissions to hospital.

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 would like to take this opportunity to give a huge 'thank you' to all our staff for your efforts in 2012. 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 confirm that, to the best of my knowledge, the information presented in this document is

accurate.

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

Quality, Effectiveness & Safety Committee (QuESt)

The Quality, Effectiveness and Safety Committee is responsible for providing information and assurances to the Board of Directors that the organisation is safely managing the quality of patient care, the effectiveness of quality interventions and patient safety.

During 2012/13, the Committee reviewed the 10 out of ten strategy indicators as stakeholder and public feedback had been that some of the indicators were causing confusion as they did not align to performance indicators and the outcomes framework. In considering this information, the Committee took this feedback

on board and agreed to changes in two indicators: mortality and readmissions. The detail of the changes is explained in the relevant sections of the report.

Priorities for improvement in 2013/14

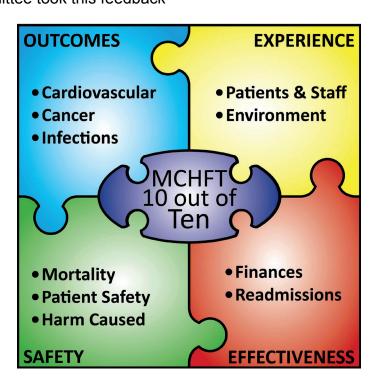
The Trust aims to be in the top 10% of all secondary care providers in England in ten agreed indicators of quality by 2014, selected through a public consultation process.

The quality consultation undertaken in January and February 2013 confirmed that these selected indicators remain a high priority to the local people.

These indicators are deliberately challenging as they are stretch targets designed to ensure the Trust drives improvement to the highest possible level, over and above nationally required targets.

Over the past year, it has been necessary to update the specific measures included within each indicator. This is explained within the summary of each indicator where this has taken place.

The following section provides an outline of each of the 10 out of ten indicators and how these are currently monitored and measured.



Progress against these targets during 2012/13 is described in part 3 of this report.

Safety

Mortality

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

This indicator has been amended from 'to reduce mortality rates by 10 percentage points in patient groups where death is not expected.' The reason for this amendment is because this was of more significance to patients and the public.

Monitored:

A Trust mortality reduction group is well established and chaired by the Medical Director. This group reviews health records to identify areas for improvement in the quality of care provided by the Trust. Action plans are developed to address lessons learnt to ensure changes in practice are made. As the Trust monitors all mortality rates the overall intention is to reduce mortality for patient groups where death is not expected.

Measured:

The Trust uses CASPE Healthcare Knowledge Systems (CHKS) as the provider of comparative information and quality improvement services. This system provides information about mortality rates on a monthly basis.

Patient Safety

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

Monitored:

The number of patient moves during each emergency admission is monitored using the Trust's information management system. The

clinical divisions monitor this information on a monthly basis.

Measured:

All patient moves are measured through the Integrated Care System (ICS) which is the patient management system used by the Trust.

Harm Caused

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

Monitored:

The patient safety team reviews all patient safety incidents in order to identify lessons to learn and implement changes in practice. This is reported in the integrated governance monthly assurance report and is presented to various committees in the Trust's governance structure.

Measured:

The Trust's incident reporting system is used to determine the number of patients who suffer avoidable harm. All patient safety incidents are reported externally via the National Learning and Reporting System (NRLS). The NRLS send the Trust a report every six months on performance measured against other small acute Trusts.

Effectiveness

Readmissions

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

(This indicator has been amended from to reduce the number of patients who are readmitted to hospital within 7 days of discharge.' The reason for this amendment was to maintain consistency with national reporting requirements. It was identified that

the use of the 7 day measure was causing confusion amongst members of the public and staff.)

Monitored:

The Trust monitors patients who have been readmitted as an emergency within 30 days.

Measured:

Readmissions to hospital within a 30 day period following discharge as an emergency admission are measured using ICS.

Finance

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

Monitored:

The percentage of non clinical spend is monitored by the Trust's finance department and compared with available benchmarking data to identify areas for improvement.

Measured:

Measurement is determined by taking the amount of actual expenditure outside of the clinical divisions and comparing this as a percentage of the total actual expenditure.

Experience

Patients & Staff

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

Monitored:

A nursing and midwifery acuity group has been established which is chaired by the Deputy Director of Nursing & Quality. This group meets bi-monthly and reports to the executive workforce committee.

Measured:

The nursing and midwifery acuity group reviews

the results of the Safer Nursing Care (SNC) acuity / dependency monitoring tool which assesses the numbers of nursing staff required in adult inpatient wards. This process is undertaken at least every 6 months.

Similar tools for nurses and midwives working in other areas of the Trust are also being reviewed, implemented and evaluated.

The ratio of doctors has, in the previous 3 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.

Environment

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

Monitored:

A delivering same sex accommodation (DSSA) group has been established which is chaired by the Deputy Director of Nursing & Quality. This group meets quarterly and reports to the Patient Experience Committee.

Measured:

The DSSA group reviews incident reports and patient feedback (via surveys and comments to the customer care team). It also evaluates progress against the Trust's self assessment toolkit and the delivering same sex accommodation improvement plan. The uptake of staff training relating to privacy and dignity is also reviewed.

Outcomes

Cardiovascular

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

Monitored:

The AMI mortality is monitored monthly by the emergency care division. The division's reducing mortality group reviews mortality and escalates issues when required to the Trust's hospital mortality reduction group. The division's performance report is also reviewed by the performance and finance committee.

Measured:

The data relating to mortality in AMI within 30 days is collated by the Trust using CHKS on a monthly basis. This rate is benchmarked against the Trust's peer organisations.

Cancer

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

Monitored:

The data for acute admissions and length of stay is monitored by the Cancer Network. The Trust's acute oncology team reports this data to the surgery and cancer divisional board.

Measured:

The acute oncology unit measures the reasons for acute admissions to ensure the preferred place of care for patients diagnosed with cancer is achieved.

Infections

To reduce the rates of Healthcare Associated Infections (HCAI).

Monitored:

MRSA and *Clostridium difficile* rates are monitored on a monthly basis and reported to

the strategic infection control committee which is chaired by the Director of Nursing & Quality.

Measured:

The rates of MRSA and *Clostridium difficile* are measured and benchmarked nationally by the Health Protection Agency (HPA).

Statements of assurance from the Board

Review of services

During 2012/13 the Trust provided and / or subcontracted 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 2012/13 represents 100% of the total income generated from the provision of NHS services by the Trust for 2012/13

Feedback from patients

National Patient survey results

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 2011/2012

Between October 2011 and January 2012, a questionnaire was sent to 850 adult inpatients who had been admitted to Leighton Hospital.

Responses were received from 454 patients which equates to a response rate of 53%.

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 achieved particularly high scores in relation to providing information about the patients' condition, providing enough privacy when they were examined in the A&E department, waiting times to get a bed on a ward and explaining how to take medication in a way that patients could understand.

Areas identified for improvements

- Explaining medication side effects
- Pharmacists now review medicines available at ward levels to reduce the drugs that are dispensed from Pharmacy and liaise closely with patients to discuss their drugs as they do this.
- Reducing call bell delays The Trust has started to introduce care rounds by nursing staff to identify any help patients need on a regular basis, therefore reducing the need for patients to call for assistance.
- Improving asking patients for their views about the quality of care they have received - Over 200 patients discharged from hospital were telephoned at home to ask their views about the care they received.
- Reducing discharge delays and improving patient information about delays - Patients are encouraged to use the discharge lounge when waiting to go home. This area is staffed by a qualified nurse who can ensure patients are kept informed about delays and proactively makes sure they are kept comfortable. Feedback from patients about the discharge lounge and its services has been very positive.

National inpatient survey 2012/2013

Between October 2012 and January 2013, a questionnaire was sent to 850 adult inpatients who had been admitted to Leighton Hospital.

Responses were received from 444 patients which equates to a response rate of 52%.

The CQC will publish a benchmark report including results later in 2013.

Examples of comments made by patients in the national inpatient survey 2012

Patients commented on what was particularly good about their care:

"I always have great confidence in the competence of doctors. The nursing staff were also absolutely excellent. Nothing was too much trouble for them. They were focused, well-informed, energetic and constantly helpful. I particularly appreciated the frequency with which my blood sugars were monitored, even in the early hours of the morning. I am glad to have the opportunity of expressing my appreciation of them."

"The nursing staff were excellent, they were very attentive and caring."

"I was on two wards whilst in hospital and on both of these wards the nursing staff were exceptional in their care of patients and skills."

"Staff at all times were helpful and courteous. The hospital was very clean."

"The doctors were meticulous in their explanations and how and why they were following certain procedures."

"Everyone – paramedics/ambulance staff/doctors/nurses and all hospital staff were appropriately pleasant. I was always a person, not a number."

Areas for action for 2012/2013

- 1. Ensuring standards of cleanliness in rooms and wards are maintained.
- 2. Continue to monitor response times to call bells for patients and ensure staffing levels are correct based on the dependency needs for each ward.
- 3. Reduce unnecessary noise on wards at night.

National accident and emergency survey

During 2012, a questionnaire was sent to 850 people who had attended the accident and emergency department (A&E) during March 2012. Responses were received from 392 patients which equates to a response rate of 46%.

The collated results of this survey show that the Trust performed about the same as other

Trusts in all categories:

- · Travel by ambulance;
- · Reception and waiting;
- Doctors and nurses;
- · Tests;
- · Hospital environment and facilities;
- Leaving the A&E department;
- Overall views on experience.
 - ✓ Overall the Trust achieved an improved set of results since the previous survey in 2008.
 - ✓ The overall average score has increased from 72% to 76%.
 - ✓ The Trust has improved by more than 5% or more on 8 questions.
 - ✓ There have been no reductions by 5% or more in any question.
 - ✓ The Trust scores around average (middle 60%) on most questions.

Patients made the following comments about their care:

"I have angina and was told I had done the right thing in going to A&E. At no time did I feel I had wasted their time (from doctors and nurses). I was well care for until my blood results were available. I was treated extremely well and have nothing but praise for the A&E department I attended".

"It would have been helpful to have an idea about timespans i.e. how long it may be before being called through. After an hour I was called through. I thought it was to see a doctor, but it was to see a nurse. It would be helpful to know how it all worked".

Areas for action for 2012/2013

- Ensure the plasma information screen is up kept up to date with details of current waiting times in the department.
- Provide information about waiting times at triage and/or reception.
- Provide information leaflets to explain processes within the A&E department.

Patient and public involvement programme

The Trust has an annual Patient and Public Involvement programme which includes a range of methods of seeking feedback from patients, carers and service users including patient satisfaction surveys.

In 2012/13, 34 local patient surveys were undertaken, 11 of which were conducted using a touch screen survey kiosk. The kiosk is an electronic, mobile device which allows patients and visitors to complete the surveys online. Once the feedback has been collated action plans are implemented to address any issues which have been identified from the survey.

The following information provides some examples of results of local patient surveys and improvements made from the results of four randomly selected surveys:

Patrick Murphy Unit (Gynaecology Clinic) 49 responses received via the kiosk.

Examples of responses received:

97% of patients felt their privacy was respected 93% of patients said they would recommend Leighton hospital to friends and family 84% of patients felt they received information that was easy to understand prior to their appointment.

Areas to action:

70% of patients were not offered an alternative private area

20% of patients did not receive any information prior to their appointment which was easy to understand.

Changes implemented following the survey:

- ✓ A new private room has been identified for patients who wish to speak in confidence with staff.
- ✓ Waiting times are now displayed and updated on a regular basis in the waiting area.

Confidentiality survey

95 responses received via the kiosk.

The following are the most recent examples of responses received:

95% of patients felt hospital staff respected the confidentiality.

95% of patients felt they could trust us as a hospital with their personal information.

Areas to action:

20% of patients did not feel adequately informed about how the hospital uses personal information.

Changes implemented following the survey:

✓ The introduction of the new "How we use your personal information" leaflet, copies now available in all areas.

A new style poster has been developed to ensure that feedback from surveys are displayed with clear actions highlighted as a result.



Macmillan Cancer Unit

92 responses received from a sample size of 100.

The following are the most recent examples of responses received:

100% of patients said staff treating them introduced themselves.

100% of patients felt staff listened carefully to what you had to say and their answers were informative and helpful'

100% of patients said the nurses gave them the opportunity to ask questions 98% of patients felt there was enough access to privacy if required

100% of patients felt the staff treated them treated them with respect

Areas to action:

Patients not always informed of clinic delays upon arrival to the unit.

Changes implemented following the survey:

✓ All patients/relatives are informed upon arrival of any clinic delays.

Nutrition survey

62 responses from a sample size of 75.

95% of patient said they were able to eat their meal without disturbance.

90% of patients felt their dignity was maintained during mealtimes.

90% of patients said they were offered regular drinks.

Areas to action:

87% of patients said they were not asked if they would like to eat their meal in the dayroom.

50% of patients were not offered the chance of washing their hands before their meal.
20% of patients said they were not offered condiments with their meal.

Changes implemented following the survey:

- Patients are now offered the use of the dayroom to eat their meals during their stay.
- All patients are now given hand wipes prior to their meals and offered condiments.

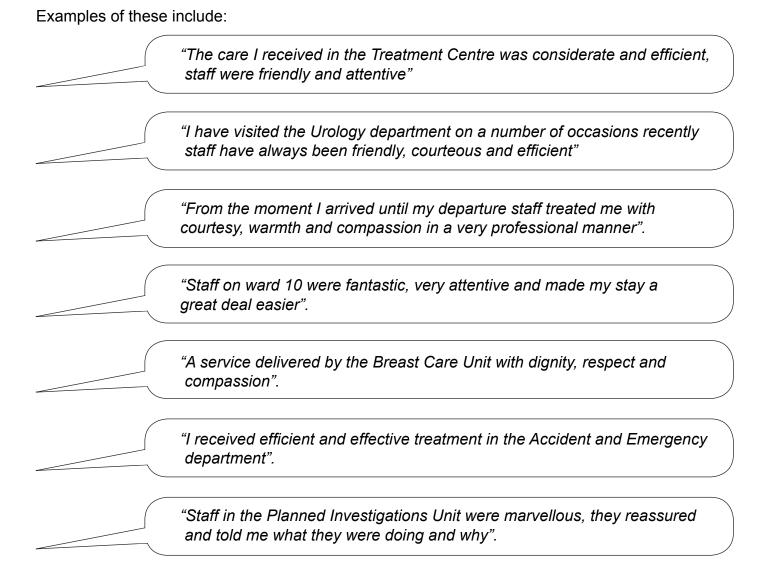
NHS Choices

Patients can comment about their experience on the NHS Choices website. There were a total of 76 new postings on the NHS Choices website in 2012/2013.

As from December 2012, NHS Choices commenced using a star rating to assess NHS organisations. Leighton Hospital has achieved a star rating of 4.5 stars out of a maximum rating of 5 stars, whilst the Victoria Infirmary in Northwich has achieved 5 stars.



The Trust displays examples of positive postings on notice boards and actions any suggestions for improvement.



Other patient and public involvement programme activities

Patient stories

Each month, the public board meeting is opened with a patient story. A patient story is where a patient, or carer, describes their experience of healthcare in their own words. The aim is to gain an understanding of what it is like to be a patient at the Trust, what was good and what could be improved. This is felt, by the organisation, to be an important way to

set the tone of the meeting and ensure the Trust is grounded in the very essence of the patient experience.

Patient Register group meetings

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 to seek views form members. The meetings, held at local libraries, covered many topics which included presentations from the Eye Care Centre, the new Stroke Unit, Elmhurst Intermediate Care Centre, Pathology and the

Infection, Prevention and Control Service.

Community talks

The Pathology Service Lead was invited to attend and talk to a community group. 2012 was National Pathology Year and an opportunity to increase public awareness and understanding. Pathology plays an important role in patient's diagnosis and treatment however, because much of the work is behind the scenes, many people are unaware of their vital contribution to medicine.

Readers' Panel

The panel has a total of 60 members and they have reviewed a total of 12 leaflets from April 2012 to March 2013. Leaflets included post operative information following surgery, Accident and Emergency information and parent information for babies who have MRSA and an easy read version of the Quality Accounts.

The panel submitted many suggestions including grammar changes and diagram or picture changes, overall the panel felt the leaflets were informative and the process supports staff in the development of patient information.

Patient Information

In 2012, the Trust introduced a patient information bedside folder. The folder includes information in relation to ward visiting times, car parking, and medication and discharge arrangements. The bedside folder was reviewed by the readers' panel, matrons, ward managers, executives and the infection control department, the folder is also available in other languages.

The Trust also has a number of leaflets now available in easy read version, all leaflets have been reviewed and approved by the Learning Disability Group. Leaflets include the following titles; Going for a blood test, Having a breast screening (x-ray), Having an ECG, Having an MRI Scan and Tell us what you think a patient feedback leaflet.

37 new patient information leaflets have been developed and an additional 36 have been reviewed either by the Patient Information Committee or Readers' Panel. 13 leaflets have been translated into other languages.

Review of complaints

The annual complaints report was produced and is available on the website via the Publication Scheme and the Customer Care pages - www.mcht.nhs.uk/customercare.

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.

As part of the Trust's commitment to continuous improvement, a service review of the management of informal and formal complaints was undertaken in 2012. This has led to the development of a dedicated Customer Care Team who provide a single point of access for service users. This supports the single approach to dealing with complaints and provides flexibility to ensure complaints are dealt with effectively and that all feedback and lessons learned from complaints contribute to service improvement.

The Trust encourages feedback from service users on its complaint management processes and participates in the independent Patients Association Complaint Survey. The results of this survey help to identify any improvements that can be made to existing practice.

Some of the key themes of complaints received in 2012/13 involved communication, nursing care and delay in review/treatment and difficulties in parking, and are detailed opposite.

Communication – issues raised in relation to lack of information for patients and relatives regarding treatment plans. Conflicting information given by different members of staff.

Pathways/protocols not always explained properly.

Actions taken:

- Communication skills workshops provided for staff.
- Communication & consultation skills training programme developed for medical staff.
- Dedicated "Nurse Co-ordinator" role introduced to wards to act as communication link for relatives.

Nursing Care – issues raised regarding lack of nursing support with eating and drinking, making patients comfortable and assisting with toilet needs.

Action taken:

 Care rounds are being introduced on a phased basis to check patients are comfortable and basic needs are met.

Delay in review/treatment – some issues raised regarding wait times in the Emergency Department.

Action taken:

 Patient assessment area (PAA) developed within the Emergency Department to aid patient flow and reduce wait times for patients for admission.

Car Parking – issues raised regarding difficulty in finding a parking space during peak periods due to extensive building works across the hospital site.

Actions taken:

 Reallocation of vacant employee parking areas to public / visitor parking. Intercom systems installed on entry and exit barriers linked directly to a Security Officer who can assist with locating a parking space. Reorganisation of security team working patterns to maximise the number of Security Officers on duty during peak periods.

The following table shows the number of complaints received, referrals to the Ombudsman and independent reviews over the past 3 years

Table 1: Overview of complaints received by the Trust

	2010/11	2011/12	2012/13
Number of complaints received	260	192	199
Number of independent reviews undertaken	1	0	0
Number of requests for review to the Ombudsman	3	10	5
Number accepted for review by the Ombudsman	0	3	4
Number upheld / partly upheld by the Ombudsman	0	1	2

Participation in clinical audits and research

The Trust is committed to embedding clinical audit throughout the organisation as a process for ensuring that healthcare provision is provided in line with best practice to optimise healthcare services. The process is facilitated through a clinical audit strategy (2010-13) that is managed through a central clinical audit function.

Both local and national clinical audit activity is instigated and led by clinicians with the support of the central clinical audit function.

National clinical audits

During 2012/13, there were 37 national clinical audits and no national confidential enquiries which covered the NHS services that the Trust provides. During the same period, the Trust participated in 70% of the national clinical audits in which it was eligible to participate.

The full list of national clinical audits can be seen in the following table which shows the clinical audits the Trust participated in and the percentage of cases submitted as required by the terms of reference for each clinical audit.

Table 2: National clinical audits participated in during 2012/13

National Clinical Audit	Participation	Data Submission
Adult community acquired pneumonia (British Thoracic Society)	Yes	100%
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	100%
National Joint Registry (NJR)	Yes	55%
Non-invasive ventilation - adults (British Thoracic Society)	Yes	In progress
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	100%
National Comparative Audit of Blood Transfusion programme	Yes	100%
Potential donor audit (NHS Blood & Transplant)	Yes	Critical Care 100% Emergency Dept. 97.8%
Bowel cancer (National Bowel Cancer Audit Project)	Yes	100%
Head and neck oncology (Data for Head and Neck Oncology)	Yes	100%
Lung cancer (National Lung Cancer Audit)	Yes	100%
Oesophago-gastric cancer (National Audit for Oesphago-gastric Cancer)	Yes	100%
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	100%
Heart failure	Yes	100%
National Diabetes Inpatient Audit	Yes	100%
Diabetes (Paediatric)	Yes	100%

National Clinical Audit	Participation	Data Submission
Pain database	Yes	44%
Carotid interventions audit	Yes	100%
Hip fracture database	Yes	95%
National audit of dementia	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Elective surgery (National PROMs Programme)	Yes	80%
Epilepsy 12 audit (Childhood Epilepsy)	Yes	100%
Maternal, infant and newborn programme (MBRRACE-UK)	Yes	100%
Neonatal intensive and special care (NNAP)	Yes	100%
Paediatric asthma (British Thoracic Society)	Yes	100%
Paediatric pneumonia (British Thoracic Society)	Yes	Data collection in progress
Emergency use of oxygen (British Thoracic Society)	No	Consultant resource implications
Adult asthma (British Thoracic Society)	No	Consultant resource implications
Bronchiectasis (British Thoracic Society)	No	Consultant resource implications
Inflammatory bowel disease	No	Consultant resource implications
Renal colic (College of Emergency Medicine)	No	Availability of staff
Fractured neck of femur (College of Emergency Medicine)	No	Availability of staff
Paediatric fever (College of Emergency Medicine)	No	Availability of staff
Cardiac arrhythmia	No	Nurse specialist resource implications
National Cardiac Arrest Audit	No	Nurse specialist resource implications
Diabetes (Adult)	No	Data collection resource implications
Child health programme	No	New May 2012 – currently being reviewed

The reports of 17 national clinical audits were reviewed by the Trust in 2012/13. The table below highlights some of the actions taken to improve the quality of healthcare provided as a result of national clinical audits.

Table 3: Action taken following national clinical audit reports

National Audit	Actions Taken
Adult critical care (Case Mix Programme – ICNARC CMP)	A quarterly formal review of unexpected deaths has been instigated within the critical care unit.
National Joint Registry (NJR)	Compliant with standards to date but action is being progressed in relation to the patient's consent process to improve the Trust's submission rate.
Severe trauma (Trauma Audit & Research Network, TARN)	Good orthopaedic outcome measures were highlighted. Actions are now being undertaken to improve the numbers of patients seen by a Consultant in the emergency department and to reduce waiting times for CT scans and surgery.
National Comparative Audit of Blood Transfusion programme	Good compliance with labelling, adherence to policy and positive identification of patients. The Trust's transfusion policy is being updated to include revised processes for the handover of blood
Potential donor audit (NHS Blood & Transplant)	There has been a new appointment made to the chair of the organ donation committee. A new Trust policy for organ donation referral processes following completion of a risk assessment is being developed.
Lung cancer	A case of need has been prepared to support a second lung cancer specialist nurse and additional Consultant time. A respiratory service concept paper is being prepared and has been outlined in the emergency care division annual plan. Recording of patient information has improved in line with peer in the current dataset. The multi-disciplinary team structure is being reviewed to improve thoracic surgical presence.
Acute coronary syndrome or Acute myocardial infarction (MINAP)	There has been an improvement in compliance with prescribing patterns following the appointment of a permanent Consultant post.
Heart failure	There is a chronic heart failure protocol and specialist heart failure team in place to comply with the requirements for a multi disciplinary team clinical assessment of patients within 2 weeks of discharge.
Diabetes (Paediatric)	The percentage of patients with HbA1c (average plasma glucose concentration) <7.5% was the fourth highest in the country for compliance. Improvements in documentation have been implemented to address low compliance with key screening processes.
Pain database	There has been a change in the management of patients with epidural analgesia so that all patients with epidural analgesia are now cared for in the critical care unit. The acute pain team are developing updated pathways for the management of post-operative nausea and vomiting.
Hip fracture database	Multi-disciplinary team meetings have been implemented within the Unit in order to improve discharge arrangements for patients.
Sentinel Stroke National Audit Programme (SSNAP)	The thrombolysis service commenced in July 2012. The inpatient stroke services moved into a purpose built stroke unit in September 2012.

National Audit	Actions Taken
Elective surgery (National PROMs Programme)	Plans are being progressed to commence oral Apixiban for the prevention of deep vein thrombosis.
Epilepsy 12 audit (Childhood Epilepsy)	A paediatric epilepsy Nurse Specialist has been appointed and plans to appoint a paediatrician with an interest in epilepsy are currently under consideration.
Paediatric asthma (British Thoracic Society)	There has been a significant improvement in the documentation of assessments of inhaler technique and written discharge plans when compared to previous local audits.

Local clinical audits

The reports of 75 local clinical audits were reviewed by the Trust in 2012/13.

The table below highlights some examples of actions taken by the Trust as a result of local clinical audits to improve the quality of healthcare provided. All actions are agreed and followed up by the relevant clinical divisions to ensure they are implemented.

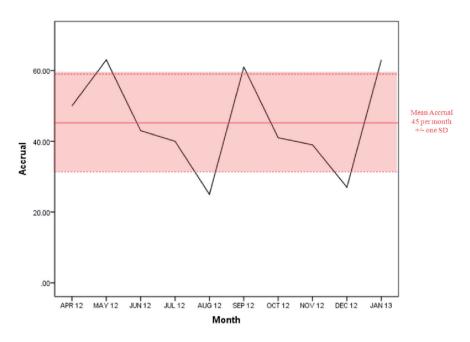
Table 4: Actions taken following local clinical audits

Local Audit	Actions Taken
Audit of Epidural Provisions within Labour Ward	A business case was presented to the Trust Board and subsequently anaesthetic cover has been increased on labour ward from 5 sessions per week to 10 sessions covering weekdays.
Re-audit of Latissimus Dorsi Flap (LDM) Reconstruction in MCHFT	The Trust VTE prophylaxis standards have been included in amended breast surgery protocols, including specific instructions around Enoxaparine, day-stay cases, in-patient cases and previous cases of VTE.
Audit of NICE CG124 Fractured Neck of Femur Patients on Orthopaedic Wards	A new pro-forma has been introduced for assessment and discharge to facilitate the mobilization and rehabilitation of patients who have undergone surgery for broken neck of femur. Plans are in place for a business case to be presented to the Clinical Commissioning Group for funding of a seven-day Physiotherapy service on the Orthopaedic wards.
Audit of Intra-Venous Urography (IVU)	Changes in practice have been agreed to stop using IVU series in favour of CT scanning where superior images are gained and improved diagnosis for treatment can be achieved.
Care of Babies with Prolonged Jaundice	A new Standard Operating Procedure and check list pathway detailing minimum tests required, in line with NICE guidelines, for prolonged jaundice cases has been introduced and now forms part of the clinical notes.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust between April 2012 and Jan 2013 that were recruited to participate in the National Institute of Health Research (NIHR) portfolio approved by a research ethics committee was 453.

The following chart shows the numbers of patients recruited to clinical trials over the past 10 months. There are, on average, 45 patients recruited each month.



Graph 1: Numbers of patients recruited to clinical trials

The Trust was involved in conducting 165 active clinical research studies during the reporting period including, but not limited to, the following areas:

- Cancer
- Cardiovascular
- · Congenital Disorders
- Diabetes
- Eves
- 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

There are nine 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.

The research and development team are constantly implementing change.
The requirement for additional research

opportunities for the local population was identified and, over the last year, partnerships have been developed with four local GP practices.

The Trust is now providing research at the primary /secondary care interface and, following feasibility assessments, NIHR studies have been implemented and successful recruitment has followed. This collaboration has sometimes proved challenging in a climate of constant change in the NHS but this has been overcome with good management support and exploring new ways of working.



Pictured above: Stephen O'Brien, MP for Eddisbury, meets with staff from the Trust's Clinical Research Department

Commissioning for Quality & Innovation framework (CQUIN)

A proportion (2.5%) of the Trust's income in 2012/13 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 2012/13 and for the following 12 month period are available online at:

www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

The financial value of the 2012/13 CQUIN scheme for the Trust was £3,532,000.

For 2012/13, there were **national** CQUIN goals which focussed on the prevention of venous thrombo embolism (VTE), patient experience, dementia care and the NHS Safety Thermometer.

There were also **regional** goals which related to cancer staging, chemotherapy prescribing and advancing quality. The Trust and the local commissioners also agreed further **local** goals which are briefly described in the following table.

This table also shows the Trust's performance against each of the CQUIN goals. It can be seen that, of the 20 goals, the Trust achieved seventeen goals and has plans in place to address the three areas that were not achieved.

Full details of the CQUIN schedule and quarterly progress reports are available on

the Trust's website under quality which can be accessed via the homepage at www.mcht.nhs.uk.

Key for Table 5 (overleaf)



= Achieved



= Not Achieved

For goals 14 – 19, the Trust has anticipated the final results. The reporting period for the advancing quality programme does not close until August 2013.

Table 5: CQUIN results for 2012/13

Goal	Goal Name	Description of Goal	Achieved?
1	VTE prevention	Reduce avoidable death, disability and chronic ill health from VTE.	V
2.	Patient Experience	Improve responsiveness to personal needs of patients.	
3.	Dementia Care	Improve awareness and diagnosis of dementia.	
4.	NHS Safety Thermometer	Improve collection of data in relation to pressure ulcers, falls, urinary tract infection and VTE	V
5.	Cancer Staging Data	Increase number of patients' pre treatment data discussed and recorded at cancer MDT meetings	V
6.	Chemotherapy Prescribing & Data Collection	Implementation of electronic prescribing of parenteral chemotherapy compatible with data collection using the systematic anti cancer therapy data set (SACT)	V
7.	Prognostication & Advanced Care Planning	Implement prognostication of the last 12 months of life to ensure advanced care planning can take place.	V
8.	Children and Young People Personal Diabetes Record	Develop and implement hand held records for children and young people with diabetes.	V
9.	Children's Integrated Care Pathway	Develop and implement an integrated care pathway for children aged 0 - 2.5 years old who have complex physical or neurological conditions.	V
10.	Co-ordinated Electronic Patient Records	Produce a strategy for a 5 year plan for hospital electronic patient records.	V
11.	Implement Essence of Care Benchmarks	Implement the essence of care benchmarks as 'always events'	V
12.	Medical Interventions and Medicines Management	Develop always events relating to medical interventions and medicine management.	\
13.	Caring for Carers of Patients with Complex Needs	Document evidence of carers being actively involved where they wish to be involved, feel well informed and supported.	\
14	AQ Acute Myocardial Infarction (AMI)	Implement the AQ care pathway for AMI	V
15.	AQ Heart Failure	Implement the AQ care pathway for heart failure	
16.	AQ Hip and Knee Replacement	Implement the AQ care pathway for hip and knee replacement	V
17.	AQ Stroke	Implement the AQ care pathway for stroke	
18.	AQ Patient Experience	All patients to complete an AQ PEMs survey	V
19.	AQ Pneumonia	Implement the AQ care pathway for pneumonia	8
20.	Integrated Neighbourhood Team	Participate in the development of an integrated neighbourhood team.	V

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 2012 to March 2013.

The Trust has participated in the following specials reviews and investigations by the Care Quality Commission during April 2012 to March 2013:

- A targeted inspection programme for all acute NHS hospitals to assess services that provide the regulated activity of terminations of pregnancy. The focus of the visit was to assess the management of documentation that is used to certify the grounds under which a termination of pregnancy can lawfully take place. A random selection of medical records was checked by the CQC Inspectors who found that the Trust was compliant with the part of the regulation under review. No further action was required.
- 2. An annual unannounced inspection took place in December 2012 which reviewed the following outcomes for essential standards of quality and safety:

Outcome 1: Respecting and involving

people who use services

Outcome 6: Cooperating with other

providers

Outcome 7: Safeguarding people who

use services from abuse

Outcome 9: Management of Medicines

Outcome 16: Assessing and measuring

the quality of service

provision

The Trust was found to be compliant in four of the five outcomes with minor concerns raised in relation to outcome 9: Management of Medicines.

In response to this, the Trust has developed an action plan to address the issues raised which will be monitored via the Trust governance processes.

The action plan included the dissemination of lessons learned posters and a list of critical medicines to all areas to raise staff awareness and remind them to report any incidents via the Trust's incident reporting system. Fortnightly audits to assess omissions and checking of controlled drugs has been commenced. A Trust-wide audit is proposed for the end of March 2013. Work is on-going on a new medication chart which will include standardised administration codes.

The report received from the CQC was very positive towards the services provided at the Trust. It included specific reference to the complimentary comments reported to the CQC Inspectors during their visit by patients regarding their care. Comments stated that staff were professional, caring and compassionate towards patients and respected their privacy and dignity.

Data quality assurance

NHS and General Practitioner registration code validity

The Trust submitted records during 2012/13 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:

99.9% 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 2012/13 was 72% and the Trust was graded "not satisfactory".

The reduction in score when compared with the 2011 – 2012 assessment can be attributed to the shift in focus from some lower priority requirements to Information Governance training. The Information Governance team supported the training of over 3,000 staff, students and volunteers over the course of the year. Additionally, a large number of policies required review during 2012/13. Those which were not reviewed in time for this submission are expected to be in place by the baseline

submission in October 2013.

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

The Trust was subject to the payment by results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding were:

Primary diagnoses incorrect: 6.7%
 Secondary diagnosis incorrect: 4.4%
 Primary procedures incorrect: 3.6%
 Secondary procedures incorrect: 8.8%

The Trust's performance in relation to the clinical coding error rate is better than the national average and has also improved in all areas when compared with the results from last year. 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:

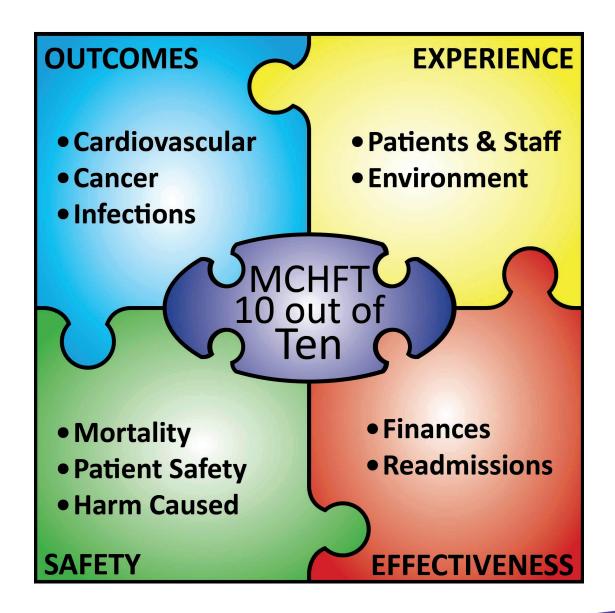
- Deliver the recommendations of the payment by results audit;
- Continue to deliver required training for all accredited coders;
- Recruit to the internal coding auditor position;
- Continually review coding resources and performance.

Part 3 - Review of quality performance

This section of the Quality Account details progress against the Trust's 10 out of Ten strategy. It also describes the Trust's performance against areas of public interest or those recommended by other bodies such as Monitor and the Department of Health.

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 2012/13 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 2:

Mortality – To reduce the 12 month rolling Risk Adjusted Mortality Priority 1:

Index (RAMI) by 10 points annually

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

Patients & staff – To ensure that the ratio of doctors & nurses to each Priority 6:

inpatient bed is appropriate for delivering safe high quality patient care

Environment - To monitor and eliminate mixed sex accommodation Priority 7:

for all patients admitted to the Trust (unless based on clinical need)



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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

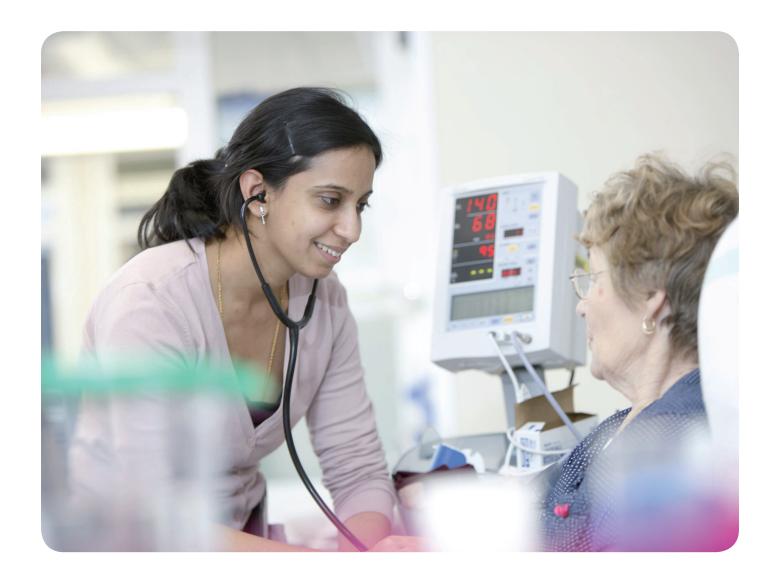
Priority 10: Infections – To reduce the rates of Healthcare Associated Infections (HCAI)

- MRSA

- Clostridium Difficile







Safety

Priority 1: Mortality

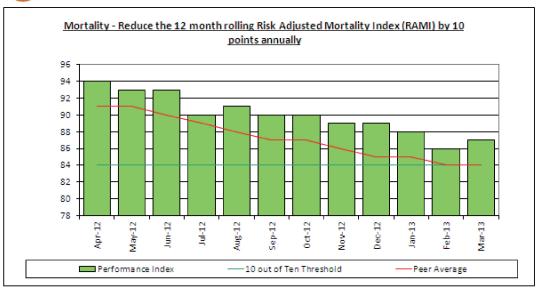
To reduce the 12 month rolling Risk Adjusted Mortality Index (RAMI) by 10 points annually

In order to understand whether people are getting healthier or the 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 past medical history and existing conditions and displays this as an index. In general terms, the rationale for calculating death rates in hospital is so that they can be used as a measure of hospital quality.

Graph 2 shows the Trust's RAMI between April 2012 and March 2013 which demonstrates that the Trust's RAMI has reduced over the 12 month period.





Graph 2: RAMI between April 2012 and March 2013

The Risk Adjusted Mortality Index (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:

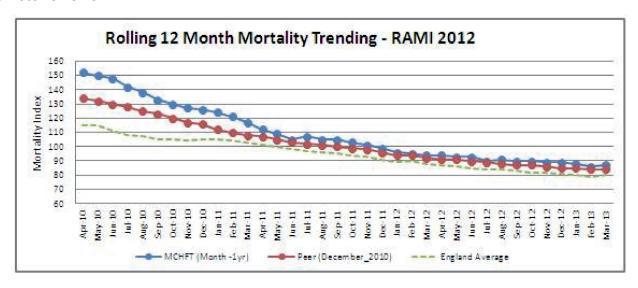
- Age
- Sex
- Diagnosis
- Procedures
- Clinical grouping
- Admission type

CHKS is the provider of comparative information and quality improvement services for healthcare professionals. The Trust uses CHKS as its provider for mortality data.

Work Programme to Improve Hospital Mortality Rates

Since 2009, the Trust has monitored its mortality rate through the Hospital Reducing Mortality Group. Data from CHKS submitted to the Board of Directors each month has shown that the Trust's RAMI has fallen year on year, and is now at 87 compared to the peer of 84. This is demonstrated in graph 3 opposite.

The Hospital Reducing Mortality Group undertakes case note reviews to identify areas of good practice. It also asks the question 'could the Trust have done things better?' An action plan for improvement is developed and monitored via the Hospital Reducing Mortality Group. The clinical divisions also undertake case note reviews.



Graph 3: Rolling Monthly Mortality Trending

Safety

Priority 2: Patient safety

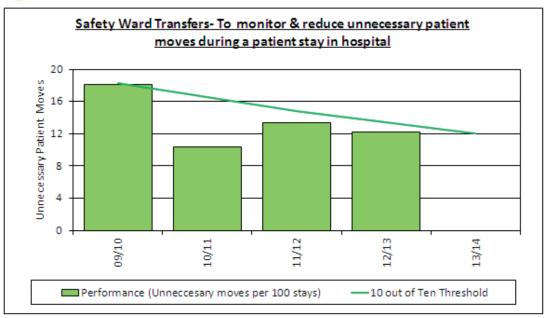
To monitor and reduce the number of unnecessary patient moves during a patient's stay in hospital

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. 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.

Graph 4 shows the average number of unnecessary patient ward moves per 100 hospital stays since April 2009. The graph demonstrates that the Trust has consistently over-achieved against the target on an annual basis with an overall reduction of approximately 35% since the measure was introduced.





Graph 4: Unnecessary Patient Moves

The Trust intends to continue to reduce the number of unnecessary patient ward moves in 2013/14 by progressing the following actions:

- Ensuring that patients are admitted to the
- appropriate specialty and ward to care for their needs
- Monitoring and investigating the care of patients who have moved frequently during their hospital stay
- 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
- Ensuring that reducing unnecessary ward moves is a personal objective of each member of the Patient Placement Team,

- who oversee ward moves within the hospital.
- 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 achieved 100%
 for not moving patients with dementia
 unnecessarily.



Safety

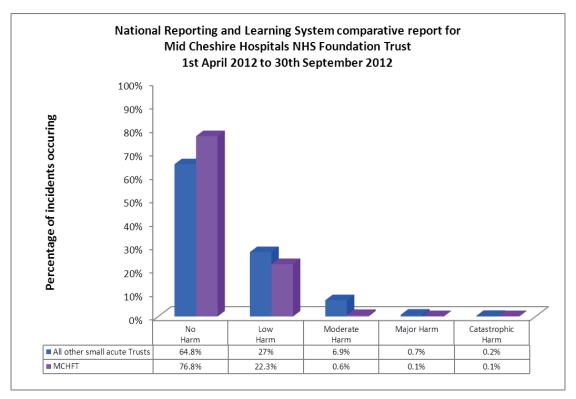
Priority 3: Harm caused

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

All patient safety incidents are reported to the National Reporting and Learning System (NRLS) on a weekly basis. The NRLS produce a comparative report on a 6 monthly basis which compares the Trust with 30 similar sized acute Trusts. From June 2012, this data has been published on the NHS Commissioning Board's Website as they have now taken over

the functions of the National Patient Safety Agency (NPSA). This will ensure that patient safety is at the heart of the NHS and builds on the learning and expertise developed by the NPSA.

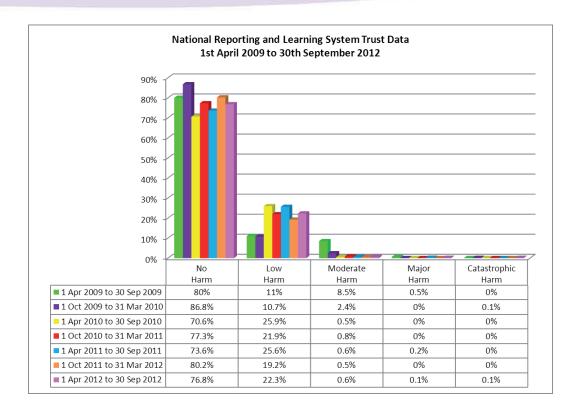
Graph 5 is the latest comparative reporting rate summary which provides an overview of incidents reported by the Trust to the NRLS between April 2012 and September 2012. This data is the latest available and was published in March 2013. The graph demonstrates that the Trust has a high number of reported no harm incidents and less harm incidents when compared to other acute Trusts of a similar size.



Graph 5: NRLS comparative data for April 2012 to September 2012

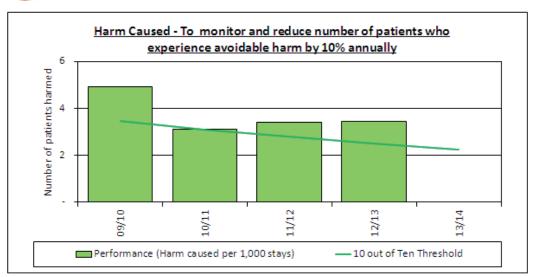
The reporting of no harm incidents is positive as it demonstrates that the Trust has a risk aware culture and that staff are open about reporting patient safety incidents.

Graph 6 (opposite) highlights the comparative data from the NRLS for the past 3 years. The graph demonstrates that the majority of incidents reported by the Trust resulted in no harm to patients and this has been consistent over the previous 3 years. The number of low, moderate and major harm incidents have all decreased in the period of October 2011 to March 2012 compared to the previous period of April 2011 to September 2011.



Graph 6: NRLS comparative data for the past 3 years





Graph 7: Avoidable harm caused

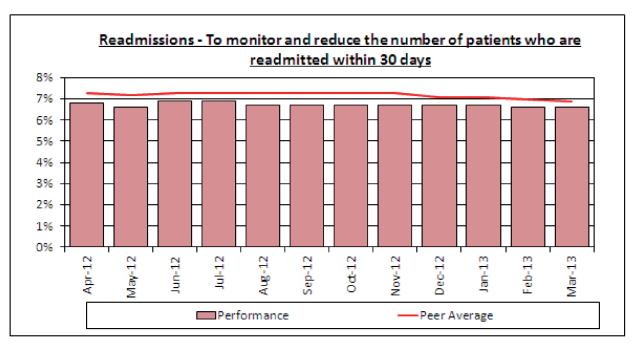
Graph 7 shows the Trust's performance against the 10 out of ten target to monitor and reduce the number of patients that experience avoidable harm by 10% annually. Although the Trust has not achieved this target, the number of patients that have experienced avoidable harm has remained the same during 2012/13 when compared to 2011/2012.

Effectiveness

Priority 4: Readmissions

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





Graph 8: Reduction in number of patients readmitted within 30 days

To demonstrate effective discharge planning the Trust's priority is to reduce the number of patients readmitted to the hospital within 30 days of discharge. The graph above demonstrates that emergency readmissions within 30 days have reduced to 6.3% against a peer of average of 7.0%.

When the Trust's readmission rates are compared against the other acute Trusts in the North West of England, the Trust is in the top 10% of Trusts for the lowest readmission rates.

This success has been achieved through the daily monitoring of patients that are at high risk of readmission to ensure that a medical review is undertaken to assess each individual patient's wider health needs.

This review is followed up by a telephone call to the patient 72 hours following their discharge home by the integrated discharge team to ensure the continuing well being of the patient and to deal with any concerns that may have arisen.

Effective links with the relevant community teams have also been progressed to ensure the continuity of care within the community.

Further work for 2013/14 will include the continued development of partnership working with Clinical Commissioning Groups (CCGs) and other community teams to develop the use of a single patient passport for patients with long term conditions and specific health needs.

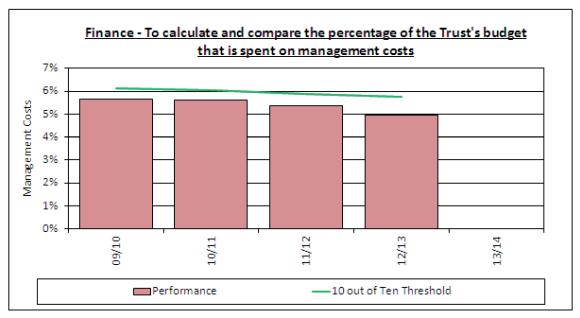


Effectiveness

Priority 5: Finance

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





Graph 9: Trust's annual spend on management costs

On a quarterly basis, the Trust measures the percentage of income spent on management and this has continued to reduce through the year.

During 2012/13, the Trust has consistently maintained a position lower than the target the Trust has 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 adult inpatients to determine the required nurse staffing levels on its wards.

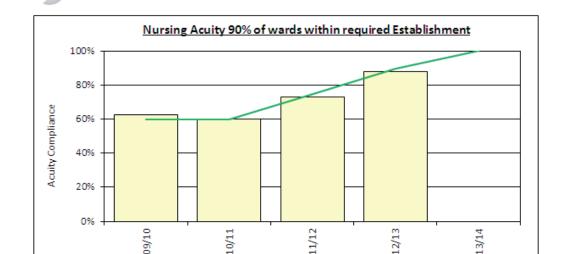
The acuity/dependency monitoring is undertaken at least every 6 months and the results are used to review staffing requirements

and to adjust establishment budgets to meet the need of patients.

Information collated during 2012/13 has been reviewed by the Trust's Acuity group and escalated to the Executive Workforce Committee and the Executive Directors.

The aim for 2012/13 was that 90% of adult inpatient wards would be within range of their required establishment. The graph below shows that the Trust achieved 88% against the target of 90%.

Actions have been taken including the redeployment of staff from over established areas, the recruitment of qualified nurses from Ireland and Spain and the use of trained and unqualified bank staff employed by the Trust on a daily basis to ensure that the required staffing levels are met.



Graph 10: Nursing Acuity of Ward Areas

Performance

Doctors

The ratio of doctors has, in the previous 3 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

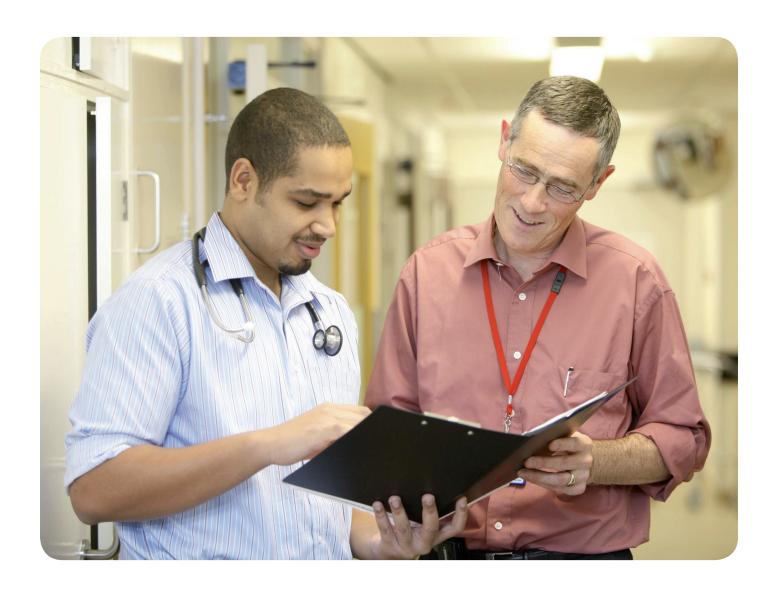
-10 out of Ten Target

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 2012/13, the Trust has appointed additional Consultants in Paediatrics, Emergency Care and 3 posts in Anaesthesia. The Trust has also received support from the Mersey Deanery to appoint an additional training grade post in Acute Medicine.

The Trust's investment in additional Consultant posts will continue in 2013/14.



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 2012, the Trust declared compliance in eliminating mixed-sex accommodation. 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.

Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in Intensive Care, Coronary Care or the High Dependency Unit) or when patients actively choose to share (for instance the renal dialysis or chemotherapy unit).

If care should fall short of the required standard, the Trust will resolve it as quickly as possible and report it via the Trust Committee Structures to the Board of Directors and also to the local Commissioners

The Trust has also set up an audit mechanism to make sure any reports are not misclassified and discusses the results of these audits at the Delivering Same Sex Accommodation (DSSA) Group.

Patient feedback

Every month, volunteers assist the Trust asking patients about their experiences of same sex accommodation. The Trust is please to report that, over the past year, there have been no patient concerns raised as a result of mixed sex accommodation and all patients surveyed have never reported either sharing accommodation or washing/toilet facilities with patients of the opposite sex.

Changes made in practice

Previously, the Trust reported two areas where patients might receive care in an area that is not single sex. One of these was the Acute Stroke Bay and, earlier this year, the new stroke unit was opened with a purpose built acute stroke bay which has same sex accommodation. This means patients requiring acute care following a stroke are now cared for, during the whole of their stay, in high quality, safe, appropriate and same sex accommodation.

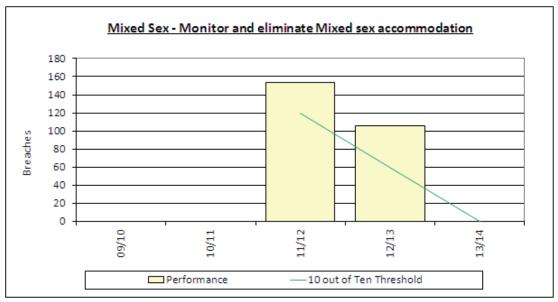
The other area where patients may receive care in a mixed sex environment is when they require clinical care in the intensive therapy unit/high dependency unit (ITU/HDU). There has been improved communication between staff working in these areas, bed managers and senior clinical staff to identify promptly when a patient is no longer likely to require ITU/HDU care. These patients are discussed at the twice daily bed meetings and plans made to move them to an appropriate ward when it is safe to do so. Unfortunately, there are occasions when this is not possible which leads to patients staying in ITU/HDU longer than they need and this is reported as a breach.

When these breaches occur, the staff always apologise to the patient and make every effort to address the situation as quickly and as safely as possible.

Graph 11 highlights the progress that has been

made since last year. The numbers of breaches are reported monthly to the Trust Board, Commissioners and Health Authority.





Graph 11: Breaches within mixed sex accommodation

The development of the new theatre complex and critical care unit which is currently being built will negate mixed sex accommodation as the new unit has been designed with the resolution of this issue in mind. The new critical care facility is due to be opened in early 2014.

Outcomes

Priority 8: Cardiovascular

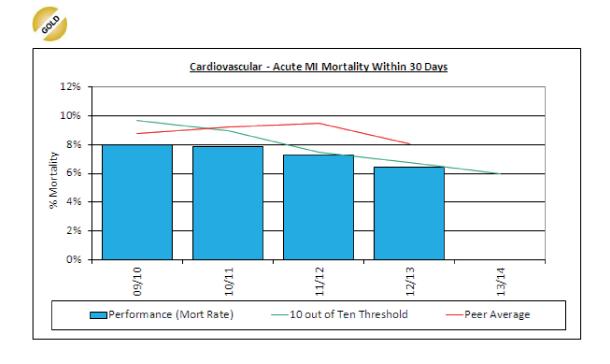
To reduce the 30 day mortality rate in patients following Acute Myocardial Infarction (AMI)

There were approximately 500 patients admitted in 2012/13 with a diagnosis of Acute Myocardial Infarction (AMI). Many of these patients were transferred to tertiary hospitals for further treatment and intervention. 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 4 phases. Phase 1 is offered whilst the patient is still in hospital, phases 2 and 3 are offered following discharge and phase 4 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 aims to reduce patient mortality and morbidity and to provide 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.

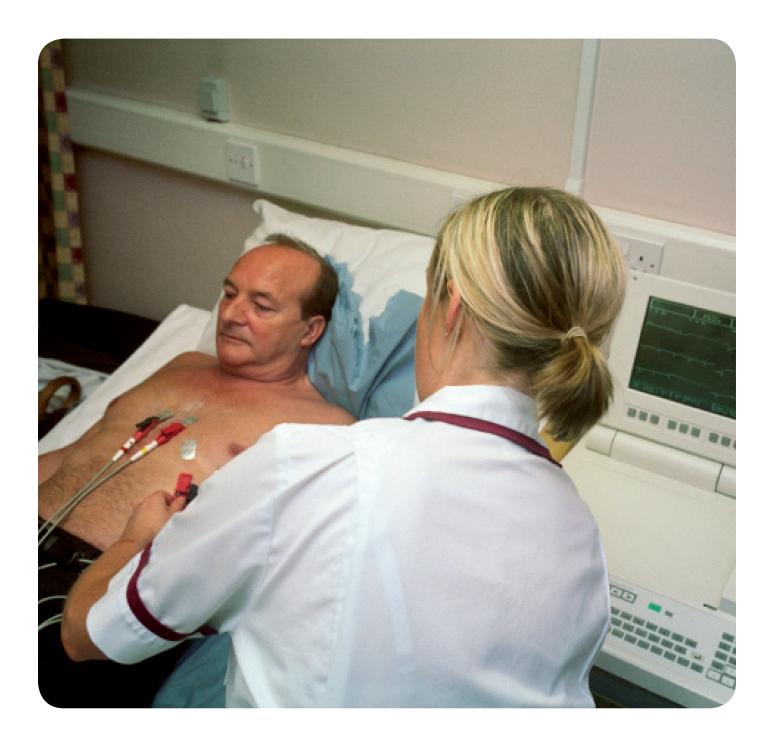
The Trust uses data from CHKS to monitor mortality within 30 days following AMI and it can be seen from the following graph that the Trust has achieved the target to reduce deaths following AMI during 2012/13.



Graph 12: Trust's performance in reducing acute MI mortality within 30 days

AMI is one of five clinical conditions that are monitored through the Advancing Quality (AQ) Programme. It has been chosen due to its high prevalence in North West England. The aim of this programme is to report on a

set of clinically agreed measures to improve outcomes for patients. The Trust compliance with the Advancing Quality Programme for AMI care and treatment is currently 98.8% (CQUIN target is 95%).



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 2 Clinical Nurse Specialists and an multi disciplinary team co-ordinator.

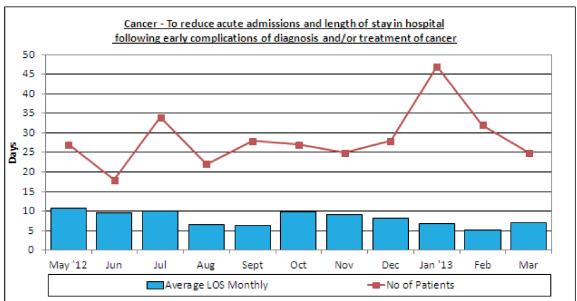
MCHFT was one of the first Trusts in the Greater Manchester and Cheshire Cancer Network to establish an Acute Oncology Service and therefore there is very little peer data available to compare the Trust against. The intention of the implementation of the

acute oncology team was to reduce the length of stay for patients admitted with complications of their cancer treatment or the cancer itself.

The introduction of a rapid alert system highlighting that a patient with a known cancer diagnosis has been admitted to A&E or into the hospital has meant that the acute oncology team can have a rapid intervention resulting in a reduction in length of stay. There is also improved patient experience as the acute oncology team know where that patient is up to on their cancer journey.

It can be seen in the data provided in graph 13 that the length of stay is decreasing steadily. The Cancer Network identified that there should be a reduction in length of stay of at least 1 day in the first 12 months, which has been achieved and exceeded by the team at MCHFT.





Graph 13: Average length of stay and numbers of acute admissions

Formal feedback from people who have used the service (patients, carers and staff) is due to take place in the summer of 2013, but initial informal feedback has shown that patients and their carers are benefitting from the service. The admitting medical teams report that they have benefitted in their decision making process with the specialist support of the acute oncology team ensuring that up to date clinical information and understanding is available from the tertiary cancer centre.

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 1

Not Achieved

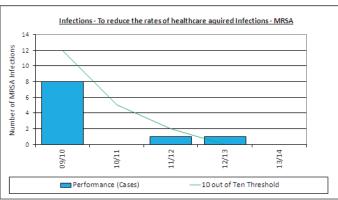
Clostridium difficile

Target: < 54 Actual 23

Achieved

MRSA bacteraemia. The Trust has had one case 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.





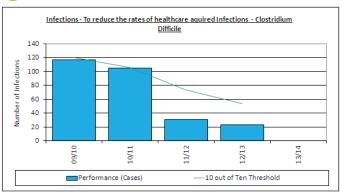
Graph 14: MRSA bacteraemia rates

Clostridium difficile - Rates of Clostridium difficile infection (CDI) Rates of Clostridium difficile infection (CDI) have continued to reduce over the last year and this is an ongoing achievement for MCHFT.

The final CDI rate for the twelve month period stands at 23 cases, representing a 23% reduction from last year's reporting total for 2011/12 which was 30 cases.

This places the Trust amongst the top performing organisations in the North of England.





Graph 15: Clostridium difficile rates

Reduction Strategies

Effective infection prevention and control strategies target all types of HCAI and over the last year some of the infection prevention improvements have included:

- ✓ Cleaning standards have improved incrementally by 4% over the last 2 years as demonstrated through the use of a national audit tool;
- The Trust now has a deep cleaning team that provides an additional 500 cleaning hours per month to perform a scheduled deep clean and ensure bed areas can be quickly prepared for the next patient;
- ✓ Hand hygiene scores (compliance with hand hygiene practice) have improved over the last 2 years;
- More staff have been trained in aseptic technique this year, which supports safe practice for patients with invasive devices or wounds;
- ✓ Student Nurses on placement have

- received dedicated teaching time from the IPCS (Infection Prevention & Control Service);
- ✓ MCHFT has established a multidisciplinary group looking at antibiotic stewardship; which supports the need to restrict certain antibiotics in specific patient groups and ensure careful and appropriate use of all antibiotics.

Next year's aim is to continue to drive up standards of clinical care by maintaining existing strategies and focus more on staff education within clinical areas.

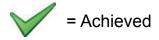
Additionally, with recent changes in the delivery of healthcare, there is a need to consider how the Trust can further support patients on discharge if there is a risk of infection developing outside the hospital setting. Simple patient education and advisory leaflets may help to reduce any further treatment or readmissions that may be required due to infection.

Performance against quality indicators and targets

National quality targets

Table 9: National priority and performance standards

Table 5: National priority and performal	2010-	2011-	2012-	Torget	A objeved 2
	2011	2012	2013	Target	Achieved?
MRSA bacteraemias	8	1	1	0	8
Clostridium Difficile infections	117	30	23	54	
Percentage of patient who wait 4 hours or less in A&E	98.1%	97.3%	95.04%	95%	\
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways	92.8%	91.1%	92.94%	90%	Y
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed non-admitted pathways	97.6%	96.8%	96.96%	95%	~
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for incomplete pathways	N/A	N/A	95.6%	92%	V
The percentage of patients waiting 6 weeks or more for a diagnostic test	N/A	N/A	0.87%	<1%	V
Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	93.2%	95.4%	95.08%	93%	V
Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected	N/A	94.6%	94.78%	93%	V
Percentage of patients receiving first definite treatment for cancer within one month (31 days) of a cancer diagnosis	98.4%	99.6%	99.25%	96%	V
Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery or anti-cancer drugs	100%	98.9%	100% 100%	98% surgery; 94% drugs	\
Percentage of patients receiving first definite treatment for cancer within 62 days of an urgent GP referral for suspected cancer	85.6%	87.9%	89.71%	85%	V
Percentage of patients receiving first definite treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	N/A	92.9%	94.68%	90%	V





National quality indicators

From 2012/13, all Trusts are required to report against a core set of indicators, for at least the last two reporting periods, using a standardised statement set out in the NHS (Quality Account) Amendment Regulations 2012. These regulations can be accessed through the following link -

www.legislation.gov.uk/uksi/2012/3081/made

Where the data is made available by the Health and Social Care Information Centre, 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.

The value and banding of the summary hospital-level mortality indicator (SHMI)

Date	Trust Performance	National Average	Highest Result	Lowest Result
July 2011 - June 2012	1.13 Higher than expected	1.00	1.25	0.71
October 2011 - September 2012	1.13 Higher than expected	1.00	1.13	0.89

The Trust is currently reviewing the data that feeds the SHMI reports and have enlisted the support of CHKS to do this. The Trust is also reviewing a selection of the SHMI categories to gain a greater understanding as to why some cases are being allocated to non-definitive categories such as:

- SHMI category 139 Malaise and fatigue;
- SHMI category 137 Nausea and vomiting;
- SHMI category 126 Open wounds of head, neck and trunk.

The Trust is also reviewing patients where their diagnosis is not recorded until after their second or third admission to hospital.

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

- Participating in the North West Mortality collaborative;
- Establishing a reducing mortality group which is chaired by the Medical Director;
- Establishing a reducing mortality group in the emergency care division;
- Reviewing case notes and developing action plans where appropriate.

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
July 2011 - June 2012	14.81%	18.6%	46.3%	0.3%
October 2011 - September 2012	15.27%	19.2%	43.3%	0.2%

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'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%	
Varicose Vei	Varicose Vein Surgery					
2011-2012	10.7	9.4	23.5	0		
2012-2013	8.2	9.3	27.2	0	Top 50%	
Hip Replacer	ment Surgery					
2011-2012	37.7	40.7	58.4	23.5		
2012-2013	49.9	43.7	69	0	Top 30%	
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	

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

- Working 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;
- Using information leaflets which describe the process and value of the information collected through the use of the PROMS questionnaire.

The percentage of patients aged 0 to 14 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%

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

- More senior medical staff are available to review patients when they arrive and make prompt decisions with regard to treatment
- and follow up care;
- The development of more robust care pathways;
- Reclassification of some patients as assessments or ward attenders, rather than admissions, if not staying overnight.



The percentage of patients aged 15 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%

The data above shows a reduction in the percentage of readmissions for patients aged 15 or over, which has brought the Trust in line with its peer group. The Trust considers that this reduction is predominantly due to the following reasons:

- Introduction of a dedicated task and finish group to focus on readmissions;
- A daily review of patients who are readmitted or flagged as at high risk of readmission by the integrated discharge team;
- The integrated discharge team work closely

- with community teams, such as community matrons, alcohol liaison services and mental health, to support discharge;
- Introduction of ward-based pharmacy reviews of medications;
- Follow-up phone calls made by the integrated discharge team 48 hours post discharge.

The Trust intends to continue progressing the above actions to maintain improvement in this result and therefore the quality of its service.

The Truet's	roenoneivonose	to the nerson:	al needs of its patients
The Trust's	responsiveness	s to the persona	ai 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

This result is slightly lower than the national average. Comments from patients completing the national inpatient survey reflect the busy nature of the clinical environment, whilst highlighting that staff are very caring (more detail on the inpatient survey is included in part 2).

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

 Formally reviewing the staffing levels and skill mix on all inpatient wards every six months:

- Reviewing patient needs for staff requirements twice daily and making adjustments as required;
- Continuing the implementation of care rounds to respond proactively to patients' needs:
- Reviewing care pathways and implementing event-led discharge to avoid delays in patients waiting in hospital when they are medically fit to go home.

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

This result is better than the national average. Staff frequently describe the Trust as a friendly place to work and, on the whole, they receive good support from their teams and line mangers.

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

 Presenting the results at key meetings and staff groups to agree which areas should be targeted for improvement. Currently, there is agreement that the Trust should focus on appraisals, involving staff in change, feedback on performance, health and well being and tacking violence;

- Meeting with senior divisional teams to discuss divisional reports:
- Undertaking further benchmarking of results with other Trusts and previous year's results.

The percentage of patients who were admitted to hospital who were risk assessed for Veneous thromboembolism (VTE)

Date	Trust Performance	National Average	Highest Result	Lowest Result
July 2012 - September 2012	96.3%	93.8%	100%	80.9%
October 2012 - December 2012	96.3%	94.1%	100%	84.6%

The Trust has consistently remained above the national average for the previous 2 reporting periods in relation to the percentage of admitted patients who were risk assessed for VTE.

The Trust has achieved the national CQUIN target of 90% in relation to VTE risk assessments for the past 2 years.

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 VTE risk assessment has been included in the Trust's admission proformas to ensure this happens;

- Establishing 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;
- Monitoring compliance monthly by the clinical divisions and quarterly by the Trust's VTE Committee.

The rate per utilised bed days of cases of Clostridium difficile infection reported within the Trust amongst patients aged 2 or over

Date	Trust Performance	National Average	Highest Result	Lowest Result
2010-2011	58.30	29.60	63.60	7.10
2011-2012	16.83	21.82	50.89	4.08
2012-2013	12.90	Not published	Not published	Not published

The above data shows a significant reduction in Clostridium difficile infections over the past three years and shows the Trust to be one of the best performing Trusts when compared to similar sized organisations. The Trust considers that this reduction is predominantly due to the following reasons:

 Limiting transfers within the Trust, particularly from viral diarrhoea and vomiting affected wards and close monitoring of symptomatic patients to ensure Clostridium difficile infection is not missed as a diagnosis;

- Providing additional cleaning resources to support the rapid response team to tackle infective areas (this has also increased cleaning scores and cleaning provision in other areas);
- Rolling out cholorine cleaning for all clinical areas and revised cleaning policy to ensure clinical equipment is effectively decontaminated;
- 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 ongoing review of all side rooms used for isolation purposes to ensure effective isolation practice and appropriate clinical management;
- Undertaking detailed root case 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;
- Reviewing the process for mattress decontamination and tagging of equipment to monitor decontamination schedules.

The number of patient safety incidents reported within the Trust

Date	Trust Performance	National Average	Highest Result	Lowest Result
October 2011 to March 2012	2511	1782	3871	809
April 2012 to September 2012	2695	1812	4545	815

It is viewed nationally and by the Trust that being a high reporter of incidents is a positive position as it demonstrates a risk aware culture within the Trust and that staff are open about reporting patient safety incidents. The Trust reports more patient safety incidents than the national average and this has been consistent for both reporting periods. The majority of the incidents reported resulted in no harm to the patient which again demonstrates a 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:

- Committing to a Just Safety culture which encourages staff to admit when an error occurs without fear of punitive measure;
- Providing training on incident reporting 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. This training is on-going and is included on induction for all new staff.

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	Lowest Result
October 2011 to March 2012	2	17	64	0
April 2012 to September 2012	6	16	69	2

The Trust considers that this data is as described for the following reasons:

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

The Trust intends to take / has taken the following actions to improve this results, 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 reoccurrence;
- Reporting all incidents which result in severe harm death to the Board to ensure openness within the Trust;
- Promoting 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 incident are shared with them.

Local quality indicators

Reducing patient falls Governors' choice of indicator

A fall is not a diagnosis and often reflects a multiplicity of risk factors with normal physiological ageing, de-conditioning from inactivity and superimposed acute and chronic disease. However, a fall is of direct clinical relevance to an individual, with a clear impact and all too often a negative outcome in terms of health and quality of life (Close, 2005).

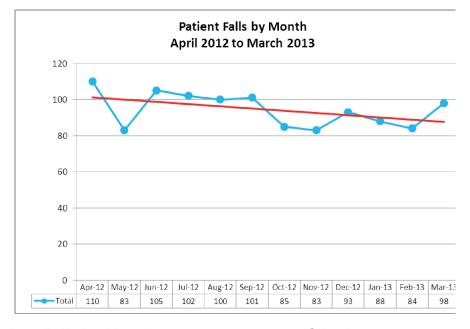
Falls are a considerable burden on patients, nurses and hospitals. Preventing falls from happening should be a priority in healthcare organisations. While the risk of falling cannot be eliminated, it can be significantly reduced through the implementation of an effective falls prevention programme (Oliver et al, 2009).

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 (Howland, Peterson & Levin, 1993).

There is a great deal of literature available in relation to patient falls that clearly demonstrates that patient falls in hospital are frequent occurrences. It is also known that patient falls in hospital can have a devastating effect on patients, their families and the nursing staff caring for the patient and that organisations as a whole also suffer in terms of reputation and financial loss.

Patient falls in hospital affect everyone involved in different ways. Despite patient falls prevention interventions being in place, patient falls remain the highest reported patient safety incident for the majority of Trusts, including MCHFT.

Graph 16 shows the number of patient falls at the Trust over a 12 month period between April 2012 and March 2013. The red line on the graph indicates that the overall number of falls has decreased over the last 12 months.



Graph 16: Patient Falls by Month

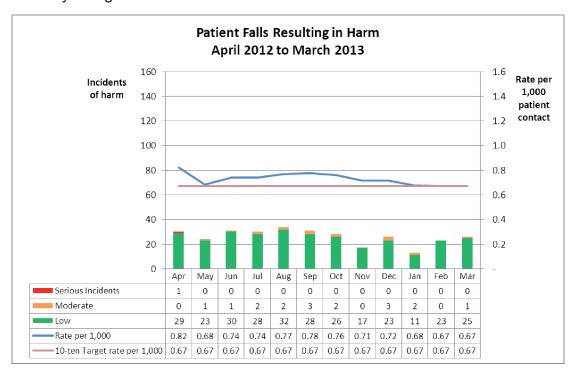
Work undertaken to reduce the number of patient falls and harm caused

The Trust has a patient falls prevention group which meets monthly. The group membership

includes Clinicians, Nurses and Therapists and the group monitors all patients' falls on a monthly basis. A successful link nurse programme has been rolled out across the Trust to deliver education for staff on falls prevention and the Trust has been involved in number

of national projects including Safety Express and FallSafe which have looked at reducing the harm from patient falls and fall prevention interventions.

Graph 17 highlights the patient falls that have resulted in harm between April 2012 and March 2013. The Trust set a target to reduce the harm from patient falls by 10% annually and this target is currently being achieved.



Graph 17: Patient Falls Resulting in Harm

References

Close, J.(2005) "Prevention of falls - a time to translate evidence into practice", Age and Ageing, vol. 34, no. 2, pp. 98-100.

Oliver, D., Britton, M., Speed, P., Martin, F. C. & Hopper, A.H. 2009, "Development and evaluation of evidenced based assessment tool (STRATIFY) to predict which elderly inpatients will fall: case control and cohort studies", British Medical Journal, [Online], vol. 315, no. 7115, pp. 16.03.10. Available from: http://www.bmj.com/cgi/content/full/315/7115/1049. [16.03.10].

Howland, J., Peterson, E.W. & Levin, W.C. 1993, "Fear of falling among the community dwelling elderly", Aging health, vol. 5, no. ., pp. 229-243.

Incidents resulting in severe harm - mandated indicator

The Trust wants to deliver high quality, safe patient care. However, despite best efforts, human factors, systems and processes contribute to prevent this desire and patients are sometimes harmed unintentionally. The Trust is dedicated to reducing the avoidable harm caused to patients.

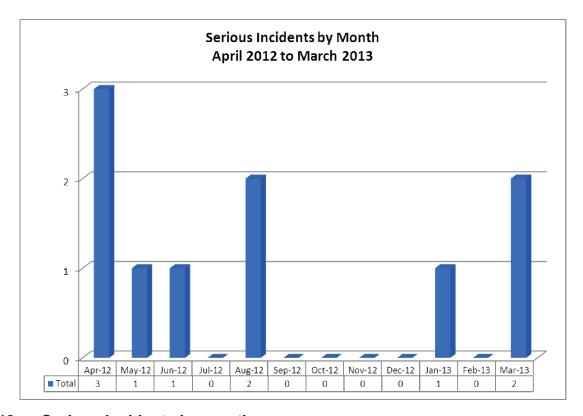
When harm is unintentionally caused, the Trust ensures that lessons are learned and that systems and processes are changed to prevent an incident from reoccurring. The Trust is committed to a Just Safety culture which encourages staff to acknowledge and report when an error occurs without fear of punitive measure.

When an incident which results in severe harm does occur, the incident is reported to the Trust Board, the local Clinical Commissioning Groups

and the Strategic Executive Information System (StEIS) to ensure learning both locally within the Trust and across other healthcare providers.

A root cause analysis (RCA) is undertaken for all incidents resulting in severe harm to ensure that all contributory factors which led to the incident occurring are fully investigated and actions are implemented to prevent a reoccurrence. A review meeting is held following the investigation and this is led by an Executive Director. Following the review meeting, an action plan is developed, implemented and lessons learned are shared throughout the Trust.

Graph 18 shows the number of serious incidents reported within the Trust between April 2012 and March 2013 which resulted in severe harm. It can be seen that there has been a significant reduction in the past six months with only three serious incidents occurring between January and March 2013.



Graph 18: Serious incidents by month

Performance against local quality indicators

Indicator	2010- 2011	2011- 2012	2012- 2013	Target	Achieved?
Cancelled operations (%)	1.19%	1.46%	1.32%	1.09%	8
Cancelled operations – % breaching 28 day guarantee	6.8%	7.9%	15.83% *	5%	&
Smoking during pregnancy	19.5%	18.3%	20.55%	< 15%	8
Breastfeeding initiation rates	59.6%	62.8%	60.91%	65%	8
Access to genito-urinary (GUM) clinics	99.9%	100%	100%	100%	
Falls risk assessments completed within 24 hours	96%	96%	96%	91%	~
Pressure ulcer risk assessments completed within 24 hours	93%	95%	94%	91%	\
Nutritional risk assessments completed within 24 hours	99%	97%	95%	91%	\
% of patients who felt they were treated with dignity and respect	96%	100%	100%	100%	\
% of patients who had not shared a sleeping area with the opposite sex	75%	100%	100%	100%	~
% of patients who would recommend the hospital to family and friends	97%	87%	93%	No target	



= Achieved



= Not Achieved

* this equates to approximately 70 patients in 2012-2013.



Consultation on quality

Over the past 4 years, the Trust has consulted with the public, patients, staff and governors on its delivery of quality. Using the Trust's quality and safety strategy, the 10 out of Ten has been the focus for discussion and comment. These comments are then used to inform the annual Quality Account.

The 2012/13 Quality Account consultation was undertaken by staff and governors working together to meet with the public and patients at a variety of locations. Events at local supermarkets in Crewe, Sandbach, Winsford and Middlewich plus outpatient clinics in Crewe and Northwich generated 320 discussions and responses.

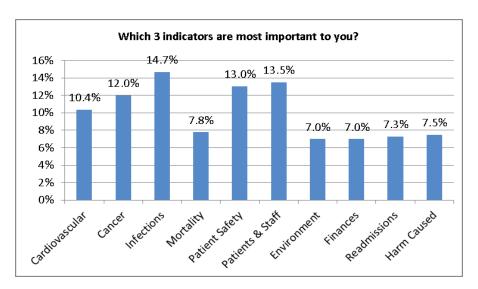
The aim of the consultation was to seek

comments from the public regarding the Trust's 10 out of Ten priorities and to ensure the ten indicators are still considered essential markers of quality.

The results of the consultation showed that all the priorities are still considered important. Nobody suggested alternatives.

When asked to identify the most important priorities, reducing healthcare acquired infections was found to be the most important. The second most important priority was having the correct numbers of nurses and doctors closely followed by patient safety.

The following graph details the indicators that are considered most important by the 320 people included in the consultation.

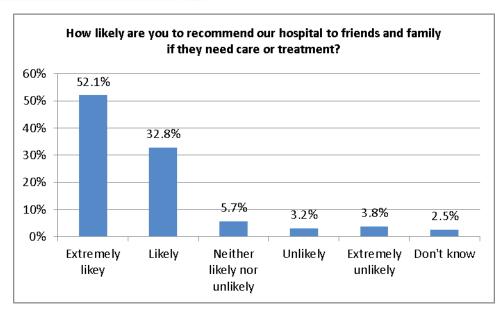


Graph 19: Most important indicators identified during the consultation

The consultation process also asked the public and patients:

"How likely are you to recommend our hospital to friends and family if they need care or treatment?"

Responses to this were very positive with over half the people saying they would be extremely likely to recommend the hospital and its services.



Graph 20: Consultation response to question about how likely people were to recommend the hospital



Statements from external agencies

South Cheshire and Vale Royal Clinical Commissioning Groups

NHS South Cheshire Clinical Commissioning Group (NHS SCCCG) and NHS Vale Royal Clinical Commissioning Group (NHS VRCCG) welcome the opportunity to provide commentary on Mid Cheshire Hospitals NHS Foundation Trust (MCHfT) Quality Account for 2012/13.

We have discussed the development of this Quality Account with MCHfT over the course of the year and have been able to contribute our views on content and consultation. This Quality Account has been reviewed within both NHS SCCCG and NHS VRCCG by colleagues in commissioning, quality and performance. After review, we believe that this Quality Account gives a fair, representative and balanced overview of performance against national and the local priorities as set by MCHfT in their 10 out of ten quality and safety improvement strategy 2010-2014 and other quality initiatives including Commissioning for Quality and Innovation (CQUIN).

We confirm that we have reviewed the information contained within the Quality Account and checked it against data sources where available to us as part of existing contractual performance monitoring discussions and found them to be accurate in relation to the services provided. There is a very strong and clear focus on patient experience and this is welcomed.

There is evidence that engagement with patients and patient experience is used to inform the organisations understanding of how it is doing, where and what is working well and areas for improvement. However, we would have expected more information on outcomes and changes made, in particular those reported

NHS Vale Royal Clinical Commissioning Group



South Cheshire Clinical Commissioning Group

by patients after discharge telephone calls. The CCGs recognise that it is an achievement for MCHfT to be a top performing Trust in the country 2012/13 for Patient Reported Outcome Measures (PROMS) for knee replacement and good results in hip replacement surgery.

This Quality Account demonstrates the commitment of the Trust Board to continue with the 10 out of ten strategy. There is evidence of triangulation of a range of data and feedback, for example patient surveys, both national and local, patient stories, complaints, internal audits. This demonstrates that patients remain at the centre of care and that patient safety and experience remains essential for delivering clinical services. The positive Care Quality Commission report also provides external evidence of quality of care, patient engagement and clinical effectiveness. However, we would have liked some initial information on the way MCHfT is responding to the Francis Report that was published in February 2013.

We acknowledge the initiatives MCHfT have implemented to reduce Clostridium Difficile infections, which is demonstrated in the continued reduction in numbers in 2012/13. This is to be congratulated.

We would like to praise MCHfT for their continuation of a Just Safety culture which encourages staff to report incidents without fear of reprisal. This has been evidenced by the number of incidents of no harm reported in year and demonstrates an open culture to reporting incidents. This is to be congratulated.

We acknowledge the continued progress in reducing the mortality rate. However, there needs to be a continued focus on this area. NHS SCCCG and NHS VRCCG welcome the open approach and the adoption and reporting of the national measure for mortality. Triangulation of relevant data and the outcome of work on specific priority areas such as general surgery will enhance understanding and support reduction in the mortality rate. NHS SCCCG and NHS VR CCG are committed to working with MCHfT in 2013/14 to continue the improvement.

We would like to see the continued progress that MCHfT are undertaking in relation to the ratio of nurses and doctors to each inpatient bed. We anticipate that, although the ratio of Doctors will not be reported nationally, MCHfT will develop a local measure to ensure that ratios are monitored throughout the year.

Overall, we welcome the vision described within the Quality Account. The CCGs agree with the priorities and will continue to work with MCHfT to seek the views of patients to ensure continuous improvement in the quality and clinical effectiveness of services provided by the organisation.

Yours sincerely



Simon Whitehouse Chief Officer NHS South Cheshire CCG NHS Vale Royal CCG

Healthwatch Cheshire East

Thank you for a copy of your Quality Accounts 2012 – 2013 for Mid Cheshire Hospitals NHS Foundation Trust.

Healthwatch Cheshire East is a new organisation that came into existence on the `1st of April 2013. We will give children, young people and adults a powerful voice locally and nationally. We will work to help people get the best out of their local health and social care services. Whether it's improving them today or helping to shape them for tomorrow.

Healthwatch Cheshire East is all about local voices being able to influence the delivery and design of local services. We therefore welcome the opportunity to work with Mid Cheshire Hospitals NHS Foundation Trust and to contribute to its annual Quality Account for 2013 -2014 but feel that we are unable to comment on the current document as we have only recently become operational and have yet to develop a evidence base from which we can make a valid and independent contribution.

We look forward to working with the Trust over the coming year



Cheshire East Council Health and Wellbeing Scrutiny Committee

Comments on Mid Cheshire Hospital NHS Foundation Trust Quality Account 2012/13

(Note: these comments are based on the first consultation draft which was submitted to the Committee on 9 May 2013; 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 Julie Smith for attending the meeting on 9 May 2013.

The Committee:

- Is generally very pleased with the achievements made by the Trust during 2012/13 including the delivery of its 10 out of ten strategy.
- Is pleased to note that the Trust has taken on board the recommendations of the Francis Report in an effort to make improvements.
- Is concerned about the level of vacancies for nurses the Trust has experienced however is satisfied that a robust recruitment and retention scheme has now been put in place which it hopes will assist in maintaining high care quality.
- Approves of the recruitment of overseas nurses in the effort to ensure adequate levels of quality care are provided.
- Would like to see a comparison with the 2011/12 Quality Account to provide an illustration of whether the Trust has improved on previous performance.
- Is pleased that despite not hitting targets for reducing smoking during pregnancy and increasing breast feeding the Trust was working with CCGs and Public Health to improve the situation and expects the targets to be met in future.

The Committee suggests the following:

 That actual patient numbers should be included in statistics alongside percentages



to provide greater context on the number of people affected.

- That statistics and information on Out Patients, particularly waiting times and care quality, should be included in the Quality Account alongside the excellent reporting on In Patients.
- That improvements to the way operations are scheduled need to be made to decrease the number of patients who do not receive an operation within 28 days of a previous appointment being cancelled.
- That statistics on incidents involving falls including why they happen need to be developed and publicised along with an action plan on how the Trust will tackle the issue.
- Although the Committee acknowledges that prescriptions cannot always be made available upon discharge more could be done to decrease delays between patients being discharged and receiving prescriptions.
- That statistics on incidents of bedsores (pressure ulcers) could be included in the Quality Accounts.

Governors

The Quality Account for 2012/13 was presented to the Council of Governors in April 2013. Governors' questions and comments have been directed to me, as Governor Representative for the Quality & Safety Improvement Strategy Committee, and I chaired a meeting on 13 May 2013 to address all matters raised. The Trust's Chairman, Director and Deputy Director of Nursing and Quality attended by invitation, and thorough questioning satisfied Governors as regards the substance and detail of the report.

The Quality Account is a fair and accurate representation of the Trust's patient-centred care, and gives a balanced view of successes and challenges. Every endeavour has been made to use clear and transparent language, graphics and data and to format the Account clearly, in the context of prescriptive rules determined by Monitor. 2012/13 was the penultimate year of the Trust's '10 out of Ten' targets; Governors are satisfied these have contributed to significant improvements in quality and outcomes for patients, staff, carers and members.

Jane Smart

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 2010 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 Accounts (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012 - 2013
- 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 2012 to March 2013
 - Papers relating to quality reported to the Board over the period April 2012 to March 2013
 - Feedback from the Commissioners dated 23 May 2013
 - Feedback from Local Healthwatch dated 9 May 2013
 - Feedback from the Health and Wellbeing Scrutiny Committee dated 16 May 2013
 - Feedback from Governors dated 21 May 2013
 - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated August 2012.

- The 2012 national patient survey
- The 2012 national staff survey
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 21 May 2013
- Care Quality Commission (CQC) quality and risk profiles dated February 2013
- The Quality Report presents a balanced picture of the NHS Foundation 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-nhsft.gov.uk/ annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/ annualreportingmanual).

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

By order of the Board, signed 28 May 2013,

John Moran 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

Mente Cld

David Pitt
Director of Service
Transformation and Workforce

Dennis Dunn
Non-Executive Director

Dame Patricia Bacon Non-Executive Director John Barnes Non-Executive Director

Mike Davis

Non-Executive Director

Ruth McNeil Non-Executive Director

Lich C. Mc Neil.

David Hopewell Non-Executive Director

Quality Account Appendices

Quality Account Appendix 1 - Glossary and Abbreviations

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.
Acute Trust		An acute Trust provides hospital services (not mental health hospital services, which are provided by a mental health trust).
Advancing Quality	AQ	A programme which rewards hospitals which improve care in a number of key areas – heart attacks, pneumonia, hip and knee replacements, heart failure and heart bypass surgery – when compared to research which identifies what best care constitutes.
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.
Care Quality Commission	CQC	The independent regulator of health and social care in England. Its aim is to make sure better care is provided for everyone, whether in hospital, in care homes, in people's own homes, or elsewhere. The CQC replaced the Healthcare Commission.
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.
Clinical Commissioning Group	CCG	This is the new GP led commissioning body who buy services from providers of care such as the hospital.
Clostridium Difficile	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.
Commissioner		A person or body who buy 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.

Terms	Abbreviation	Description
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.
Eliminating Mixed Sex Accommodation	EMSA	Please see description of Delivering Same Sex Accommodation.
Foundation Trust		A type of 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.
Healthcare Associated Infections	HCAI	A generic name to cover infections like MRSA and C-diff.
Health Protection Agency	HPA	The HPA was set up in 2003 to provide advice and information to protect the public in England from threats to health from infectious diseases and environmental hazards. In April 2013, the HPA will become part of Public Health England, a new executive agency of the Department of Health.
Health Service Ombudsman		The role of the Health Service Ombudsman is to provide 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.
Hospital Episode Statistics	HES	This is the national statistical data warehouse for England for the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations and individuals.
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	The ICNARC CMP is a high quality, clinical database holding over 18 years data relating to patient outcomes from adult, general critical care units in England, Wales and Northern Ireland.

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
Mothers and Babies: reducing Risk through Audits and Confidential Enquiries across the UK	MBRRACE- UK	A new organisation appointed by the Healthcare Quality Improvement Programme to investigate maternal deaths, still births and infant deaths to support the delivery of safe, equitable, high quality, patient centred maternal, newborn and infant health services.
Monitor		This is the regulator of NHS Foundation Trusts. It is an independent body detached from central government and directly accountable to Parliament.
Myocardial Ischaemia National Audit Project	MINAP	MINAP is a national audit established in 1999 to enable hospitals to measure their performance against targets and improve the care of patients following a heart attack.
National Neonatal Audit Programme	NNAP	An audit programme established with the aim of informing good clinical practice in aspects of neonatal care by auditing national standards.
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: Inpatients, Outpatients, Emergency care, Maternity care, Mental Health services, Primary Care services and Ambulance services.
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
Patient Experience Measures	PEMS	PEMS are used to measure the patient's view of their experience during the clinical episode, looking at how patients feel at an emotional and physical level.
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.

Terms	Abbreviation	Description
Patient Safety Metrics		A number of measures which together can be used to assess how well a hospital keeps patients safe from harm whilst under their care.
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.
Re-admission Rates		A measure to compare hospitals which looks at the rate at which patients need to be readmitted to hospital after being discharged (leaving hospital).
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.
Safer Nursing Care Tool	SNCT	The safer nursing care tool was launched in 2010 by the NHS Institute based on the work undertaken by the Association of UK University Hospitals (AUKUH). It is used to measure patient dependency/acuity to help determine nurse staffing levels on the wards.
Safety First		A report commissioned by Sir Liam Donaldson, Chief Medical Officer, to reconsider the organisational arrangements currently in place to ensure that patient safety is at the heart of the healthcare agenda. The report explicitly aimed to address issues raised by the National Audit Office in its report, A Safer Place for Patients, as well as to look at the NHS approach to patient safety more widely.
Secondary Users Service		This is the NHS data system for recording all NHS patient activity. It enables correct payments by commissioners for care provided by all provider services including acute trusts.
Sentinel Audit		A national audit that measures the care delivery provided for patients following the diagnosis of a stroke.
Sentinel Stroke National Audit Programme	SSNAP	SSNAP is a programme of work which aims to improve the quality of stroke care by auditing stroke services against evidence based standards.
Situation, Background, Assessment and Recommendation	SBAR	A national tool to standardise handover of care between clinicians

Terms	Abbreviation	Description
Stroke 90:10		An initiative, launched in North West England, which aims to significantly change frontline care practice for stroke patients in order to increase the number of stroke sufferers leaving hospital without serious disability.
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 Depending on the SHMI value, Trusts are banded between 1 and 3 to indicate whether their SHMI is low (3), average (2) or high (1) compared to other Trusts. SHMI is not an absolute measure of quality. However, it is a useful indicator for supporting organisations to ensure they properly understand their mortality rates across each and every service line they provide.
Systemic anti cancer therapy data set	SACT	The SACT collects clinical management information on patients undergoing chemotherapy in England.
Ten out of 10		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.
Venous Thrombo- Embolism	VTE	This is 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).

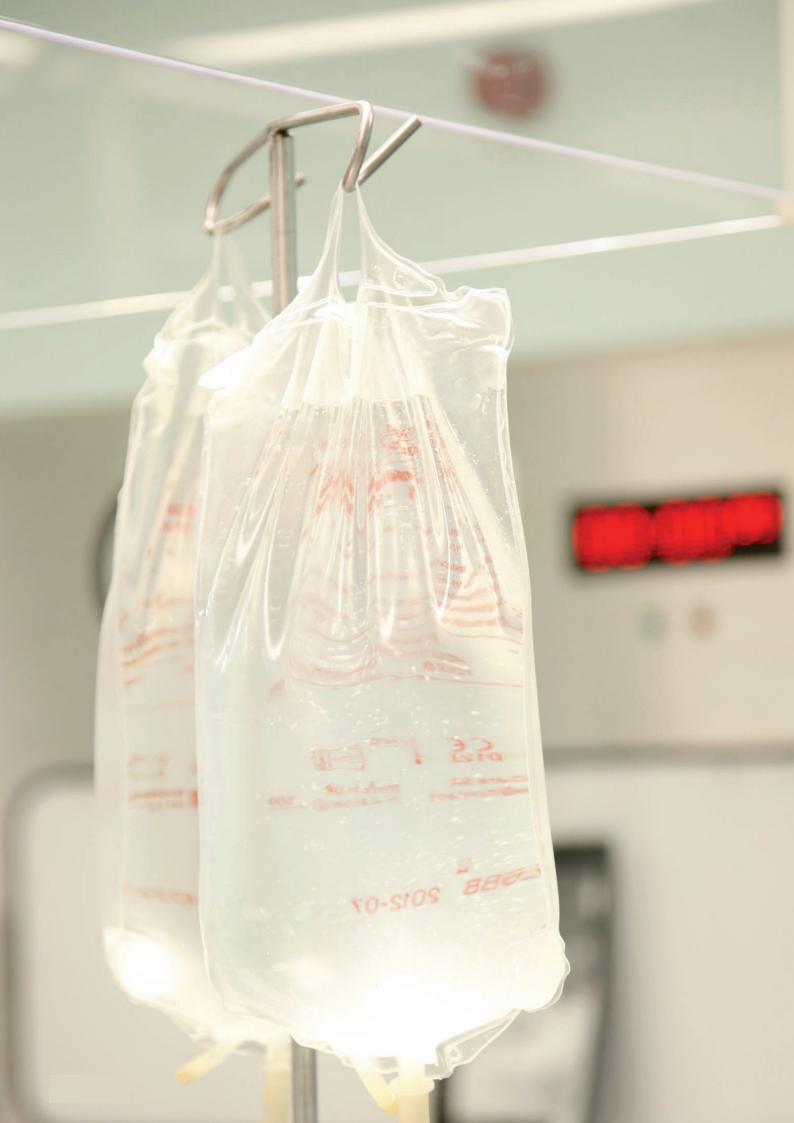
Quality Account Appendix 2 - Feedback Form

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 content	rs?
Too simplistic	
About right	
Too complicated	
Is the presentation of da Yes, completely Yes, to some exter No	
If no, what would have h	nelped?
Is there anything in this	report you found particularly useful / not useful?
	



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 did not meet during 2012/13. A meeting was held on 8 April 2013 to consider a number of items including Executive Pay.

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. In line with the two-year national pay freeze, 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 2012/13, there was no policy on performance-related 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.

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 2013, 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 Notes 5.4 in the accounts on Page 179. Benefits in kind relate to the provision of lease cars.

Director Expenses and Remuneration

In line with the Health & Social Care Act, detailed below are non-audited Expenses which have been claimed by Directors during 2012/13. Details of remuneration and Benefits in Kind are provided in the audited accounts.

Name	Amount
Dame P Bacon	£105.40
Mrs T Bullock	£4,409.21
Mr B Craig	£641.79
Dr P Dodds	£1,872.18
Mr D Dunn	£136.50
Mrs D Frodsham	£378.16
Mr D Hopewell	£592.21
Mrs R McNeil	£470.41
Mr J Moran	£1,029.39
Mr M Oldham	£747.49
Mrs J Shaw	£793.38
Mrs J Smith	£2,901.29
Mr D Pitt	£204.30
Dr A Wood	£586.00

Governor Expenses

Details of those Expenses which have been claimed by Governors during 2012/13 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.

Name	Constituency	Amount
Mr D Bone	Public Constituency	£32.00
Mr K Dawson	Patient & Carers	£184.75
	Constituency	
Mr N Dibben	Patient & Carers	£18.20
	Constituency	
Mr H	Public Constituency	£9.55
Mawdsley		
Mrs J Smart	Public Constituency	£282.80

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 2013.

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 January 2012	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

Chapter 10

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. I 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 2013 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

During 2012/13 through the Integrated Governance Framework, with support from the Trust's Medical Director & Deputy Chief Executive, I provided leadership in respect of risk management processes which is evidenced through the Integrated Governance and Risk Management Strategy and the Corporate Governance Handbook. These set out the responsibilities at all levels including senior-level leadership, for the risk management process. Responsibility for risk management is included in job descriptions and all staff have clearly defined responsibilities which are reviewed as part of the appraisal process.

An integral part of the Trust's mandatory training schedule, appropriate and targeted risk management training is delivered 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. Staff have an equal responsibility to attend statutory and mandatory training and to work in accordance with such training. This training is supplemented through the management development programmes, which risk and governance training is part of. New starters receive information on risk management as part of the Trust's general induction arrangements. 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. The Board Committees have responsibility for risk assurance in their particular areas and the Audit Committee has provided the Board with independent and over-arching assurance of the effectiveness of internal controls and the risk management system.

The Trust is committed to a Just Safety Culture and learning from best practice. Lessons Learned posters are generated in response to internal and external reviews of incidents and events. External guidance and reviews (e.g. Mid Staffordshire NHS Foundation Trust, National Confidential Enquiries, Royal College publications on best practice and pertinent Care Quality Commission reviews of other organisations) are subject to a gap analysis and action plan development, which is reviewed and monitored in accordance with the Trust's governance framework. In response to the Francis Report of care at Mid Staffordshire NHS Foundation Trust, the Trust is currently reviewing the recommendations and to ensure a patient-led response, will be conducting a number of engagement events with public, patients, carers and staff around the main themes of:

- Common values:
- Fundamental standards;
- Openness, transparency/candour;
- · Compassionate/caring & committed staff;
- Strong patient centered leadership;
- · Accurate information.

The outputs from this engagement will direct the focus on the Trust's response.

The Risk and Control Framework

The Board of Directors formally assesses quality governance arrangements using Monitor's Quality Governance Framework for Foundation Trusts. The Trust has conducted this assessment on a six-monthly basis. An action plan is in place to address any gaps

identified and this is monitored by the Board of Directors. Key elements of the 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.

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 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 Strategic Risk Register is maintained and updated quarterly. The Register contains Divisional and Corporate Service risks identified as 20 and above and where appropriate is cross referenced to the Board Assurance Framework or Divisional Board Assurance Frameworks. These risks are reviewed at the Strategic Integrated Governance Committee to ensure the risks are being mitigated as promptly as possible.

The Trust follows the guidance set out in the Information Governance Toolkit in respect of monitoring and assuring the security of patient related information. Quality of performance

information is also considered of paramount importance. An Information Governance Overarching Risk Assessment has been developed which documents all major data security risks and the actions being taken to mitigate those risks.

The Trust seeks assurance in a number of ways in relation to data security and the quality of performance information:

- Procures an annual internal audit of clinical coding. This is carried out by the Mersey Coding Academy
- Performs an annual completeness and validity audit of Admitted Patient Care and Outpatient Commissioning Data Submissions
- Has a regular rolling accuracy audit of admissions, outpatient attendances and waiting list entries
- Uses external data quality reports from benchmarking services to monitor data quality
- External Audit conducts an annual review of the Trust's Quality Account in respect of the provenance of three key performance indicators
- Involves clinical staff in the validation of data

The Trust takes a number of steps to ensure data security is being managed and controlled. The Senior Information Risk Officer and Caldicott Guardian receive a monthly update which includes details of all information governance incidents.

In Year Major and Significant Risks (N.B. these risks are not listed in order of priority)

Corporate Risks

Objective Risks	Mitigation
Insufficient capacity to deliver safe high quality care to patients	 Regular executive meetings in place with key partners Monthly monitoring of delivery against key performance indicators Monthly contract meeting with commissioners Capacity and demand bed model and template tested and introduced Patient flow / bed management meetings 3 x day to proactively manage flow of patients through the hospital Escalation policy and awareness training Receipt of non-recurrent money from the Clinical Commissioning Group to support delivery of
	access targets
Failure to progress on schedule the delivery of theatre and critical care build to deliver the Clinical Services Strategy	 Business case approved December 2012 Project board in place and project manager appointed Governance arrangements established Clinician engagement underway

Clinical Risks (N.B. these risks are not listed in order of priority)

Objective Risks	Mitigation
Reduced Numbers of Junior Doctors, particularly in the Emergency Care Division	 Use of Locum medical staff Forward planning of on-call rotas Divisional Board monthly monitoring of length of stay and discharge performance Recruitment processes Clinical workforce model is being developed to address workforce issues Use of alternative roles (e.g. Advanced Practitioners)
Provision of Ophthalmology Services including Backlog of Follow-Up Appointments	 All referrals are graded by Consultants Dedicated glaucoma eye clinics Dedicated waiting lists for glaucoma and diabetes Use of external support to review follow-up routine appointments Ophthalmic triage service Locum Consultants and SAS Doctors appointed to work on backlog activity Partnership working with the local Clinical Commissioning Groups to redesign clinical pathways Non-recurrent funding from Clinical Commissioning Group
The resources and infrastructure to deliver high quality clinical care 24/7	 24 hour senior medical staff cover Increased Consultant on site presence at weekend 24 hours senior nursing staff cover including Night Nurse Practitioner Team Critical Care Outreach Service 24/7 Early warning scores in place to enable staff to detect and manage the deteriorating patient Escalation plan for the detection and management of the deteriorating patient Increase in Consultant posts in Emergency Department, Anaesthetics, General Surgery, Care of the Elderly & Cardiology
Poor State of Repair of the Patient Case Notes	 Medical records rebind case notes as necessary Health Records Management Policy in place with clear actions for staff Updated Trust IM&T Strategy centred around the implementation of an electronic patient record
Recruitment to the high number of nursing vacancies	 Recruitment and Retention Strategy for Nurses & Midwives Very successful international recruitment from Ireland and Spain Proactive recruitment of newly qualified nurses Regular review of nursing vacancies at Executive level

Future Risks (N.B. these risks are not listed in order of priority)

Objective Risks	Mitigation
Long term clinical and financial sustainability of the Organisation	 Clinical Services Strategy Partnerships established with key strategic partners reviewing opportunities for horizontal and vertical integration Partnership Board established Monitor Phase 2 review completed – Deloitte service lines reviews of Maternity Provision, Elderly Care and General Surgery Non-Elective Admissions Identified CIP Schemes with delivery monitored through monthly meetings with Divisions and the Director of Finance and the Chief Operating Officer Divisional targets monitored monthly
 Ensure full compliance with Monitor's term of authorisation and deliver the agreed financial surplus. From 1 April 2013 this will be Monitor's new Provider Licence Maintain a financial risk rating of 3 or above and the appropriate rating as outlined in the new Risk Assurance Framework when implemented in during 2013. Prudential borrowing limit remains within the Trust's PBL 	 Clinical Services Strategy Monthly strategic review meetings Contracted Divisional targets monitored monthly Monthly contract meeting with commissioners CQuINs/Quality Strategy
Failure to deliver all local and national targets and standards	 Monthly monitoring through Performance and Finance Committee, Contract meeting with Clinical Commissioning Group and Board of Directors Performance Report Monthly strategic review meetings with Divisional Teams Regional Cancer Board monthly meetings Service Development Programme – non elective flow Improved information systems and data management Implementation of Divisional Business Continuity Plans at times of high non elective activity
Failure to meet the 6 Week Target for Diagnostic Testing	 All requests are vetted and prioritised Extra sessions in CT & MR scanning Use of locum consultant radiologists Use of external reporting service

Objective Risks	Mitigation
Failure to implement the Information Management & Technology Strategy	 IM&T Strategy updated in 2012 and delivery monitored through Infrastructure Development Committee Capital costs included in capital programme Key performance indicators in place Protection for main systems and edge equipment installed Partnership working with CCGs to deliver local health economy electronic patient record commenced as part of CQuIN programme.
Information Governance – compliance with Information Rights Law	 Information Governance Training Confidentiality & Data Protection Policy IM&T, Medical Records, Data Quality Policies Information Governance Committee meetings quarterly and work plan in place

The Trust has an organisation wide Risk Register. 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". Risk control measures are included in the action plan of those risks deemed unacceptable and monitored in accordance with the Risk Management Strategy. In terms of Acceptable Risk / Risk Appetite, the Trust recognises that it is impossible and not always appropriate to eliminate all risks and that the systems of controls must be balanced. Additionally the Trust maybe willing to accept a certain level of risk when the cost of mitigating the risk is high in comparison to the potential severity of the risk or the likelihood of it occurring. The assessed rating of the risk determines what action is taken, who is authorised to manage the risk and the subsequent review dates. Risks are reviewed by the Divisions, Integrated Governance Department and Board Committees. The Board is kept fully informed of all significant risks and the plans to manage and mitigate them.

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 and relatives, and are reported to the Strategic Integrated Governance Committee. Lessons to be learned from incidents, claims and complaints, together with examples of good practice, are disseminated throughout the Trust. Action plans are followed up through the Board Committees. Aggregation of incidents, claims, complaints and inquests are undertaken at the Complaints, Litigation, Incidents and PALS Committee and shared throughout the Trust.

All patient safety incidents are reported automatically to the National Reporting and Learning System (NRLS) run by the NHS Commissioning Board (known as NHS England from April 2013). This is a voluntary scheme for Trusts which allows national benchmarking of the number, type and severity of incidents against those reported by other similar sized Trusts. Mid Cheshire Hospitals NHS Foundation Trust has participated in this scheme for the past 8 years. Twice a year the NRLS provides the Trust with data collated from the NRLS. This data is shared with

staff via the governance reporting structures. The Trust has been recognised as being a consistently high reporter of incidents. The NRLS maintain that a Trust that has a higher rate of incident reporting has a safety and risk aware workforce who are not afraid to admit to errors and will therefore learn more and patients will be safer.

At times staff may have concerns that they feel need to be addressed but are unsure of how to do this. The Trust has a 'Whistle Blowing' procedure in place and staff can report incidents anonymously. This will ensure that concerns will be addressed anonymously. This may include issues of unlawful conduct or financial malpractice. In addition there is a Patient Safety Hotline where staff can report patient safety concerns or seek confidential advice and support from the Patient Safety Team.

A Quality and Safety Improvement 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. 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. Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human legislation are complied with. The key control measures in place include:

- Equality and Diversity post provides specialist support (being recruited to following retirement of previous post holder):
- Equality and Diversity Committee, which monitors progress against the Trust's single equality scheme and specific actions identified through equality impact assessment. The Equality and Diversity Committee reports to the Operational Integrated Governance Committee;

- 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. All assessments are published on the Trust's internet site.

The Trust is unconditionally registered with the Care Quality Commission (CQC). The Trust has participated in a special review by the CQC relating to the following during April 2012 to March 2013:

 A targeted inspection programme in Acute NHS Hospitals to assess services that provide the regulated activity of terminations of pregnancy. The focus of the visit was to assess the use of forms that are used to certify the grounds under which a termination of pregnancy can lawfully take place. A random selection of medical records was checked by the CQC Inspectors, who found that the trust was compliant with the part of the regulation under review.

The CQC also conducted an unannounced inspection in December 2012 and reviewed the following outcomes:

Outcome 1: Respecting and involving people

who use services

Outcome 6: Cooperating with other providers

Outcome 7: Safeguarding people who use

services from abuse

Outcome 9: Management of Medicines

Outcome 16: Assessing and measuring the

quality of service provision

The Trust was found to be compliant in four of the five outcomes with minor impact concerns raised with Outcome 9, Management of Medicines. In response to this the Trust developed an action plan to address the issues raised, which is monitored via the Trust's governance process. The report received from the CQC was very positive towards the services provided at the Trust and included

specific reference to the complimentary comments reported to the CQC Inspectors during their visit, by patients, regarding their care. Comments received included that staff were professional, caring and compassionate towards them and respected their privacy and dignity.

The Trust successfully achieved compliance at Level 2 in the Clinical Negligence Scheme for Trusts Maternity Clinical Risk Management Standards undertaken by the National Health Service Litigation Authority.

The Trust has self-assessed against the Information Governance Toolkit. The Trust must achieve a score of at least two out of three on all 45 requirements in order to be rated as satisfactory, which the Trust did not achieve in 2012/13. However the Trust has a robust action plan in place to work towards attaining the required standard in 2013/14 which includes:

- A formal annual work-plan monitored by the Information Governance Committee, which reports to the Operational Integrated Governance Committee;
- Formal assignment of leads for individual toolkit requirements;
- Issues outstanding are reported and monitored at each Information Governance Committee.

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.

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. The Lead 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. Governors are actively involved in monthly Patient Safety Walkabouts with an **Executive and Non-Executive Director visiting** selected clinical areas. In addition Governors provide valuable assistance in undertaking patient surveys and in the annual consultation exercise on the Trust's five year quality strategy, 10 out of Ten. This also gives the public and wider stakeholders the opportunity to comment on the Trust in regard to any other concerns or issues they may wish to raise.

Directors also 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 attend and contribute to Trust strategy developments to ensure the risk of misalignment with health economy commissioning intentions does not happen.

Concerns relating to patient experience are considered and acted on by the Patient Experience Committee which is chaired by a Non-Executive Director and has six Governor representatives. This includes all elements of patient experience, positive and negative, through the review of information obtained from patients and the public via surveys, engagement events and complaints.

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 Trust was successful in achieving two awards at the CHKS event in May 2012; one for being the 'Most Improved Trust' in the country, and the other for being rated as one of the top 40 hospitals in the UK. 134 organisations were included in the analysis for both awards, which are based on 23 indicators that recognise continuous improvement in clinical effectiveness, efficiency, health outcomes, safety, patient experience and quality of care. The 'Most Improved' award was achieved as the Trust showed the most significant improvement across the 23 indicators in the previous 12 months. The Trust's performance against a number of these indicators has been at an outstanding level for a considerable time, such as hospital infection and day case rates. Additionally, the Trust has seen significant improvement across all the other indicators, in particular mortality rates and results for patient and staff surveys.

The Trust has a number of programmes and initiatives in place to review the economy, efficiency and effectiveness of the use of resources. The Trust also uses benchmarking information to support these activities. Below is a brief outline of a range of key areas:

- The Trust continues to roll out its patient level costing system. Where in use it has identified areas of waste and influenced the need for greater standardisation;
- In August 2012 the Trust underwent an Annual Plan Phase Two Review which was conducted by McKinsey on behalf of Monitor. The analysis confirmed that 95%

- of the Trust's service lines were in the upper quartile of efficiency;
- January 2013 saw the publication of the NHS Benchmarking Network which nationally benchmarked corporate functions. The results of this benchmarking project identified the Trust as performing in the 'best in class group' in terms of cost efficiency for a range of corporate functions. As a result, a number of other member organisations have asked if it would be possible to make contact with this 'best in class' group to share experiences and learn from our practice.

The Trust engages with initiatives which ensure that cost effective, high quality care is provided to patients where ever possible. As a subscribed member of the Advancing Quality Alliance (AQuA), the Trust is able to access a wide range of benchmarking information and productivity tools. The Trust is involved in a number of AQuA work streams and projects (e.g. Enhancing Recovery) and has two members of staff who are associates with AQuA. Through these associates there is an opportunity to share learning and skill development around service transformation tools and techniques between the two organisations.

The Chief Executive of the Trust also leads the regional Enhanced Recovery Programme on behalf of AQuA. This work stream supports the wider health system in identifying efficiency opportunities and facilitating the adoption and spread of best practice.

The Trust continues to work with the North West Advancing Quality initiative. This entails the introduction of a number of care bundles and then incentivising performance against a number of key quality indicators, benchmarked against other organisations. Also, the Trust has developed plans to invest in the delivery of best practice to improve performance and attract additional CQUIN / Best Practice Tariff income.

The Trust routinely uses benchmarking data and can evidence significant achievements in improving efficiency by doing so. The national Better Care Better Value indicators are routinely reviewed through the Performance and Finance Committee and below are a number of examples of efficiencies created as a result:

- Clinic did not attend rates the Trust continues to operate in the upper quartile as a result of introducing an electronic text system to reduce non-attendance.
- Length of stay (LOS) programmes of work continue to develop patient pathways, which have enabled a continued reduction in LOS.
- Day Case Rates although benchmarking favourably, work is ongoing to improve speciality performance e.g. laparoscopic surgical techniques and enhanced recovery programmes.

A sickness absence project has been initiated to reduce sickness absence which has initially focused on reducing long term sickness across the Trust. The fundamental principle of the project is to implement a culture of improved health and wellbeing supporting improved attendance levels, and enabling earlier return to work as appropriate. This project is led by Human Resources supported by the Occupational Health Service. The project will be continued for the coming year with a revised focus to make continued improvements.

The Trust recognises the importance of extending efficiency opportunities across the health economy and as such has embarked on a number of projects requiring collaboration with other partners. In line with the Carter Review which recommends that pathology services are provided for a population of one million, the Trust is part of a long term strategy to progress a wider collaborative with four other acute Trusts. As an interim, the Trust is

reviewing its current collaborative arrangement with East Cheshire NHS Trust to ensure delivery of a sustainable, efficient and cost effective service.

Annual Quality Account

The Board of Directors is required under the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 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 and Safety Improvement Strategy. This Group has senior representation from the Patient Experience team, Integrated Governance, performance, nursing and quality, the information department and the Clinical Commissioning Groups. Each section of the Quality and Safety Improvement 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 and Safety Improvement 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 Improvement Strategy Group.

The Quality Account is used to update the public about the Trust's achievements in respect of the Trust's Quality and Safety Improvement Strategy and other quality

initiatives. During the year a public consultation exercise is undertaken to gather the views of the local population on the quality and safety strategy (including 10 out of Ten). The consultation also enables 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. The consultation includes the views of over 300 members of the public, across all age ranges.

The Quality Account is shared with the Governors, Commissioners, Health and Wellbeing Scrutiny Committee and the Local Improvement Network (LINKs) before publication to allow their views of the Trust and the report to be incorporated into the document. The Quality Account is assessed by the readers' panel prior to publication and is produced in an easy read format 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.

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.

Board of Directors

The Board of Directors is ultimately responsible for managing risk. The Board is accountable for key functions within the governance framework. There is an established system of risk management throughout the Trust in accordance with the law and Government policy, in order to:

- Minimise the risk to the Trust's patients, assets, its employees, visitors and business:
- Comply with its contractual commitments with commissioning bodies and others for the volume and quality of its services, within its statutory responsibilities, financial and otherwise;
- Identify, prioritise and treat risks, including those deriving from the Care Quality Commission, through an effective Board Assurance Framework.

The Board meets its statutory duty of quality by putting and keeping in place arrangements for maintaining, monitoring and improving the quality of health care which the Trust provides to individuals. The Board receives assurance through the Audit Committee minutes on the system of internal control.

Audit Committee

The Audit Committee provides independent assurance to the Board of Directors that there are adequate controls in place to ensure that the Trust's key objectives and statutory obligations are being met (both clinical and non-clinical). Membership comprises of Non-Executive Directors with attendance from other professionals as required. The Audit Committee's terms of reference are based on those recommended by the NHS Audit Committee Handbook and are compliant

with the FT Code of Governance. All Board Committees have had a remit to provide assurance on risk relating to their specific terms of reference.

Risk and Governance Structure

The function and purpose of the Integrated Governance Department is to:

- (a) Co-ordinate and facilitate the implementation of the Integrated Governance and Risk Management Strategy
- (b) Monitor progress against the strategy
- (c) Provide support to Divisional management and staff in relation to the identification and management of risk and governance issues.

The Department monitors the corporate risk profile of the Trust including the maintenance of the risk register and dealing with escalated risks. It highlights any risk management issues that it considers should be brought to the attention of Board Committees and provides assurance that these are adequately managed. The Department prepares regular reports for the Board and its committees on areas of significant risk and identifies any internal audit and other assurance requirements.

The Divisional Clinical Director is supported by the Divisional General Manager and Professional Lead to provide assurance to the Divisional Boards and the Divisional Board sub committees that all significant risks are adequately managed and the risk management principles are embedded across the Division.

In addition to the above, all Divisions undergo a Divisional Quarterly Performance Review (DQPR) which allows the Executive Team to undertake an assessment that covers a range of criteria, which are aligned to the organisational objectives and provides assurance in relation to the effectiveness of systems and the identification of gaps and risks in governance processes. Following the

review and evidence provided at the DQPR the Divisions are assigned a rating level by the Executive Team depending on their performance against key corporate objectives which includes risk management. The ratings are:

- Low Intensity;
- · Medium Intensity;
- High Intensity;
- Special Measures.

The rating assigned to a Division will determine the level of support and on-going assurance arrangements that are required.

Quality Committee

The Quality Effectiveness and Safety Committee (QuESt) is responsible for providing information and assurances to the Board that the Trust is safely managing the quality of patient care, effectiveness of quality interventions, and patient safety which includes outcomes from the Leading Improvement in Patient Safety (LIPS) programme and the Patient Safety First Campaign. The quality directorate, under the supervision of the Director of Nursing and Quality, supports the implementation of the Trust's Quality and Safety Improvement Strategy and a number of quality initiatives such as Advancing Quality and delivery of the Commissioning for Quality and Innovation (CQUIN).

Clinical Audit

The Clinical Audit Committee is responsible for providing assurances that all issues relating to clinical audit are being managed safely and for the strategic direction of clinical audit within the Trust. The Trust supports the National Institute of Clinical Excellence (2002) definition of clinical audit:

"Clinical Audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

Aspects of the structure, processes and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery."

The strategic aims of clinical audit at the Trust as defined in the Clinical Audit Strategy 2010/13 are:

- To deliver demonstrable improvements in patient care
- To encourage evidence-based practice
- To contribute to the process of continuing clinical education
- To comply with national standards and indicators on clinical audit activity

The Clinical Audit Team provides a return on the investment of staff through implementation of the clinical audit framework and compliance with key indicators and standards for clinical audit externally.

Internal Audit

Internal Audit provides independent assurance that the Trust's risk management, governance and internal control processes are operating effectively. They evaluate risks and controls and provide advice to management. Internal audit also review compliance to ensure that the Trust is adhering to rules, regulations, laws, codes of practice, guidelines and principles as they apply individually and collectively to all parts of the Trust.

Internal Audit has reviewed the effectiveness of internal control and given a positive opinion in the Head of Internal Audit report highlighting that in the areas which have been reviewed, there are no significant internal control issues which need to be highlighted in the Annual Governance Statement.

Review / Assurance Mechanisms

The Trust ensures that the quality and governance of services undergo internal and external review and assurance on a regular basis. The following identifies a number of the processes in place:

- Board Assurance Framework reviewed on a quarterly basis by the Trust;
- Monitor Quality Governance Framework

 six monthly self-assessment, action
 plan development and monitoring of
 improvements in performance and an
 annual review by internal audit, specifically looking at process delivery against the
 action plan;
- Robust Governance and Committee Structure;
- Internal and External Auditor reports;
- Board Effectiveness Survey conducted six monthly by the Board of Directors and annually to also include staff and Governor assessments of the Board's effectiveness;
- · Policies and Procedures in place;
- NHSLA reviews;
- Care Quality Commission reviews and reports:
- Clinical Audit;
- Divisional Quarterly Performance Reviews (DQPR):
- Divisional Board Assurance Frameworks reviewed on a quarterly basis as part of DQPR process.

Where any internal control issues and gaps are highlighted through internal audit, management produces an action plan, the delivery of which is monitored by the Audit Committee through annual follow up audits.

Conclusion

The Head of Internal Audit Opinion has indicated that significant assurance can be given that there is a sound system of internal control, designed to meet the Trust's objectives, and that controls are being applied

consistently in all areas reviewed.

Internal audit reports in the year highlighted no significant risks to objectives being achieved, and no areas of limited assurance were identified, however where control improvements or enhancements were identified, action plans are put in place. These can be evidenced through the minutes of the respective monitoring committee or Divisional Board.

From the systems and mechanisms outlined above the Board is able to take assurance that the governance systems in place are robust and functional.

Buller

Tracy Bullock
Chief Executive Officer / Accountable Officer

Chapter 11

Annual Accounts

Foreword to the accounts

These accounts for the year ended 31 March 2013 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.

Buller

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 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; and
- Prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable 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

28 May 2013

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 2013 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 33. 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 of 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 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 nonfinancial information in the annual report to identify material inconsistencies with the audited financial statements. 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 Trust's affairs as at 31 March 2013 and of its 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 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 FCA (Senior Statutory Auditor) for and on behalf of Deloitte LLP Chartered Accountants and Statutory Auditor

Leeds, UK 28 May 2013

Statement of Comprehensive Income for the Year ended 31 March 2013

ρ. σ.		2012/13	2011/12
	Note	£000	£000
Operating Income from patient care activities	3	157,524	152,871
Other operating income	4	19,671	20,883
Operating expenses	5-7	*(181,549)	*(178,878)
OPERATING DEFICIT		(4,354)	(5,124)
Finance Costs:			
Finance Income	8	75	29
Finance expense – financial liabilities	9.1	(104)	(131)
Finance expense – unwinding of discount on provisions	22	(29)	(32)
PDC Dividends paid	28	(2,170)	(2,917)
NET FINANCE COSTS		(2,228)	(3,051)
DEFICIT FOR THE YEAR		(6,582)	(8,175)
Other comprehensive income			
Impairments on property, plant and equipment	23	(16,163)	(41,326)
Revaluations gains on property, plant and equipment	23	10,412	16,545
Other reserve movements		-	(2)
TOTAL COMPREHENSIVE EXPENSE FOR THE PERIOD		(12,333)	(32,958)
The notes on pages 159 to 207 form part of these accounts. All income and expenditure is derived from continuing operation	ıs.		

^{*}Impact of Property Plant and Equipment valuations

	2012/13	2011/12
	£'000	£'000
Operating Surplus before adjustments for valuation	3,647	6,448
Impairment of Property Plant and Equipment	(8,001)	(12,296)
Reversal of previous impairments charged to the Statement of Comprehensive Income	-	724
Operating deficit	(4,354)	(5,124)

Operating Expenses include a non-cash adjustments £8,001k. The adjustments reflect the changes in the value of the Trust's property, plant and equipment. Accounting standards require that these adjustments are recognised in operating income and expenditure. The underlying operating surplus was £3,647K which would leave a net surplus of £1,419K after interest and dividend charges.

2012/13 2011/12

Statement of Financial Position as at 31 March 2013

		31 March 2013	31 March 2012
	Note	£000	£000
Non-current assets			
Intangible assets	10	815	850
Property, plant and equipment	11	66,683	73,410
Trade and other receivables	14	438	513
Total non-current assets		67,936	74,773
Current assets			
Inventories	13	3,337	3,234
Trade and other receivables	14	7,269	7,080
Cash and cash equivalents	24	10,304	8,956
Non-current assets held for sale	12	31	31
Total current assets		20,941	19,301
Current liabilities			
Trade and other payables	17	(14,579)	(14,020)
Borrowings	19	(1,064)	(1,071)
Provisions	22	(277)	(428)
Other liabilities	18	(131)	(320)
Total current liabilities		(16,051)	(15,839)
Total assets less current liabilities		72,826	78,235
Non-current liabilities			
Trade and other payables	17	-	(4)
Borrowings	19	(1,176)	(1,524)
Provisions	22	(1,408)	(1,332)
Total non-current liabilities		(2,584)	(2,860)
Total assets employed		70,242	75,375
Financed by taxpayers' equity			
Public dividend capital		58,046	50,846
Revaluation reserve	23	11,605	17,718
Income and expenditure reserve		591	6,811
Total taxpayers' equity		70,242	75,375

The financial statements on pages 155 to 207 were approved by the Board and signed on its behalf on 28 May 2013.

Chief Executive

Statement of Changes in Taxpayers' Equity as at 31 March 2013

	Public dividend capital (PDC)	Retained Earnings	Revaluation Reserve	Total
	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2012	50,846	6,811	17,718	75,375
Retained deficit for the year	-	(6,582)	-	(6,582)
Transfer between reserves	-	362	(362)	-
Impairments	-	-	(16,163)	(16,163)
Revaluations	-	-	10,412	10,412
Public Dividend Received	7,200	-	-	7,200
Other reserve movement	-	-	-	-
Taxpayers' equity at 31 March 2013	58,046	591	11,605	70,242

Statement of Changes in Taxpayers' Equity as at 31 March 2012

	Public dividend capital (PDC)	Retained Earnings	Revaluation Reserve	Total
	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2011	49,946	14,912	42,575	107,433
Retained deficit for the year	-	(8,175)	-	(8,175)
Transfer between reserves	-	76	(76)	-
Impairments	-	-	(41,326)	(41,326)
Revaluations	-	-	16,545	16,545
Public Dividend Received	900	-	-	900
Other reserve movement		(2)	-	(2)
Taxpavers' equity at 31 March 2012	50.846	6.811	17.718	75.375

Statement of Cash Flows for the Year ended 31 March 2013

	2012/13	2011/12
	£000	£000
Cash flows from operating activites		
Operating deficit	(4,354)	(5,124)
Non-Cash income and expense		
Depreciation and amortisation	4,859	4,827
Impairments	8,001	12,296
Reversal of impairments	-	(724)
Loss on disposal	-	(1)
(Increase) / Decrease in trade and other receivables	(327)	1,348
Increase in Inventories	(103)	(68)
(Decrease) / Increase in trade and other payables	(158)	1,558
Decrease in other current liabilities	(189)	(70)
(Decrease) / Increase in provisions	(75)	204
Other movements in operating cash flows	(91)	(32)
Net cash generated from operations	7,563	14,214
Cash flows from investing activities		
Interest received	75	29
Payments for intangible assets	(199)	(156)
Payments for property, plant and equipment	(10,138)	(4,737)
Sales of plant property and equipment		11
Net cash used in investing activities	(10,262)	(4,853)
Cook flows from financing activities		
Cash flows from financing activities	7 200	000
Public dividend capital received Capital alament of finance lease rental neumants	7,200	900
Capital element of finance lease rental payments	(1,132)	(1,461)
Interest element of finance lease	(104)	(131)
Public Dividend Capital paid	(1,917)	(3,069)
Net cash used in financing activities	4,047	(3,761)
Increase in cash and cash equivalents	1,348	5,600
Cash and Cash equivalents at 1 April	8,956	3,356
Cash and Cash equivalents at 31 March	10,304	8,956

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 2012/13 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 and certain financial assets and financial liabilities.

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 Trust is the Corporate Trustee of Mid Cheshire Hospitals NHS Charitable Funds which under IAS 27 potentially could be considered a subsidiary and require consolidation. However the application of IAS 27 relating to the consolidation of charitable funds has been deferred by Monitor until 1 April 2013.

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, has been part of the Central Cheshire Urgent Primary Care Consortium providing urgent care facilities on 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 the 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 attributable to incomplete spells cannot be accurately calculated, the basis of the calculation is described under note 3.1 Income from activities.

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 2013 is £81,285.

In addition there are four Employment Tribunal claims which are on-going. The Trust's solicitors have estimated the potential value of the claims and the Trust's percentage of success. The total provision as at 31 March 2013 is £43,000.

Employees' Expenses - At 31 March 2013 the accrual for outstanding holidays is £358,493. Staff other than Medical Staff are expected to take all annual leave by 31 March. The Medical staff has been based on a percentage of 97% 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

The main source of income for the Trust was from Primary Care Trusts, which are government funded commissioners of NHS health and patient care. Income is recognised in the period in which services are provided and is measured at the fair value of the consideration receivable.

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 employees. The cost of annual leave entitlement which is earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of 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.

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 1 April 2008 and interim valuations as at 4 January 2011, 31 March 2012 and 31 March 2013. The depreciated replacement cost of specialised buildings for these valuations were valued on a Modern Equivalent Asset (MEA) basis. However, the Trust, in the most recent valuation as at 31 March 2013, used a 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 sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or 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 assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use:
- the intention to complete the intangible asset and sell or use it;
- the ability to use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service delivery;
- the availability of adequate technical, financial and other resources to complete the intangible asset and use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

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.

Expenditure on research is not capitalised.

Expenditure on development is capitalised if it meets all the following criteria:

- 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:
- 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 the 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.

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 Annual Reporting Manual, 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 5 to 85 years.

Plant and Equipment are depreciated evenly over the estimated life of the asset, as follows:

- Plant and Equipment 2 to 15 years
- Information Technology 1 to 5 years
- Furniture & Fittings 5 to 10 years

1.12 Borrowing costs

Borrowing costs are recognised as expenses as they are incurred.

1.13 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.

1.14 Revenue government and other grants

Government grants are grants from other Government bodies other than income from primary care trusts 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.

1.15 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable i.e.

- management is committed to a plan to sell the asset:
- the asset is available for immediate sale in its present condition subject only to terms which usual and customary for such sales;
- 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 complete 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 are made to it

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

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 arsing 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 2012/13 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 profit and loss'; '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 profit and loss

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 profit and loss. 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 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

The 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. HMRC 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,

- the Trust has no beneficial interest in them;
- 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, HM 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 HM 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) net cash balances held with the Government Banking Services and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.31 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 a 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.

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 atrust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, a trust makes a transfer from its income and

expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that a 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 1	Presentation of financial statements (Other Comprehensive Income)	Effective date of 2013/14 but not yet adopted by the EU
IAS 12	Income Taxes (amendment)	Effective date of 2012/13 but not yet adopted by the EU

IAS 19	(Revised 2011) Employee Benefits	Effective date 2013/14
IAS 27	Separate Financial Statements	Effective date of 2013/14 but not yet adopted by the EU
IAS 28	Associates and Joint Ventures	Effective date of 2013/14 but not yet adopted by the EU
IAS 32	Financial Instruments: Presentation amendment - Offsetting financial assets and liabilities	Effective date of 2014/15 but not yet adopted by the EU
IFRS 7	Financial Instruments: Presentation amendment - Offsetting financial assets and liabilities	Effective date of 2013/14 but not yet adopted by the EU
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 date of 2013/14 but not yet adopted by the EU
IFRS 11	Joint Arrangements	Effective date of 2013/14 but not yet adopted by the EU
IFRS 12	Disclosure of Interests in Other Entities	Effective date of 2013/14 but not yet adopted by the EU

IFRS 13		Effective date of 2013/14 but not
		yet adopted by the EU

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 2013 meeting.

The Trust received 87% of its total income from Primary Care Trusts mainly for patient care activities.

3. Income from Activities

3.1 Income from patient care activities comprises:

	2012/13	2011/12
	£000	£000
Elective Income	26,383	26,378
Non Elective Income	52,068	53,897
Outpatient Income	34,374	33,090
A & E Income	7,001	6,582
Other NHS Clinical Income	34,992	30,343
Income from activities (before private patient income)	154,818	150,290
Other non-protected clinical income	1,130	1,092
Private patient income	1,576	1,489
Total Activity Income	157,524	152,871

The elective and non-elective income includes the levels of incomplete spells as at 31 March 2013. 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 an increase of £62,471. An increase of £34,166 is due to a change in price and an increase of £28,305 is due to a change in volume.

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. In addition there is £1.8m non-recurrent support agreed with Central and Eastern Cheshire PCT.

Injury Cost Recovery income included in 'Other non-protected clinical income' is subject to a provision for doubtful debts of 12.6% (2011/12 10.5%) to reflect expected rates of collection.

The Terms of Authorisation set out the mandatory goods and services that the Trust is required to provide (protected services). All of the income from activities before private income shown above is derived from the provision of protected services.

3.2 Private patient income

The statutory limitation on private patient income in section 44 of the National Health Service Act 2006 was repealed with effect from October 2012 by the Health and Social Care act 2012. The financial statements disclosure regarding private patient income is no longer required. However for 2012/13 the percentage of private patient income to total patient income was 1.00% compared to 0.98% in 2011/12.

Other Operating Income 4.

4. Other Operating income		
	2012/13	2011/12
	£000	£000
Education and training	5,258	5,315
Received from NHS Charities: Receipt of grants/donations for capital acquisitions - Donation	12	-
Received from other bodies: Receipt of grants/donations for capital acquisitions - Donation	-	249
Received from NHS charities: Other charitable and other contributions to expenditure	19	64
Received from other bodies: Other charitable and other contributions to expenditure	24	34
Non-patient care services to other bodies	10,752	10,765
Other	2,844	2,812
Profit on disposal of other tangible assets	-	3
Reversal of impairments of property, plant and equipment	-	724
Staff Recharges	527	576
Rental Revenue from operating leases	235	341
Total other operating income	19,671	20,883
4.1 Operating lease income		
	2012/13	2011/12
Operating Lease Income	£000	£000

	2012/10	2011/12
Operating Lease Income	£000	£000
Rents recognised in the period	235	341
Total	235	341

Future minimum lease payments due	2012/13 £000	2011/12 £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	185	183
Sub Total	195	193
On Leases of Buildings expired		
- Not later than one year	318	234
 Later than one year but not later than five years 	662	635
- Later than five years	201	-
Sub Total	1,181	869
Total	1,376	1,062

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 Operating expenses comprise:

	2012/13	2011/12
	£000	£000
Employee expenses - Staff	119,954	115,219
Employee expenses - Directors' costs	864	860
Employee expenses - Non-Executives' Costs	136	134
Supplies and services - clinical	13,000	13,134
Depreciation on property, plant and equipment	4,625	4,658
Amortisation on intangible assets	234	169
Impairments of property, plant and equipment	8,001	12,296
Premises	6,626	6,443
Inventories written down	44	47
Drug Costs (non-inventory costs)	289	333
Drug Costs (inventories consumed)	9,107	8,259
Clinical negligence	3,555	3,464
Other	1,485	928
Consultancy services	989	581
Supplies and services – general	2,256	2,144
Printing, stationery, travel & recruitment advertising	1,724	1,754
Services from NHS bodies	5,751	5,688
Transport	306	317
Rentals under operating leases	744	582
Auditor's remuneration	74	72
Other Auditor's remuneration	62	-
Purchase of healthcare from non-NHS bodies	681	636
Provision for impairment of receivables (including provision against Road Traffic income)	152	476
Legal Fees	193	79
Hospitality	33	10
Redundancies	192	74
Training Courses and Conferences	284	294
Patient Travel	26	25
Insurances	96	133
Other services	57	59
Losses, ex gratia and special payments	9	8
Loss on disposal of other property, plant and equipment	-	2
Total	181,549	178,878

5.2 Auditor's Remuneration

The analysis of auditor's remuneration is as follows:

	2012/13	2011/12
	£000	£000
Fees payable to the auditor for the audit of the company's annual accounts	74	72
Total audit fees	74	72
Other services	62	
Total non-audit fees	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		
	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
	2011/12	2011/12	2011/12	2011/12
	Buildings	Plant and Machinery	Other	Total
	£000	£000	£000	£000
Lease payments	6	526	50	582
Total	6	526	50	582

There are no significant leasing arrangements included in the above.

5.3.2 Arrangements containing an operating lease

Future non-cancellable minimum lease payments due:

- Not later than one year;
- Later than one year and not later than five years;
- Later than five years.

Total

2012/13	2012/13	2012/13	2012/13
Buildings	Plant and Machinery	Other	Total
£000	£000	£000	£000
-	531	27	558
-	814	30	844
-	-	-	-
-	1,345	57	1,402

Future non-cancellable minimum lease payments due:

- Not later than one year;
- Later than one year and not later than five years;
- Later than five years.

Total

2011/12	2011/12	2011/12	2011/12
Buildings	Idings Plant and Other Machinery		Total
£000	£000	£000	£000
4	499	18	521
-	880	14	894
	-	-	-
4	1,379	32	1,415

5.4 (A) Senior Manager remuneration and benefits - Emoluments

Name	Title	Gross Pay 2012/13	Other Remuneration 2012/13	Superannuation Contributions 2012/13	Total Emoluments 2012/13	Total Emoluments 2011/12	Benefits in Kind * 2012/13	Benefits in Kind * 2011/12
		£000s	£000s	£000s	£000s	£000s	£00s	£00s
Board								
Moran J	Chairman	45	-	-	45	45	40	37
Godfrey V	Non-Executive (until 30/04/12)	1			1	12	-	-
Hopewell D	Non-Executive	15	-	-	15	15	19	22
Wood A	Senior Independent Director and Deputy Chairman	15	-	-	15	15	6	8
Chandler M	Non-Executive (until 31/10/11)	-	-	-	-	8	-	-
Craig WD	Non-Executive (until 31/01/13)	10	-	-	10	12	5	5
Dunn D	Non-Executive	12	-	-	12	12	-	-
McNeil R	Non-Executive	12	-	-	12	5	3	-
Bacon P	Non-Executive (from 01/05/12)	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	-	20	165	165	-	-
Oldham M	Director of Finance & Strategic Planning	105	-	15	120	120	97	126
Alcock R	Director of Workforce & Service Development (until 31/12/11)	-	-	-	-	75	-	-
Shaw J	Interim Director of Workforce & Organisational Development (until 31/12/12)	66	-	9	75	25	-	-
Smith J	Director of Nursing & Quality	90	-	13	103	103	41	32
Frodsham D	Chief Operating Officer	95	-	13	108	108	62	63
Pitt D	Director of Service Transformation & Workforce (from 01/01/13)	25	-	3	28	-	-	-
Dodds P	Medical Director & Deputy Chief Executive Officer	157	18	24	199	198	-	-
Total Board	Members Remuneration	808	18	97	923	918	273	293
Employers' I					94	94	-	-
	Members Remuneration nployers' NI and tion				1,017	1,012	273	293

^{*} 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 which are recorded under the benefit in kind heading are recorded in 'hundreds', whereas the emoluments' are recorded as 'thousands'.

5.4 (B) Salary and Pension entitlements of senior managers - Pension Benefits

Name	Title	Real increase in pension and related lump sum at age 60	Total accrued pension at age 60 at 31 March 2013	Total accrued lump sum at age 60 at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2013	Transfer Value at 31 March 2012	Real Increase in Cash Equivalent Transfer Value
		£000s	£000s	£000s	£000s	£000s	£000s
Board Memb	oers						
Bullock T	Chief Executive	(3)	52	156	856	803	6
Dodds P	Medical Director & Deputy Chief Executive	6	61	184	1,136	1,025	33
Oldham M	Director of Finance & Strategic Planning	(2)	36	108	564	528	5
Frodsham D	Chief Operating Officer	(1)	29	87	543	507	6
Smith J	Director of Nursing & Quality	(1)	27	80	386	360	4
Pitt D	Director of Service Transformation and Workforce	(1)	30	91	516	490	-
Shaw J	Director of Workforce and Development	-	31	92	521	479	8

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.

5.4 (C) Notes to Senior Managers 5.4 (D) Multiple Statement remuneration and Pension benefits

The other remuneration for Dr Dodd's relates to his remuneration as a consultant.

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 employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

	2013	2012	Change
	£000	£000	%
Highest Paid Director gross cost	175	175	0.00
Median Total earnings	25	25	(0.01)
Ratio	6.97	6.90	0.01

The median total earnings was calculated using the full-time equivalent gross cost of all staff paid through the Trust's payroll in March 2013 which is then annualised.

6. Staff Costs and Numbers

6.1 Staff Costs

	2012/13	2011/12
	£000	£000
Salaries and wages	97,828	94,473
Social Security Costs	6,718	6,411
Employer contributions to NHS Pensions Authority	10,588	10,340
Termination Benefits	192	74
Agency and contract staff	6,008	5,105
Total Gross Staff Costs	121,334	116,403
Of which		
Costs capitalised as part of assets	(324)	(250)
Total Employee benefits excluding Capitalised Costs	121,010	116,153
Analysed into Operating Expenses (5.1 Op Ex)		
Employee Expenses - Staff	119,954	115,219
Employee Expenses - Executive directors	864	860
Redundancy	192	74
Total Employee benefits excl. capitalised costs	121,010	116,153

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 2012/13	Other permanent employees	Directors	Other	Total 2011/12
	Number	Number	Number	Number	Number
Medical & Dental	290	290	-	-	285
Administration & estates	628	622	6	-	611
Healthcare Assistants & other support staff	463	463	-	-	453
Nursing, midwifery & health visiting staff	817	817	-	-	797
Scientific, therapeutic and technical staff	400	400	-	-	393
Bank and Agency	211	-	-	211	174
Other	295	295	-	-	289
Total average numbers	3,104	2,887	6	211	3,002
of which					
WTE engaged on capital projects	7	7		_	6

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 employees pay a fair rate for private mileage.

6.4 Retirements due to ill-health

During 2012/13 there were 2 (2011/12: 3) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £317,944 (2011/12: £265,297). The cost of these ill-health retirements will be borne by the NHS Business Services Authority – Pensions Division.

6.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

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 HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the 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:

Annual Pensions

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Pensions Indexation

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).

III-Health Retirement

Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

Death Benefits

A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

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.

Additional Voluntary Contributions (AVCs)

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

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.

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.

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.

6.6 Staff exit packages

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	- (1)	1 (-)	1 (1)
£10,000 - £25,000	- (1)	1 (1)	1 (2)
£25,001 - £50,000	- (-)	3 (1)	3 (1)
£50,001 - £100,000	- (-)	1 (-)	1 (-)
Total number of exit packages by type	- (2)	6 (2)	6 (4)

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	- (8)	6 (-)	6 (8)
£10,000 - £25,000	- (19)	13 (21)	13 (40)
£25,001 - £50,000	- (-)	118 (25)	118 (25)
£50,001 - £100,000	- (-)	56 (-)	56 (-)
Total number of exit packages by type	- (27)	193 (46)	193 (73)

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 2011/12.

7. Better Payment Practice Code

7.1 Better Payment Practice Code - measure of compliance

	2012	2012/13		/12
	Number	£000	Number	£000
Total Trade bills paid in the year	48,214	117,170	45,910	102,632
Total Trade bills paid within target	44,586	110,480	40,724	96,413
Percentage of Trade bills paid within target	92%	94%	89%	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 Commerical Debts (Interest) Act 1998

The Trust had no interest payable for the year ended 31 March 2013 under the Late Payment of Commercial Debts (Interest) Act 1998.

8. Finance Income

	2012/13	2011/12
	£000	£000
Interest on bank accounts	75	29
Total	75	29

9. Finance Costs

9.1 Finance Cost - Interest Expense

	2012/13	2011/12
	£000	£000
Interest on obligations under finance lease	104	131
Total	104	131

9.2 Impairment of Assets

	2012/13	2011/12
	£000	£000
Loss or damage from normal operations	942	_
Unforeseen Obsolescence	-	35
Changes in market price	23,222	53,587
Reversal of impairments	_	(724)
Total	24,164	52,898

Included in the above is the impact of the revaluation of the premises as at March 2013. In addition as part of the new Theatre and Intensive Care Unit a proportion of Ward 6a has been demolished which is reflected in the £942,000 impairment.

10. Intangible Fixed Assets

	Software Licences 2012/13	Assets under construction 2012/13	Total 2012/13
	£000	£000	£000
Gross cost at 1 April 2012	1,341	224	1,565
Additions purchased	75	124	199
Reclassifications	224	(224)	-
Gross cost at 31 March 2013	1,640	124	1,764
Amortisation at 1 April 2012	715	-	715
Provided during the year	234		234
Amortisation at 31 March 2013	949	-	949
Net book value			
- Total purchased at 1 April 2012	626	224	850
- Total purchased at 31 March 2013	691	124	815

	Software Licences 2011/12 £000	Assets under construction 2011/12 £000	Total 2011/12 £000
Gross cost at 1 April 2011	1,267	-	1,267
Additions purchased	68	150	218
Reclassifications	6	74	80
Gross cost at 31 March 2012	1,341	224	1,565
Amortisation at 1 April 2011	546	-	546
Provided during the year	169	-	169
Amortisation at 31 March 2012	715	-	715
Net book value			
- Total purchased at 1 April 2011	721	-	721
- Total purchased at 31 March 2012	626	224	850

The reclassification is the transfer from intangible assets under construction to intangibles. All intangible assets relate to purchased software licences.

10.1 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

•	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	610	179	-	10,799
Additions - leased	-	-	-	-	598	241	-	839
Additions - donated	-	-	-	-	12	-	-	12
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 surpluses	-	(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 change of £8,001K was made to the Operating Expenditure, reflecting the difference between the downward valuation and the balance in revaluation reserve. The net change to the revaluation reserve was £5,571K.

	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 2011	9,500	88,494	3,379	275	17,981	3,011	299	122,939
Additions – purchased	-	3,991	-	722	27	-	-	4,740
Additions – leased	-	-	-	-	350	-	-	350
Additions – donated	-	160	-	-	89	-	-	249
Impairments	(6,900)	(33,762)	(664)	-	-	-	-	(41,326)
Revaluations	-	2,799	-	-	-	-	-	2,799
Reclassifications	-	3	-	(274)	11	180	-	(80)
Disposals		(12)	-	-	(1,350)	(40)	(34)	(1,436)
Cost or valuation at 31 March 2012	2,600	61,673	2,715	723	17,108	3,151	265	88,235
Accumulated depreciation at 1 April 2011	-	442	18	-	11,303	1,885	119	13,767
Provided during the year	-	1,692	69	-	2,373	490	34	4,658
Impairments	-	12,261	-	-	35	-	-	12,296
Reversal of impairments	-	(724)	-	-	-	-	-	(724)
Revaluation	-	(13,659)	(87)	-	-	-	-	(13,746)
Disposals	-	(12)	-	-	(1,340)	(40)	(34)	(1,426)
Accumulated depreciation at 31 March 2012	-	-	-	-	12,371	2,335	119	14,825
Net Book Value								
NBV - Purchased at 31 March 2011	9,500	86,041	3,361	275	2,250	1,077	116	102,620
NBV – Finance Lease at 31 March 2011	-	-	-	-	4,065	49	64	4,178
NBV - Donated at 31 March 2011	-	2,011	-	-	363	-	-	2,374
NBV total at 31 March 2011	9,500	88,052	3,361	275	6,678	1,126	180	109,172
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

During 2011/12 a valuation was carried out by the District Valuation Office (DVO), however the previous valuation was carried out by a different professionally qualified valuer. Whilst the valuers have used the same method of valuation, that is Modern Equivalent Asset (MEAV), the approaches adopted are different, particularly in two key areas; the remaining lives on the various component parts of a Depreciated Replacement Cost valuation and the classification of land. The DVO has generally reduced the remaining lives of the component parts, and consequentially the value, in comparison to the previous valuation as the DVO has determined that there is greater physical deterioration and technical obsolescence. Land has reduced in value as the DVO has assumed that the land on the Leighton Hospital site should be classed as agricultural/greenbelt for the purposes of MEAV instead of employment use, as in the previous valuation, with agricultural/greenbelt land attracting a lower value. The valuation reduced the value of land and buildings by £36,318K. A charge of £12,261K was made to the Operating Expenditure, reflecting the difference between the downward valuation and the balance in the revaluation reserve. A reversal of previous impairments previously charged to operating expenditure of £724K has been reflected within Operating Income. The net charge to the revaluation reserve was £24,781K.

11.2 Analysis of tangible fixed assets

	Land	Buildings Excluding Dwellings	Dwellings	Assets under Construction and payments on account	Plant & Machinery	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value								
Protected 31 March 2013	2,478	50,008	-	-	-	-	-	52,486
Unprotected 31 March 2013	122	1,730	2,280	4,863	4,240	842	120	14,197
Total at 31 March 2013	2,600	51,738	2,280	4,863	4,240	842	120	66,683

	Land	Buildings Excluding Dwellings	Dwellings	Assets under Construction and payments on account	Plant & Machinery	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value								
Protected 31 March 2012	2,478	59,480	-	-	-	-	-	61,958
Unprotected 31 March 2012	122	2,193	2,715	723	4,737	816	146	11,452
Total at 31 March 2012	2,600	61,673	2,715	723	4,737	816	146	73,410

11.3 Net Book Value (NBV) of property, plant and equipment in Revaluation Reserve

	Land	Buildings Excluding Dwellings	Dwellings	Plant & Machinery	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000
NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2013							
-as at 1 April 2012	1,300	15,017	516	874	2	9	17,718
-movement in year	-	(5,429)	(325)	(355)	-	(4)	(6,113)
-as at 31 March 2013	1,300	9,588	191	519	2	5	11,605
=							
	Land	Buildings Excluding Dwellings	Dwellings	Plant & Machinery	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000
NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2012							
Nevaluation Neserve as at 31 March 2012							
-as at 1 April 2011	8,200	32,328	1,094	941	3	9	42,575
	8,200 (6,900)	32,328 (17,311)	1,094 (578)	941 (67)	3 (1)	9	42,575 (24,857)

11.4 Economic life of property, plant and equipment

	Min. Life	Max. Life
Buildings excluding dwellings	5	85
Dwellings	20	50
Assets under construction	-	-
Plant & machinery	2	15
Information Technology	1	5
Furniture and Fittings	5	10

Land is treated as having an infinite life.

11.5 Assets held at open market value

At the statement of financial postion date there was no land, buildings or dwellings valued at open market value.

12. Non-Current Assets for sale and assets in disposal groups

Non-current assets for sale and assets in disposal groups 2012/13	Total	Property, plant and equipment
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2012	31	31
NBV of non-current assets for sale and assets in disposal groups at 31 March 2013	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.

13. Inventories

13.1 Inventories

Inventory Movements 2012/13	Drugs	Consumables	Energy	Total
	£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

Inventory Movements 2011/12	Drugs	Consumables	Energy	Total
	£000	£000	£000	£000
Carrying value at 1 April	836	2,204	126	3,166
Additions	8,661	8,384	29	17,074
Inventories recognised in expense	(8,609)	(8,319)	(30)	(16,958)
Write down of inventories recognised in expense	(48)	-	-	(48)
Carrying value at 31 March	840	2,269	125	3,234

14. Trade and other Receivables

	2013	2012
	£000	£000
Current:		
NHS receivables	4,191	3,499
Provision for impaired receivables	(139)	(410)
Prepayments	1,157	1,574
PDC Receivable	-	213
VAT Receivable	253	109
Other receivable	1,807	2,095
Total current trade and other receivables	7,269	7,080
Non-current:		
Other receivables	524	589
Provision for impaired receivables	(86)	(76)
Total non-current trade and other receivables	438	513
Total trade and other receivables	7,707	7,593

14.1 Provision for impairment of receivables

	2012/13	2011/12
	£000	£000
At 1 April	486	193
Increase in provision	404	482
Amounts utilised	(413)	(183)
Unused amounts reversed	(252)	(6)
At 31 March	225	486

Included above is a provision of £181,191 which is based on 12.6% on the outstanding receivables from the Compensation Recovery Unit.

14.2 Ageing of receivables

0 to 30 days - 34 30 to 60 days - 26 60 to 90 days 3 38 90 to 180 days 2 66 180 to 360 days 220 322 Total 225 486 Ageing of non-impaired receivables past their due date \$\frac{	Ageing of impaired receivables	31 March 2013 £000	31 March 2012 £000
60 to 90 days 3 38 90 to 180 days 2 66 180 to 360 days 220 322 Total 225 486 Ageing of non-impaired receivables past their due date \$\frac{\text{\$1 \text{ March 2013}}{\text{\$2000}}\$ \$\frac{\text{\$31 \text{ March 2012}}}{\text{\$2000}}\$ 0 to 30 days 386 191 30 to 60 days 386 191 60 to 90 days 89 23 90 to 180 days 91 164 180 to 360 days 13 118	0 to 30 days	-	34
90 to 180 days 2 66 180 to 360 days 220 322 Total 225 486 Ageing of non-impaired receivables past their due date 31 March 2013 31 March 2012 £000 £000 0 to 30 days 386 191 30 to 60 days 232 430 60 to 90 days 89 23 90 to 180 days 91 164 180 to 360 days 13 118	30 to 60 days	-	26
180 to 360 days 220 322 Total 225 486 Ageing of non-impaired receivables past their due date 31 March 2013 31 March 2012 0 to 30 days 386 191 30 to 60 days 232 430 60 to 90 days 89 23 90 to 180 days 91 164 180 to 360 days 13 118	60 to 90 days	3	38
Total 225 486 Ageing of non-impaired receivables past their due date 31 March 2013 £000 \$2000 0 to 30 days 386 191 30 to 60 days 232 430 60 to 90 days 89 23 90 to 180 days 91 164 180 to 360 days 13 118	90 to 180 days	2	66
Ageing of non-impaired receivables past their due date 0 to 30 days 30 to 60 days 430 60 to 90 days 90 to 180 days 180 to 360 days 180 to 360 days 181 March 2013 2000 £000 £000 £000 £000 £000 £000 £00	180 to 360 days	220	322
Ageing of non-impaired receivables past their due date 0 to 30 days 386 191 30 to 60 days 232 430 60 to 90 days 89 23 90 to 180 days 91 164 180 to 360 days 113	Total	225	486
Ageing of non-impaired receivables past their due date 0 to 30 days 386 191 30 to 60 days 232 430 60 to 90 days 89 23 90 to 180 days 91 164 180 to 360 days 113			
0 to 30 days 386 191 30 to 60 days 232 430 60 to 90 days 89 23 90 to 180 days 91 164 180 to 360 days 13 118	Ageing of non-impaired receivables past their due date	31 March 2013	31 March 2012
30 to 60 days 232 430 60 to 90 days 89 23 90 to 180 days 91 164 180 to 360 days 13 118	rigoring of non impariou receivables past their due date	£000	£000
60 to 90 days 89 23 90 to 180 days 91 164 180 to 360 days 13 118	0 to 30 days	386	191
90 to 180 days 91 164 180 to 360 days 13 118	30 to 60 days	232	430
180 to 360 days 13 18	60 to 90 days	89	23
	90 to 180 days	91	164
Total <u>811</u> 926	180 to 360 days	13	118
	Total	811	926

15. Other Financial Assets

The Trust had no other financial assets as at 31 March 2013 or 31 March 2012.

16. Other Current Assets

The Trust had no other current assets as at 31 March 2013 or 31 March 2012.

17. Trade and Other Payables

17.1 Trade and other payables at the statement of financial position date are made up of:

	31 March	31 March
	2013	2012
	£000	£000
Current:		
NHS Payables	1,404	2,000
NHS Pensions	1,380	1,291
Trade Payables Capital	1,972	1,300
Social Security costs	1,099	1,079
Other taxes payable	1,152	1,190
Other payables	116	148
Other Trade payables	4,323	3,615
PDC dividend payables	40	-
Accruals	3,093	3,397
Total Current Trade and other payables	14,579	14,020
Non-current:		
		4
Other payables	-	4
Total non-current trade and other payables	-	4
_	14,579	14,024

18. Other Liabilities

	31 March	31 March
	2013	2012
	£000	£000
Current:		
Deferred income	131	320
Total current liabilities	131	320

19. Borrowings

	31 March 2013	31 March 2012
	£000	£000
Current:		
Obligations under finance lease	1,064	1,071
Total current borrowings	1,064	1,071
Non-current		
Obligations under finance lease	1,176	1,524
Total non-current borrowings	1,176	1,524

20. Prudential Borrowing Limit

NHS foundation trusts are required to comply and remain within a prudential borrowing limit. This is made up of two elements:

- The maximum cumulative amount of long-term borrowing. This is set by reference to the four ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit; and
- The amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

	31 March 2013	31 March 2012
	£000	£000
Total long term borrowing limit set by Monitor	24,700	21,700
Working capital facility agreed by Monitor	11,000	11,000
Total Prudential Borrowing limit	35,700	32,700
Actual (contracted) working capital facility	11,000	11,000
Long term borrowing at 1 April	2,595	3,706
Net actual borrowing (repayment) in year - long term	(355)	(1,111)
Long term borrowing at 31 March	2,240	2,595
Working capital borrowing at 1 April	-	-
Net actual borrowing (repayment) in year - working capital	-	-
Working capital borrowing at 31 March	-	-

The four ratio tests and the Trust's performance against them is set out below;

Financial Ratios	Actual 2012/13	Approved 2012/13	Actual 2011/12	Approved 2011/12
Minimum Dividend cover	3.9x	3.1x	3.8x	3.3x
Minimum Interest cover	81.8x	35.4x	86.1x	30.3x
Minimum Debt Service cover	6.9x	3.8x	7.1x	3.4x
Maximum Debt Service to Revenue	0.7%	1.1%	0.9%	1.1%

The approved financial ratios are those submitted to Monitor as part of the Trust's 2012/13 financial plans.

21. Financial Lease Obligations

31 March 2013	31 March 2012
£000	£000
2,363	2,748
1,128	1,154
1,161	1,594
74	-
(123)	(153)
2,240	2,595
1,064	1,071
1,102	1,524
74	-
2,240	2,595
	£000 2,363 1,128 1,161 74 (123) 2,240 1,064 1,102 74

22. Provisions for Liabilities and Charges

	Cur	Current		urrent
	31 March 2013	31 March 2012	31 March 2013	31 March 2012
Legal Claims	81	57	-	-
Pensions	112	107	1,408	1,332
Other	84	264	-	
Total	277	428	1,408	1,332

	Legal Claims	Pensions	Other	Total
	£000	£000	£000	£000
At 1 April 2012	57	1,439	264	1,760
Change in the discount rate	-	43	-	43
Arising during the year	68	121	84	273
Utilised during the year	(32)	(112)	(153)	(297)
Reversed unused	(12)	-	(111)	(123)
Unwinding of discount	-	29	-	29
At 31 March 2013	81	1,520	84	1,685
Expected timing of cash flows:				
Not later than 1 year	81	112	84	277
Later than 1 year and not later than 5 years	-	423	-	423
Later than 5 years	-	985	-	985
At 31 March 2013	81	1,520	84	1,685

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.

A provision of £43,000 has been made in the accounts which relates to a number of employment tribunal issues.

The Trust has provided £40,565 for one voluntary redundancy payments.

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 2013 and 31 March 2012 (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.

£25,846,828 (2011/12: £25,409,945) is included in the provision of the NHSLA at 31 March 2013 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 2013
	£000	£000
Revaluation reserve at 1 April 2012	17,718	17,718
Impairments	(16,163)	(16,163)
Revaluations	10,412	10,412
Transfers to other reserves	(362)	(362)
At 31 March 2013	11,605	11,605
	Revaluation Reserve Property, plant and equipment	Total 2012
	£000	£000
Revaluation reserve at 1 April 2011	42,575	42,575
Impairments	(41,326)	(41,326)
Revaluations	16,545	16,545
Transfers to other reserves	(=0)	(70)
Transiers to other reserves	(76)	(76)

24. Cash and Cash Equivalents

	31 March	31 March
	2013	2012
	£000	£000
At 1 April	8,956	3,356
Net change in year	1,348	5,600
At 31 March	10,304	8,956
Broken down into:		
Cash at commercial bank and in hand	567	538
Cash with Government Banking Service	9,737	8,276
Other current investments		142
Cash and Cash equivalents as in SoFP and SoCF	10,304	8,956

The other current investments in 2012 relates to the Trust's share of the cash balance held by the Central Cheshire Urgent Primary Care Consortium joint venture. The joint venture has now been dissolved. However the Trust continues to provide the services provided by the joint venture.

25. Capital Commitments

Commitments under capital expenditure contracts at the statement of financial position date were £413,000 (2011/12: £149,000).

The commitments are for HV Substation £191,000, Anaesthetics office £32,000, Constant temperature/Variable temperature Mains £31,000, Aseptic Unit £90,000, Building Management System Upgrade £36,000 and Treatment Centre Uninterruptible Power Supply upgrade £33,000.

In addition a new theatre and intensive care unit are being constructed under a P21+ scheme. However under this type of scheme the contract can cease at any point. The scheme is being funded via Public Dividend Capital from the Department of Health.

26. Post Balance Sheet Events

There are no post balance sheet events 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:

Total value of contingent disputed claims
Amount recoverable under insurance
arrangements in the event of these claims
being successful - payable by NHSLA
Net contingent liability

Total	Other Legal	Clinical Negligence
31 March 2013	31 March 2013	31 March 2013
£000	£000	£000
12,384	566	11,818
(12,327)	(509)	(11,818)
57	57	

Total value of contingent disputed claims
Amount recoverable under insurance
arrangements in the event of these claims
being successful - payable by NHSLA
Net contingent liability

Clinical Negligence	Other Legal	Total
	31 March 2012	
£000	£000	£000
8,361	390	8,751
(8,361)	(348)	(8,709)
-	42	42

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. The Trust's public dividend paid in year totals £1,917,000 which included a receivable of £213,000 from 2011/12, however based on actual average relevant net assets this figure should be £2,170,000 and a payable of £40,000 has been recognised.

29. Related Party Transactions

The 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 the Mid Cheshire Hospitals NHS Foundation Trust.

Other main NHS entities with which the Trust are regarded as related parties. During the year the Trust had a number of material transactions with other NHS entities which are listed below:

Related Party Transactions

	Income	Expenditure
	£000	£000
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	-	-
Value of Transactions with board members 2011/12	-	_
Value of Transactions with key staff members 2011/12	-	-
Value of Transactions with other related parties 2011/12		
Department of Health	-	418
Other NHS Bodies	166,064	10,925
Charitable Funds	311	311
Subsidiaries/Associates/Joint Ventures	346	166
Other	171	17,469
NHS Shared Business Services	-	-

Related Party Balances

	Receivables	Payables
	£000	£000
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
Value of balances (other than salary) with board members at 31 March 2012	-	-
Value of balances (other than salary) with key staff members at 31 March 2012	-	-
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2012	-	-
Value of balances (other than salary) with related parties in respect of doubtful debts written of in year at 31 March 2012	-	-
Value of balances with other related parties 31 March 2012		
Department of Health	213	27
Other NHS Bodies	3,499	2,000
Charitable Funds	20	3
Subsidiaries/Associates/Joint Ventures	-	-
Other	160	4,045

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, Cheshire East Council.

The Trust has also received revenue and capital payments from a number of charitable funds, for which the Trust Board 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 Primary Care Trusts, 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 quarterly 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. To alleviate this issue the Trust has continued to put in place a £11,000,000 working capital facility with its current Bankers, which it has yet to draw on. 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 Department of Health 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

NHS Trade and other receivables excluding non-financial assets
Non – NHS Trade and other receivables excluding non- financial assets
Non-current assets held for sale and assets held in disposal group excluding non-financial assets
Cash and cash equivalents (at bank and in hand) Total

Total	Loans and receivables	Available for sale
31 March 2013	31 March 2013	31 March 2013
£000	£000	£000
4,191	4,191	-
2,359	2,359	-
31	-	31
10,304	10,304	
16,885	16,854	31

NHS Trade and other receivables excluding non-financial
assets
Non-NHS Trade and other receivables excluding non-financial assets
Non-current assets held for sale and assets held in disposal
group excluding non-financial assets
Cash and cash equivalents (at bank and in hand)
Total

Total	Loans and receivables	
31 March 2012	31 March 2012	31 March 2012
£000	£000	£000
3,499	3,499	-
2,520	2,520	-
31	-	31
8,956	8,956	-
15,006	14,975	31

All financial assets are denominated in Sterling.

30.4 (ii) Financial liability by category

Obligations under finance leases
NHS Trade and other payables excluding non-financial liabilities
Non NHS Trade and other payables excluding non-financial liabilities
Provisions under contract
Total

Total	Other financial liabilities
31 March 2013	31 March 2013
£000	£000
2,240	2,240
1,404	1,404
10,884	10,884
1,685	1,685
16,213	16,213

	Total	Other financial liabilities
	31 March 2012	31 March 2012
	£000	£000
Obligations under finance leases	2,595	2,595
NHS Trade and other payables excluding non-financial liabilities	2,000	2,000
Non NHS Trade and other payables excluding non-financial liabilities	9,755	9,755
Provisions under contract	1,760	1,760
Total	16,110	16,110

30.4 (iii) Maturity of Financial liabilities

	31 March 2013	31 March 2012
	£000	£000
In one year or less	15,037	14,582
In more than one year but not more than two years	1,102	1,528
In more than two years but not more than five years	74	-
In more than five years	-	-
Total	16,213	16,110

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 2013.

31. Third Party Assets

	2012/13	2011/12
	Money on deposit	Money on deposit
	£000	£000
At 1 April	7	2
Gross inflows	21	17
Gross outflows	(26)	(12)
At 31 March	2	7

The Trust held £2,340 cash at bank and in hand at 31 March 2013 (£7,337 at 31 March 2012) 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 2013.

33. Losses and Special Payments

There were 193 cases of losses and special payments totalling £119,846 approved during 2012/13. These have been prepared on an accruals basis. During 2012/13 there have been no individual cases of fraud, personal injury, compensation under legal obligation and fruitless payment cases, where the net payment exceeds £100,000.



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