



Mid Cheshire Hospitals **NHS**  
NHS Foundation Trust

# Annual Report and Accounts 2010/11





Mid Cheshire Hospitals NHS Foundation Trust  
Annual Report and Accounts 2010/11

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





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## Chapter 1

# Chairman's Foreword

I am delighted to present to you our results for the year ending 31 March 2011 evidencing a further year of progress during a period when the budgetary constraints I spoke of last year started to impact.

Once again we have experienced an increased demand for our services and hospital staff at all levels worked tirelessly in the year to face up to this challenge as we cared for an increasing number of patients.

As I write this foreword the NHS is facing one of the most radical reforms in its 60 year history. As a Foundation Trust of some years standing we are already in a position to respond to these reforms vigorously. In this respect, we are engaging well with our new GP Consortia as they seek to take over the responsibility, from the existing Primary Care Trust, for commissioning hospital services.

It is absolutely vital that in the new world as envisaged by the Secretary of State that health care free at the point of delivery continues to provide the following main attributes:

- High quality care with better outcomes
- Continued value for money solutions
- Clinical leadership driving improvements
- Sustainable local health services able to compete on a level playing field in a new market economy.

We are already in good shape to help our colleagues in the health economy to deliver on these promises. Good clinical leadership across the health economy will be crucial in joining up services and making patient



pathways seamless between doctors surgeries and our hospitals. During the year we reorganised our top team and our CEO Tracy Bullock, a Nurse by background, and our Deputy CEO and Medical Director Dr Paul Dodds are well placed to provide clinical leadership to help drive this agenda forward.

The Health and Social Care Bill has already passed through the committee stages of the parliamentary process although progress is temporarily paused whilst further consultations take place with professionals and the public. We will obviously watch this position carefully and ensure we continue to play an important part in local decisions regarding changes to health care organisations across the local health economy.

I would like to highlight a number of our successes and challenges that we faced in this last year:

- We admitted over 66,000 patients during the year

- We are very pleased to be able to announce that we have had no recorded infections of MRSA bacteraemia in the year. We placed a lot of emphasis on ensuring robust infection control measures are in place and our Infection Control Team and Trust staff are to be congratulated on such an outstanding achievement. Our challenge now is to sustain this and our programme of educating visitors and staff continues unabated
  - We should end the year with a Governance rating of Amber/Green from our regulator, Monitor, although at the current time Monitor have still to agree this. The rating could be Amber/Red if Monitor do not accept the verbal assurances provided to them by the CQC relating to the completion of action plans following a responsive review. We hope to agree with Monitor that the plans are complete and a rating of Amber/Green is appropriate. Not achieving the 62 Day Cancer target in the final quarter also affected this governance rating. The Trust expects to restore our Green rating at the earliest opportunity. Our finances were managed well in the year and we expect Monitor to award us a financial risk rating of 3, in line with our plans
  - The 18 week referral to treatment target was achieved and on this occasion across all of our specialties in accordance with the new targets set in year
  - We achieved our A&E targets in the year even with an increase in the number of patients attending
  - We established a Hospital Mortality Reduction group and have been engaged with the Northwest Mortality Collaborative with the aim of reducing our mortality rates by 10 points. We are delighted to have been able to exceed this and achieved a reduction of 16 points
  - Our Treatment Centre saw 18,573 day case patients in the year, a record number
  - And in recognition of the outstanding work undertaken by our staff we held another Celebration of Achievement Evening in March of this year attended by over 300 colleagues and representatives of our Governing Council.
- As I have mentioned before, after a decade of growth in health budgets, we are now facing real challenges to the amount of funding that is available to meet an ever increasing demand for our services. In the year we saw at first hand the problems that can be encountered as funding starts to tighten. We were instructed to cancel all non-urgent operations in December 2010 as the Primary Care Trust was facing a budget deficit. The resultant impact on patient disruption and waiting lists was not one we could easily accept and therefore we brokered a financial settlement with the Primary Care Trust that enabled our pre-planned activity to continue but provided the Primary Care Trust with an effective rebate of £1.7m.
- We have a duty to use our resources carefully and wisely for the benefit of our community so that we remain a strong and robust organisation able to invest and develop services for the long term. I am therefore pleased to say that even with the rebate referred to we achieved a financial surplus before asset revaluations and impairments of £1.6m on a turnover of £169.8m.



The surplus we achieved is lower than the amount that we realistically need to continue to invest in our estate at a level that maintains our infrastructure. Added to this we need to continue to refurbish the existing wards and hospital corridors and in due course rebuild our main theatres. This is an area where a joined-up approach with our GP Consortia will be required. We know for example that new theatres costing in the region of £13m will be required within the next 3 to 5 years and working closely with our GP Consortia we will need to find a way to fund these essential investments for the benefit of our patient population. I repeat my comments of last year when I said that capital funding represents one of our major challenges and also risks as we move forward.

I would like to comment further on some of the changes to our Board of Directors in the year. First of all I would like to pay tribute to Phil Morley, our previous CEO, who has now taken up the CEO position at Hull University Teaching Hospital. Phil was an outstanding leader and we are grateful to him for his work in developing our Trust so well during his time at Mid Cheshire Hospitals NHS Foundation Trust. I was delighted to welcome Tracy Bullock as CEO as she stepped up from Deputy Chief Executive and Director of Nursing & Quality following a rigorous selection process. I am confident that under Tracy's leadership the Trust will continue to flourish. Dr Paul Dodds, our Medical Director, took on additional responsibilities as Deputy CEO and will play a key part in developing relationships with our GP Consortia. I was also pleased to welcome Julie Smith as our Director of Nursing & Quality in February 2011. Julie has a background of nursing in acute Trusts and joined us from the East Midlands Strategic Health Authority. Andy Ennis left us during the year to further his career at Wirral University Teaching Hospital and Denise Frodsham, our

previous Director of Service Development, was appointed as Chief Operating Officer as part of our review of executive portfolios consequent upon these changes.

There were no changes to Non Executive Director members in the year although a number of appointment tenures (including my own) will be expiring in 2011 and 2012 and I will be addressing this with our Council of Governors, as we move through this next year. My thanks go to all the Board Members who have worked hard and effectively during this last year.

Our Foundation Trust membership continues to grow and reached 8,000 by 31 December 2010 achieving the target set, and remained at this level at our year end. We have been able to engage with members and the public via our newsletters and public events over the year and it is heartening to see more and more members taking a real interest in what we do and joining us at a number of interesting and informative events that we have been able to arrange during this last year. Engagement with our members and the public is a vital part of our accountability and our Governors have worked hard to help develop these areas over this last year.

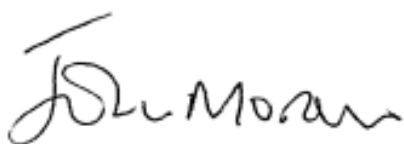
I would also, once again, like to thank our Governors for all their work over this last 12 months as we continued the work of the Council in developing our governance structures and the role that Governors undertake to hold the Trust accountable to our members and the public. We further refined the committee structure in the year, formed a new Governor Strategy Committee and introduced patient safety walkabouts that Governors play a key role in.

The three year term of our inaugural Council of Governors naturally came to

an end on 31 March 2011 and with the assistance of Electoral Reform Services we went through a process of election during the first 3 months of 2011. I am delighted to report that two thirds of our Governors were re-elected to continue in office for a further three year period. I am equally delighted to welcome ten new Governors to Council and look forward to working with them over this next year as the important work of our Council of Governors continues to develop. My thanks are also extended to those Governors who have retired from our Council in this period.

I do hope you enjoy reading the information we have published about your hospitals in this report. You will see that we have included a wealth of information about our clinical activities and of course we have a whole section dedicated to Quality Accounts. I would also encourage you to access information that we routinely publish on our web-site that provides information about our progress during the year.

Finally can I once again pay tribute to all staff who work for our Trust and all of our volunteers who willingly give up their time to assist us. They have all made an outstanding contribution to the achievements recorded in this Annual Report and on behalf of the Board of Directors I should like to thank them for your continued enthusiasm and support.

A handwritten signature in dark ink, appearing to read 'John Moran', with a stylized, cursive script.

John Moran  
Chairman

## Chapter 2

# About the Trust

We were established as an NHS Trust in April 1999, and were licensed as an NHS Foundation Trust from 1 April 2008. The Trust is managed by a Board of Directors and is supported by the Acting Trust Secretary. The Board comprises:

- The Chairman, John Moran.
- The Chief Executive, Tracy Bullock (appointed October 2010)
- Six Non Executive Directors and five Executive Directors

We provide a comprehensive range of acute, maternity, child health services and intermediate care to a population of almost 300,000 living in Alsager, Crewe, Congleton, Knutsford, Middlewich, Nantwich, Northwich, Sandbach and Winsford. We provide services from Leighton Hospital in Crewe, Victoria Infirmary in Northwich and Elmhurst Intermediate Care Centre, Winsford.

Employing approximately 3,000 staff, we provide clinical services through four Clinical Divisions:

- Diagnostic and Clinical Support, including Medical Imaging, Pathology, Dermatology, Victoria Infirmary Northwich, Elmhurst Intermediate Care Centre, Winsford, and the Urgent Care Centre in conjunction with the Shropdoc Consortium, GPs and Cheshire East Community Health
- Emergency Care, including Accident & Emergency and Minor Injuries, General Medicine, and Rheumatology
- Surgery and Cancer, including Anaesthetics and Intensive Care,

ENT, General Surgery, Gynaecology, Ophthalmology, Orthopaedics and Trauma, the Treatment Centre for day case work, and Urology

- Women, Children and Sexual Health, including Genito-Urinary Medicine, Neonatology, Obstetrics, and Paediatrics.

During 2010/11 over 66,000 admissions were recorded by the Trust as well as 242,300 attendances at Outpatients. There was also 77,400 attendances at A&E. Of those who were admitted or attended Outpatients, 72,000 underwent a surgical procedure, either elective or non-elective.

Our outreach facilities include community midwifery, child health, paediatric home care, phlebotomy, anticoagulant and a number of outpatient services in primary care environments. We also participate in a joint collaborative partnership to provide primary care services within an Urgent Care Centre which is based to the rear of the A&E Department.

The Estates & Facilities Division is the non Clinical Division of the Trust which works with the Clinical Divisions to establish the Trust as the health care provider of choice.

In addition, the Corporate teams provide back office functions for the Trust.

The Trust provides care to patients through its contracts with Primary Care Trusts. Central and Eastern Cheshire Primary Care Trust currently accounts for approximately 95.0% of our work.

Our Income for year ended 31 March 2011 was £169.8m.





## Chapter 3

# Director's Report

## *Board of Directors*

The Board of Directors serving in the financial year 2010/11 are listed below:

<b>Name</b>	<b>Position</b>
Mr P Morley	Chief Executive to 6 October 2010
Mrs T Bullock	Chief Executive appointed 12 October 2010, formerly Deputy Chief Executive & Director of Nursing
Ms R Alcock	Director of Workforce & Organisational Development
Dr P Dodds	Medical Director, appointed Deputy Chief Executive 12 October 2010
Mrs D Frodsham	Chief Operating Officer
Ms J Hartley	Acting Director of Nursing (to 6 February 2011)
Mr M Oldham	Director of Finance & Strategic Planning
Mrs J Smith	Director of Nursing & Quality (Appointed 7 February 2011)
Mr J Moran	Chairman
Dr A Wood	Senior Independent Director & Deputy Chairman
Mr M Chandler	Non Executive Director
Mr D Dunn	Non Executive Director
Mr W Craig	Non Executive Director
Mrs V Godfrey	Non Executive Director
Mr D Hopewell	Non Executive Director

## *Introduction*

The Board of Mid Cheshire Hospitals NHS Foundation Trust has clearly laid out a five year strategy that will underpin all financial decisions, clinical investments, business priorities and behaviours. This programme of work created a strategic vision:

**“To be a reputable provider of high quality, safe, cost effective and sustainable healthcare services”**

The Trust has agreed six strategic objectives to support the delivery of the Trust's aims and vision:

- Quality & Safety
- Organisational Delivery
- Strong Independent FT
- Workforce Development & Effectiveness
- Emergency Preparedness
- Fit for Purpose Infrastructure



These six strategic objectives set the framework for all decision making within the Trust. For the period 2009/10 the Trust had noted seven strategic objectives. It was agreed that the objective 'To be a World Class Provider of Choice', whilst remaining an aspiration of the Trust, was an overarching objective that will be attained through the achievement of the remaining six strategic objectives. All the targets noted under the objective of World Class Provider of Choice lie within the remaining six objectives.

## Quality & Safety

### *Nurses' Day 12 May 2010*

12 May is International Nurses Day celebrating the birthday of Florence Nightingale. The Trust has chosen to mark the occasion in a variety of different ways over the years, but 2010 was particularly special.

The Trust, jointly with Cheshire and Wirral Partnership NHS Foundation Trust, through the Learning Disability Development Group looked at how the Trust could celebrate nursing whilst making a visit to a hospital less daunting for people with a learning disability.

Consequently the Trust organised a wonderful, interactive day where both adults and children with learning disabilities visited Leighton Hospital.

In the morning adults from a variety of community settings arrived and took part in activities which included fire safety, hand washing, having blood pressure checked and having a plaster of paris applied. The adults also visited the Emergency Department and a surgical ward in the hope that should they ever need to be admitted to hospital, the experience would be less distressing.



The afternoon brought a group of children from Springfield School who engaged in similar activities to the adults, but also included a very successful trip to the Children's Ward. The Play Leaders introduced the children to the delights of the ward playroom and the outside play area, with the added advantage of familiarising the children with the ward environment in a fun, non-threatening way.

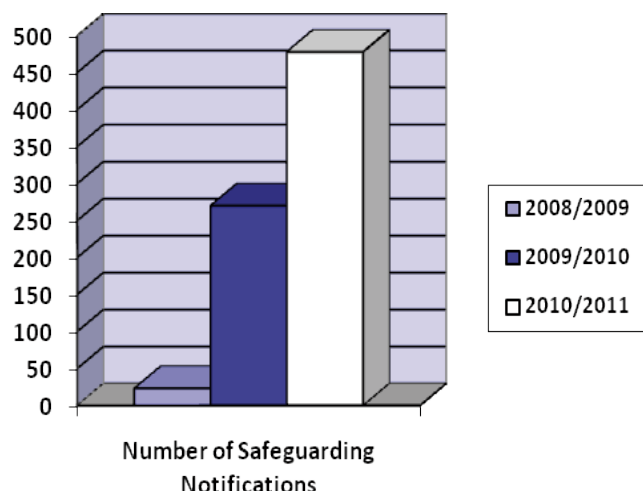
The photographs show how much both the adults and children enjoyed themselves, as did all the hospital staff who took part.



*"This is one of the best and most rewarding days I have spent as a nurse so far"*  
Sandra Glover, Matron

## Safeguarding Children

There is documented evidence to determine that staff are becoming more confident and competent at recognising and reporting safeguarding concerns.



In 2008/09, there were a total of 23 reported safeguarding concerns; all identified by members of staff within the Paediatric Wards and all relating to the recognition of physical harm. By 2009/10, the numbers of reported safeguarding concerns had risen to 270 and were now being identified by staff across the Trust. It was also evident that the concerns were no longer confined solely to the recognition of physical abuse.

Between April 2010 and January 2011, there has been another significant increase of reported safeguarding issues, to a total of 478. Issues continue to be identified across the Trust and consist of all categories of abuse; including physical, emotional, sexual and neglect issues.

Increased reporting has been achieved through improved processes and increased awareness amongst staff. The increased identification and reporting ensures that actions are taken to keep these children safe.

## Releasing Time to Care

The Productive Ward Project maintained momentum through 2010 and into 2011. Releasing Time to Care (RTTC) is now well known across the Trust and aims to allow nursing staff to increase the time they spend directly caring for patients.

Over the past twelve months the Trust has continued to focus its efforts on the two show case wards: Ward 7 and Ward 12, with successful implementation of key projects being filtered into other areas.

A key focus has been the drug round and wards are benefiting from a reduction in the length of time to conduct drug rounds:

- A decluttering of the medicine trolleys and having a standardised check list for all items on the trolley
- Working closely with the Pharmacy Department to ensure stock levels are accurate and patients' own medication is used whenever possible
- Drug charts not being removed from the ward other than in exceptional circumstances
- Staff wearing Red tabards stating - 'Drug Round in Process Do Not Disturb'. This ensures staff are not unnecessarily disrupted during a drug round.

A meal ordering web site on the intranet has also been set up so wards can make changes to orders and/or request meals quickly and easily.





The ordering system provides benefits to patients; allowing delivery of meals to other wards if the patient has moved, facilitating changes to meal choices and allowing late requests for meals when patients have been admitted later in the day.

### **Patient Safety Walkrounds**

*‘Strong effective leadership is essential to build a safety-oriented organisational culture, as evidence suggests that without this, many other interventions are likely to fail. Leaders of all organisations must be seen to be committed in both word and visibility to the primary aim of ‘first, do no harm’. To deliver the necessary culture change, leaders are required not only to ‘talk the talk’ but to ‘walk the walk’.*

*They are a way of demonstrating visible commitment by listening to and supporting staff when issues of safety are raised (Patient Safety First Campaign 2009).*

In summary, walkrounds can:

- Demonstrate top level commitment to patient safety
- Establish lines of communication about patient safety among staff, executives, and managers
- Identify opportunities for improving safety
- Encourage reporting of issues, errors and near misses
- Promote a culture for change pertaining to patient safety
- Establish local solutions to minimise risk.

Aim:

*‘To ensure a leadership culture at Board level, which promotes quality and patient safety and provides an environment where continuous improvement in harm reduction becomes routine throughout the organisation’ (Patient Safety First Campaign 2009).*

The Patient Safety Leadership Walkrounds commenced in January 2011. In brief the patient safety walkround is a fortnightly visit to wards and departments. Each visit will comprise of one person from at least two of the following groups:

- Executive Director
- non-Executive Director
- Council of Governors

Members of the Divisional Management Team and Patient Safety Team are also in attendance.

Changes in practice following walkrounds have included:

- Ordering additional essential equipment
- Repair to facilities
- Improvements in blood transfusion practice.

Comments received:

- *‘The walkround is a demonstration of how the Trust is listening to staff’*
- *‘The walkround has been the highlight of my day’*
- *‘It’s really nice to meet members of the Council of Governors’.*



### **Serious Incidents**

A serious incident is defined by the National Patient Safety Agency (NPSA) as an incident that occurs to one or more persons (patients, staff, visitors or members of the public) where the outcome requires life saving intervention, major or surgical / medical intervention, permanent harm, will shorten expectancy of life, results in prolonged pain or psychological harm or

avoidable death (NPSA 2010).

Serious incidents in healthcare are uncommon but when they occur the NHS has a responsibility to ensure that there are systematic measures in place for safeguarding people, property, NHS resources and reputation. This includes responsibility to learn from these incidents to minimise the risk of them happening again (NPSA 2010).

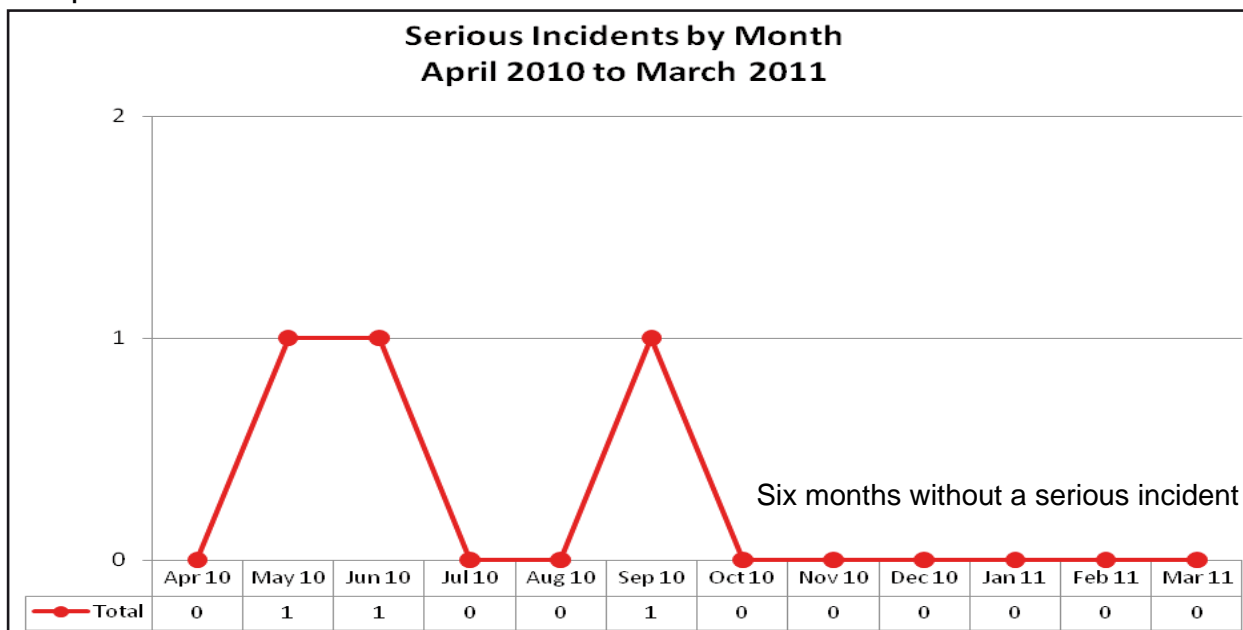
Graph 1 below shows the number of reported serious incidents from 1 April 2010 to 31 March 2011.

Incident Description	Lessons Learned
May - Information Governance Incident	Patient records are now collected from the place where the incident occurred rather than being posted. This removes the risk of patient records being issued to the wrong address and thus will prevent a reoccurrence of the incident.

Incident Description	Lessons Learned
June - Unexpected death of a patient	Increased training for staff on the mental health liaison referral pathways. Implementation of new nursing admission documentation which includes assessment of patient's anxieties.
September - Surgical complications	The process for recruiting temporary staff is being reviewed. The questions asked on interview are being reviewed to reflect specifics for the post.

Following each serious incident a Root Cause Analysis (in-depth investigation) is carried out by trained and experienced staff. The review meetings are held with an Executive Director in an honest and open manner. This is to ensure that lessons are learned to prevent reoccurrence of the incident.

Graph 1



(Source: Ulysses 2011)

## **Patient Advice and Liaison Service (PALS)**

PALS is a free, confidential service for people who want to give feedback about any aspect of the NHS care that they have received. PALS staff provide information about local health services and help to resolve problems for patients or visitors who may not want to make a formal complaint, but certainly wish to register a concern. PALS can be accessed by telephone, in person, fax, e-mail, letter or 'How Are We Doing' comments cards.

During 2010/11 PALS have given presentations to groups in the community including Diabetes UK and the Masonic Widows. PALS also carry out presentations to staff and deliver a session on communication through the Customer Care Training Programme.

In 2010/11, 1,375 concerns were raised with PALS, regarding the care of the person, or that of a relative. This is a decrease of 2% on the previous year. PALS resolved 97% of those concerns, with only 3% (39) intending to make a formal complaint.

Of the concerns raised, 68% were resolved within one day, and a further 10% within three working days. Service improvements that were introduced in 2010/11 as a result of issues raised with PALS included:

- The need for an additional telephone number to be added to patient's appointment letters to ensure appropriate access to the department
- Purchase of additional seating to support patient choice, for example chairs without arms were purchased
- Additional training for staff to ensure effective use of Trust administrative

systems thus reducing delays for patients.

An evaluation of PALS demonstrated that people who used the service valued it highly. Examples of the positive comments that were made about PALS in 2010/11 included:

- *"The PALS lady was lovely. She listened and offered help and support. She was very friendly and kind, followed up my problems and got it all sorted. Very happy"*
- *"I was most impressed with the speed and positive response to my problems which were resolved in a matter of days"*
- *"Excellent service, the staff were most helpful."*

## **Complaints**

The Trust welcomes feedback from the people who use its services as this helps to identify areas for improvement. The Trust is committed to providing an explanation, offering an apology where required and taking action to avoid similar incidents occurring in the future.

A new Complaints Management Policy was developed to incorporate the new legislative framework for handling complaints that came into effect in April 2009. Following implementation of the new guidance, 79 meetings were held with complainants and there has been improved satisfaction with the complaints handling process, with the number of complaints reopened falling by 50%.

In 2010/11 the Trust received 260 complaints, an increase of 15 over the previous year. Of the complaints received, 52% were fully upheld, 31% were partially upheld and 17% were not upheld. This is a significant achievement given that there was an overall increase of patient activity at



the Trust of 1.9%.

Complainants who are dissatisfied with the Trust's response to their complaint have the right to ask the Health Service Ombudsman for a review. In 2010/11, 3 complainants asked the Ombudsman to review their complaint. To date, no complaints have been accepted for review by the Ombudsman after the initial assessment.

Complainants may also make their complaint to Central and Eastern Cheshire Primary Care Trust, our local Commissioner. In 2010/11 the Primary Care Trust received 18 complaints about the Trust.

The Trust is keen to ensure that, where appropriate, actions are identified in order to strengthen systems and to reduce the likelihood of similar issues recurring. Some of the key lessons learnt/actions taken during the year were:

- All patients with dementia now have a capacity assessment and a dietician referral on admission
- A web cam service has been introduced on the Neonatal Intensive care Unit so that all mothers who are separated from their babies are able to see them at any time
- Improvements to patient information leaflets, for example patient information packs have been developed for patients in the Discharge Lounge which explains food options, including hot meals, which are available while waiting to be discharged
- A patient passport has been introduced for patients with learning disabilities so that staff can be made aware of their important clinical information, together with their likes and dislikes.

## Patient Satisfaction Surveys

*[Further information is provided within the Quality Accounts Section, page 100]*

A programme of local and national patient surveys are monitored by the Patient Experience Committee and a patient representative from one of the Divisional Board Committees to ensure satisfaction levels in all areas. The Trust website continues to display details of the survey results. The results can be found via the following link : <http://lhcs2/areas/patientinfo/patientsurveys.asp>

In 2010, 4,000 patients were asked, in over 25 local patient surveys, if they would recommend the Trust to family and friends based on their experience as a patient: 91% of patients declared that they would recommend the Trust to others compared to 86% in 2009 whilst 90% said they were treated with respect and dignity.

## National Patient Surveys

*[Further information is provided within the Quality Accounts Section, page 100]*

The Trust participates in an NHS Survey programme, co-ordinated by the Care Quality Commission, which enables the Trust to build a picture of a patient's experiences over time. In 2010/11 national surveys were completed for Maternity Services, Inpatients and Cancer Services.

The questionnaires ask patients a range of questions about what happened during their hospital visit giving patients an opportunity to tell Trusts about their experience and how it could be improved for patients in the future.

Some improvements made by the Trust during the year include:

- All wards aim to ensure patients have been offered a choice from a daily food

- menu and an alternative if required
- Further choice is now available on the vegetarian menu and quorn has been introduced
- Pictorial menus are available
- A halal option is available on request
- Supporting information for patients on taking medications which includes Questions & Answers has been made available on all wards and within the Pharmacy Department.

### Realtime Survey Kiosk Feedback



The Trust has deployed a touch screen multi language kiosk into wards and departments including the Ante-Natal Clinic, Treatment Centre, Urgent Care Centre, Phlebotomy Service and Maternity Ward. The kiosk asks

patients to respond to a number of questions about the experience they have had whilst in hospital.

Survey results are displayed on posters in waiting rooms with a summary of results and actions. Positive comments are reported on Customer Service Stars.

The following comments were made by women attending the Ante-Natal clinic:

- *"5 star treatment"*
- *"Efficient and friendly"*
- *"I felt they listened"*
- *"Staff were all friendly and approachable – instilled confidence in their skills"*
- *"Brilliant service all round"*
- *"Receptionist & Sonographer both lovely."*

All action plans are monitored by the Department that has carried out the survey and are audited on a regular basis.

### Patient Information

The Trust's Readers' Panel membership has increased to 65 and members have been asked which specialties they are interested in reviewing leaflets for. During the year, 74 leaflets have been reviewed including :

- Day Surgery – Post Operative Information
- Are you at Risk of Falling?
- Transient Ischaemic Attack (TIA)
- Having a Skin Biopsy
- Fertility Treatment
- Cataract – Consent
- Brain Stem Death.

Staff welcome the feedback from the Readers' Panel and comments confirm

information does meet patients' needs e.g.,

*"I think this leaflet has been well*

*thought out. It is important that the*

*patient should not*

*become anxious but at the same time be*

*made aware of what action to take. The*

*step by step approach is straight to the point, very easy to grasp the meaning and urgency of any occurrence."*

Members of the Readers' panel also assisted in reviewing other publications including the Quality Accounts for the period of April 2009 to March 2010.

An Annual Focus Group is held inviting members of the Readers Panel to attend to discuss a range of topics. Members also have an opportunity to see the final



documents and witness the influence panel members have in improving information for patients.

### ***Nursing and Midwifery Innovations Conference***

On Wednesday, 9 June 2010 the first Nursing and Midwifery Innovations Conference took place within the Trust. The Conference was organised by a small committee of specialist nurses whose remit was to showcase, raise awareness and celebrate the excellent nursing and midwifery achievements and innovations that had been developed by the Trust. The day was opened and closed by Mrs Tracy Bullock as Director of Nursing, Deputy Chief Executive.

The day included eleven presentations from either individuals or teams that not only highlighted achievements, but also enabled the audience to learn from the experiences with the intention of influencing best practise and promoting new developments and new innovations amongst other teams and individuals within the Trust. Examples of the topics included Nurse Facilitated Discharge within the Trust, the impact of the Stroke Care Pathway on patient experience and the developing role of the Advanced Nurse Practitioner.

### ***Research***

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care offered and making a contribution to wider health improvement. The number of patients receiving NHS services provided or sub-contracted by the Trust between April and December 2010 that were recruited during that period to participate in the National Institute of Health Research (NIHR) portfolio research which was approved by a research ethics committee was 668. This is a 108% increase since the previous

reporting period (March 2009 to February 2010). However, it should be noted that one study: Fungal Infection Risk Evaluation (F.I.R.E) accounts for nearly all of this increase.

The Trust was involved in conducting 139 active clinical research studies during 2010/11 including, but not limited to, Cancer Medicines for Children, Cardiovascular Mental Health, Congenital Disorders, Musculoskeletal, Diabetes, Oral and Gastrointestinal Generic Health Relevance.

There were 9 (7.45 Whole Time Equivalent) clinical research staff participating in research approved by a research ethics committee at the Trust during the 2010/11. The Trust was involved in conducting 2 clinical research studies in cardiovascular medicine during 2010/11. The High Cholesterol Levels Research Programme, to reduce the incidence of vascular events, has been recruiting and treating patients since 2007. Over the same period, mortality amenable to mortality rates from causes considered preventable in cardiovascular medicine changed from the previous year and Cardiology improved its risk adjusted mortality index by 28.5%.

Further detail on research can be found in the Quality Account for 2010/11 on page 84.



## Organisational Delivery

### Operational Delivery

Operational Delivery is a key strategic objective for the Trust and is also considered a national priority. As a result of this the Trust has focused on improving its operational processes in order to deliver against national requirements for the year ending March 2011. This section of the report provides narrative and key performance data in relation to the Trust's activity and achievement against national performance targets. The section also describes service developments and initiatives which have

been introduced to improve performance across the Trust and with external partners. This is intended to complement the quality information reported within the Quality Accounts (Chapter 7).

The high level activity data detailed below demonstrates the continued increase in levels of patient attendances and care delivered during 2010/11 for both non elective admissions and elective treatments.

	2010/11	2009/10	2008/09	2007/08	2006/07
Emergency episodes of care requiring the use of a bed	32,766	31,347	30,894	27,699	24,544
Attendances at accident and emergency and minor injuries	77,416	75,461	76,590	76,664	75,696
Elective episodes requiring a procedure to be performed	64,178	61,843	53,453	48,460	46,330
Total attendances at outpatient clinics	242,322	246,760	244,371	229,070	203,825
Births	3,004	2,991	2,947	2,953	2,783
Requests for medical imaging	163,438	164,623	154,846	162,871	136,966
Average number of beds open in the year	584	605	574	539	520
Average % Occupancy*					
Overall	84.4%	87.1%	89.0%	85.0%	83.0%
General Medicine	89.6%	91.9%	94.0%	92.0%	91.0%
General Surgery	89.4%	88.7%	91.0%	88.0%	88.0%
Orthopaedics	83.4%	90.8%	97.0%	87.0%	94.0%

In terms of achievement against key national performance targets, the Trust achieved its year end targets in all areas including the four hourly performance for emergency care (95% of patients treated within four hours), referral to treatment (admitted and non admitted pathways) as well as those relating to cancer services (14 days from referral to being seen, 31 days diagnosis to treatment and 62 days referral to treatment). However, the key challenge for the Trust during 2011/12 was in relation to the impact of winter pressures and for a number of weeks during December to mid January, the Trust was requested by

the Strategic Health Authority to cancel all non urgent elective activity to ensure there was sufficient bed capacity, including intensive care and high dependency beds, to be available for non elective admissions including those patients with serious health issues as a result of contracting swine flu.

As a result of this waiting lists for inpatients elective operations have increased but work over March and April 2011 will focus on recovering this position to ensure the Trust has sufficient capacity to meet the needs of the population as the Trust moves into 2011/12.

The following table lists all of the key targets the Trust has been working towards this year. The figures demonstrate sustained progress against targets which year on year are become greater in number and increasingly challenging in order to bring about sustained progress in service delivery and patient care.

Performance Standard	National Target	Trust Performance Year End	Trust Position
Patients whose operation is cancelled on the day	ACHIEVE ≤0.8% cancelled on day & ≤5% are not rebooked within 28 days = achieve	0.95% operations cancelled on day	<b>UNDERACHIEVED</b>
Patients whose operation once cancelled is rebooked within 28 days	UNDERACHIEVE ≤1.5% cancelled on the day & ≤15% are not rebooked within 28 days	7.9% not rebooked within 28 days	
For non-admitted patients, maximum of 18 weeks from referral to treatment	95%	98.1%	<b>ACHIEVED</b>
For admitted patients, maximum of 18 weeks from referral to treatment	90%	93.2%	<b>ACHIEVED</b>
Percentage of patient records with recorded ethnic group information	ACHIEVE ≥85%	Outpatients = 90.41%	<b>ACHIEVED</b>
	UNDERACHIEVE ≥70%	Finished Consultant Episodes = 89.41%	<b>ACHIEVED</b>



Performance Standard	National Target	Trust Performance Year End	Trust Position
Maximum time of waiting of four hours in A & E from arrival to admission, transfer or discharge	ACHIEVE > 95% UNDERACHIEVE <95% BUT >94% FAIL <94%	97.34%	<b>ACHIEVED</b>
Maximum 2 week wait from urgent GP referral to be seen for all suspected cancers including referred those from the breast screening programme	93%	94.46% (breast screening actual 95.72%)	<b>ACHIEVED</b>
Maximum 31 day wait from diagnosis to treatment for all cancers	96%	98.55%	<b>ACHIEVED</b>
Maximum 31 day wait for treatment for all subsequent cancers for drug therapy	94%	100%	<b>ACHIEVED</b>
Maximum 31 day wait for subsequent treatments all cancers for surgery	94%	100%	<b>ACHIEVED</b>
Maximum 62 day wait from referral to treatment for all cancers	85%	87.73%	<b>ACHIEVED</b>
Maximum 62 day wait to first treatment from all consultant cancer screening service referrals	90%	95.38%	<b>ACHIEVED</b>
People suffering a heart attack to receive Thrombolysis within 60 minutes of the call	68%	67.86%	<b>NOT ACHIEVED</b>
Percentage of women who initiated breast feeding on delivery	>65%	61.39%	<b>NOT ACHIEVED</b>
Percentage of women who are smoking at delivery	<15%	20.51%	<b>NOT ACHIEVED</b>

## ***Clinical Service Strategy***

During 2010/11, the Trust reviewed its Clinical Services Strategy to ensure that services being delivered and developed for the future were in line with population needs and reflected the direction described within the Government White Paper (Equality and Excellence: Liberating the NHS). A wide range of clinicians covering all specialties, the Board of Directors, Governors and commissioning consortia worked together to agree a four year plan which transforms the Trust from that of a secondary care hospital provider to one which is a partner within an integrated whole system service. The Strategy determines that the key objective of the Trust is to ensure the delivery of safe, effective and affordable services for the local population and that these may be delivered alone, in partnership with others or by others and will be delivered at the hospital or in other community settings closer to the home of our patients.

The strategy was formally launched in March 2011 and will see a series of projects undertaken to deliver the agreed priorities between now and 2014.

## ***Service Developments / Clinical Improvements***

The Trust developed a wide range of service developments and clinical improvements during 2010/11 which enhanced the provision of local health care in areas of most need and deliver the Trust's strategic and operational objectives.

Initiatives undertaken included the following:

- Development of the Medical Admissions Lounge. The facility opened in October 2010 as an additional facility aligned to the Emergency Assessment Unit. Its role is to provide rapid access appointments to patients who are referred by their GP for urgent diagnostics and physician assessment but may not require hospital admission. The facility is now regularly assessing over 120 patients per month with over 50% being discharged home under the care of the GP with an appropriate treatment plan.
- This project forms the first phase of a longer term programme to improve non elective care services across primary and secondary care and involves further development of an acute medical unit with wider integration with partners from social services, intermediate care and ambulance teams.
- Expansion of services delivered in the community. During the year 2010/11, further services have been expanded to provide greater access and choice to patients. These include provision of a dermatology service from the Ashfields Primary Care Centre in Sandbach, a one stop cardiology service at Victoria Infirmary and Consultant Diabetes Clinics at Waters Green Medical Centre in Macclesfield. Further expansion of out of hospital service delivery will continue to be a key priority for the Trust where the service can be delivered efficiently and effectively for patients.
- Quality investments for 2010/11 once again focused on increasing levels of front line clinical staff including additional nurses in our Emergency Department, Medical Assessment Unit and core wards along with additional consultants in Gynaecology and Orthopaedics. These investments support the longer term vision of increasing consultant presence on wards and in outpatient clinics, supporting pathway developments for earlier discharge, reduced readmissions and delivery of services which are consultant delivered

rather than consultant led.

- Investments to complete the redevelopment of the Imaging Department saw the installation of a new state-of-the-art CT scanner, reducing scanning times from an average of 30 minutes per patient to 5 minutes along with the replacement of the mammography scanner by digital mammography equipment to improve earlier diagnosis of breast cancer. These investments were supported by the modernisation of the imaging facilities to include patient changing facilities that ensure compliance with privacy and dignity requirements and a preparation room for injections to increase capacity within the department.
- October 2010 saw the Theatre Redesign Project move to its implementation phase. The project which had been in development over the previous year had robust objectives to improve efficiency through achievement of an 85% utilisation of the theatres facility, offering consultants more flexibility to undertake additional theatre lists, reducing costs and increasing theatre capacity so that patients requiring urgent operations e.g. hip fractures, can have these much sooner as well as ensuring that patients who are booked for elective operations do not have their operations cancelled due to insufficient capacity.

## Partnerships

The provision of high quality services delivered by the Trust continued to be of the utmost priority. During 2010/11 this has involved partnership working with patients, relatives and carers as well as jointly delivering services between the Trust and other voluntary and statutory organisations. During 2010/11 the Trust continued to focus on ways in which these relationships could be improved to enhance patient experience

and improve the quality of care delivered.

Below are some examples of areas where the Trust has worked in partnership to improve the quality and range of services we deliver to patients.

## Partnering Health and Social Care

Additional government funding was released in November 2010 to support community reablement programmes and hospital admission avoidance schemes. The funding provided the opportunity for the Trust to develop closer links with a number of other organisations including general practitioners, social services, mental health and intermediate care/community nursing teams. A number of developments have been implemented from this including:

- *Care Home Assessment.* A number of care homes have been allocated specific links to a GP practice. GPs from the practice will visit the patients in the care home on a regular basis to undertake patient reviews and develop patient passports which detail the patients' health and future care wishes. Communication between hospital clinicians and the GP practice have been strengthened to support this admission avoidance project. This has already shown evidence of reducing the number of patients who are admitted to hospital from these homes and the project is now likely to be extended to other care homes in the area.
- *Integrated Discharge Team.* A multidisciplinary team has been established to support patients and their families when the patient has complex discharge needs. This includes a family liaison officer to support choice of nursing/residential homes, social service officers to rapidly implement home care packages and community nursing teams to support continuing care at home. This

has resulted in reducing the length of stay of patients who are medically fit but require other services to enable safe and effective discharge from acute care.

- *Alcohol Liaison.* Funding has been identified to support the development of alcohol project workers into the Emergency Department. These staff, working under the Cheshire and Wirral Mental Health Team, will assess patients attending A&E with alcohol related disease and support access to community services thus offering alternative care to hospital as well as offering alcohol cessation support. This service is expected to be fully operational during the Spring of 2011.

### **Partnering Volunteers**

The Trust has a very long and happy tradition of welcoming volunteers from our local community into wards and departments, and works closely with the many voluntary organisations that raise funds or provide services for patients and staff.

Currently, more than 350 volunteers offer support and assistance to staff, patients and visitors. Around 200 volunteers are supported by the Voluntary Services Manager, while many others work for organisations such as the ABC Association, the British Red Cross, The Hospital Broadcast Service, the League of Friends, the Ray of Hope Appeal and the WRVS.

The contribution of all volunteers is greatly valued by the Trust and an annual Volunteers Evening is organised to thank volunteers and to reward long service. In addition coffee mornings were held and newsletters published to keep volunteers up to date with Trust news and other issues which may be of interest.

### **Partnering Patients and the Public**

The Local Government and Public Involvement in Health Act (2007) details the duty on 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.

An example includes the pathway redesign for orthopaedic hip and knee replacements. This clinically led project included consideration of patients experience from their first contact with their GP to the provision of physiotherapy, hospital appointments, preoperative assessments and subsequent inpatient stay, equipment and other aids as well as discharge with planned follow up care. The revised pathway is now in the process of being implemented and further patient engagement will be undertaken to monitor improvements during 2011/12.



## ***Strong Independent Foundation Trust***

### ***Delivering on Financial Performance***

During 2010/11 the Trust has continued its strong financial stewardship delivering an income and expenditure surplus of £2.7m, however a significant element of this (£1.1m) was due to gains associated with a revaluation of the Trust's estate. This gives a normalised surplus of £1.6m, representing a small reduction on the previous years' surplus and underachieved against the planned surplus of £2m.

This underperformance is primarily attributed to an agreed cap on income from Central and Eastern Cheshire Primary Care Trust in order to support what continued to be a financially challenged Local Health Economy.

Overall the Trust's financial performance remains sound and this is reflected in an anticipated score of 3 against Monitor's financial risk rating, maintaining the level achieved in 2009/10.

The Trust's full accounts can be found from page 135.

### ***Analysis of Income***

The total income received by the Trust in the financial year was £169,760k. This represents an increase on the previous year of £5,258k or 3.2%. However, this includes £1,619k attributable to reversal of previous years impairments associated with the Trust's revaluation of its estate. This gives a net normalised income increase of £3,639k which represents a 2.2% increase.

An analysis of key income streams can be seen below :

#### *Analysis of Income 2010/11*

<b>Income Source</b>	<b>2010/11 £000s</b>	<b>2009/10 £000s</b>	<b>Change £000s</b>	<b>%</b>
Patient Care Activities	149,047	148,320	727	0.5
Education and Training	5,266	5,218	48	0.9
Non Patient Care Services to Other Bodies	10,716	7,890	2,826	35.8
Income from impairment	1,619	-	1,619	-
Other Non-Clinical Income	3,112	3,074	38	1.2
<b>Total</b>	<b>169,760</b>	<b>164,502</b>	<b>5,258</b>	<b>3.2</b>

The significant increase of £2.3m in non patient care services to other bodies relates in the main to a recharge to East Cheshire Hospitals Trust for pathology staff who transferred to the Trust on the 1 April 2010 as part of the joint pathology collaborative.

## Trust Operating Expenses

The total operating expenditure incurred in 2010/11 was £163,320k, the key areas and comparison with 2009/10 can be seen below :

Expense	2010/11 £000s	2009/10 £000s	Change £000s	%
Employee Expenses - Staff	114,703	112,042	2,661	2.4
Supplies and Services - Clinical	12,006	11,771	235	2.0
Premises Costs	6,045	6,078	(33)	0.5
Drug Costs	8,166	8,037	129	1.6
Clinical Negligence Insurance	3,030	2,741	289	10.5
Services from other NHS Bodies	4,306	2,156	2,150	99.7
Other	15,064	15,914	(850)	(5.3)
<b>Total</b>	<b>163,320</b>	<b>158,739</b>	<b>4,581</b>	<b>2.9</b>

During the year the Trust employed an average of 3,034 full time equivalent staff, a decrease of 21 on the previous year. The average staff cost rose from £36.7k to £37.8k an increase of 3% resulting from annual cost of living rises and staff progressing through the salary scales.

Whilst clinical supplies, and premises costs have been contained below the inflationary increases expected, the costs of clinical negligence insurance continues to grow in line with national trends.

In previous years' annual reports the Trust highlighted the focus on prescribing costs, where increases have reduced significantly compared with the previous years' experience.

The significant increase in services from other NHS bodies is due to the transfer of therapy staff to Central and Eastern Cheshire Health for which a service charge is now made back to the Trust.

## Capital Investments

During the year the Trust made £5.3m of capital investment to improve services for both patients and staff. The key developments included completion of improved CT scanning facilities, refurbishment of 2 full wards, conversion of non clinical areas on wards to bedded areas and significant areas of asbestos removal to enable future ward refurbishments.

## Prudential borrowing limit

As an NHS foundation trust, the Trust is required to comply and remain within a prudential borrowing limit, which consists of two elements :

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

The Trust prudential borrowing limit is :

- Long term borrowing facility - £38.1m
- Working capital facility - £11m

In the financial year 2010/11, the Trust reported accumulated borrowings against the long term facility of £3.7m associated with finance leases. The Trust has not utilised its working capital facility during the year.

### ***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 2010/11 is at level 3, as compared with a plan of 3, as shown below :

<b>Metric 2010/11</b>	<b>Achieved Rating</b>	<b>Plan Rating</b>
Earnings before interest, tax, depreciation and amortisation (EBITDA)	3	3
EBITDA % of plan achieved	4	5
Return on Assets	4	4
Income and Expenditure surplus margin	3	3
Liquidity ratio	3	3
<b>Overall Rating</b>	<b>3</b>	<b>3</b>

The Compliance Framework covers a risk rating from "1" (very high risk) through to "5" (minimal risk). All financial monitoring returns were submitted on time and were complete and correct.

The tables below detail the governance ratings for 2009/10 and 2010/11.

*Table of Analysis – 2009/10 Governance Ratings*

	Annual Plan 2009/10	Q1 2009/10	Q2 2009/10	Q3 2009/10	Q4 2009/10
Governance Risk Rating		G	A	A	A
Mandatory Services	G	G	G	G	G

*Table of Analysis – 2010/11 Governance Ratings*

	Annual Plan 2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
Governance Risk Rating		G	G	AG	AR
Mandatory Services	G	G	G	G	G

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.

The tables on page 36 outline the Trust's quarterly ratings for 2010/11 along with a comparison against the 2009/10 rating. In 2010/11 the Trust declared a risk rating against the following targets:

- Achievement of the MRSA bacteraemia target. The target of 5 was significantly lower than the 2009/10 target. This was considered to be an ongoing risk.
- Clostridium difficile target for the year was 106 cases, again significantly reduced from 2009/10 target and, again, the Board felt that there was an ongoing risk due to increased incidences of norovirus.
- Compliance with access to healthcare for learning disabilities due to non compliance with all aspects of the 6 nationally determined criteria.

However, the Trust was delighted to have met all these targets and in particular with the achievement of no MRSA bacteraemia in year.

The Trust received an Amber/Red rating in Quarter 4 due to an underachievement against the 62 day cancer target. However, cumulatively for the year this target was achieved.

In addition, the Care Quality Commission raised moderate concerns in relation to medicine's management and care and welfare of people who use services in Quarter 4 which led to the amber/red rating. However, the Trust is pleased to confirm

that the action plan was delivered during April.

For the year the Trust underachieved against the thrombolysis target and action plans are in place going forward to address this.

### ***Payment of Suppliers***

The Trust operates a policy of payment of suppliers within terms agreed with suppliers, in most cases this is within 30 days of the invoice date. During the year ended 31 March 2011, the Trust paid 97% by value (2009/10 : 97%) of bills within this timescale. There has been no interest payments made under the Late Payment of Commercial Debts Act.

### ***Governance Declaration***

The Trust has reviewed the Foundation Trust Corporate Governance Manual and is satisfied that it can declare compliance.

### ***Private Patient Cap***

In accordance with Section 44 of the National Health Service Act, the Trust must not 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 was 1.5%, with actual income within this level at 0.97%.

### ***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. The LCFS works to ensure a

strong anti-fraud culture across the Trust.

### **External Auditors**

The existing Auditor (Deloitte LLP) were appointed in October 2008 for a five year period. The fee for audit was £70k as set out in 5.1 to the Accounts. This consists of

- Annual Audit Fee (£50k)
- Audit of Quality Accounts (£20k).

### **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 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 2011/12 plan which gives a surplus of £1.0m and a positive cashflow throughout the year.

### **Cost Allocation and Charging Requirements**

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

Guidance.

### **Data Loss**

There have been no serious untoward incidents involving data loss or confidentiality breaches during the year.

### **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 2010/11, 5.1% of total income was incurred on management costs.

Whilst this represents a small decrease on the previous year (2009/10 : 5.2%), 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.

## **Workforce Development and Effectiveness**

### **Staff Engagement**

#### **Investors in People (IiP)**

The Trust undertook its yearly IiP assessment from September 2010 to January 2011 and is delighted to report that not only has the Trust maintained its IiP status, but this year was also awarded the next level Bronze Status which means the Trust met 81 of the new IiP standards.

The assessment interviews took place with 4% of the Trust staff including 13 senior managers. The interviews were conducted by a team of internal assessors and an external assessor from Investors in People Northwest.

#### **Staff Survey**

The Trust participates in the NHS annual staff survey which usually takes place between September and December each year. For the 2010 survey, the Trust had a response rate of 57% and continues to report a response rate higher than the national average for acute hospitals in England.

A review of the findings shows that the Trust's score for staff engagement is 3.58 (possible scores range from 1 to 5 with 1 indicating that staff are poorly engaged and 5 indicating that staff are highly engaged). The national average for acute trusts for 2010 was 3.62 and whilst the Trust's score identifies a number of areas where staff experience has deteriorated, encouragingly there have been a number of areas where staff experience has also improved.

Areas of noted improvement were the percentage of staff reporting errors, near

misses or incidents witnessed in the last month, the percentage of staff appraised with personal development plans in the last 12 months and the percentage of staff appraised in the last 12 months.

Work on the action plans from the 2009 survey continues to take place within Divisions; in particular focus has been on the ten areas of the survey that the Trust chose to work on to make improvements. Some of the ten areas are as follows:

- % satisfied with quality of work and patient care they are able to deliver
- % feel valued by work colleagues
- % with a well structured appraisal
- % believe the Trust provides equal opportunities for career progression or promotion
- % report good communication between senior management and staff.

A "You said... we did" poster campaign took place in December 2010 to show staff that the Trust had listened to what was said and pointed to a variety of specific actions that have taken place as a result of survey feedback, for example, the introduction of a Ward Managers development programme to help address concerns reported about team working.

Analysis of the staff survey from 2004 to 2009 demonstrated that levels of staff engagement have shown a marked increase and at a much higher rate than comparable organisations.

Following release of the 2010 results, work continues to increase overall staff engagement. Areas where staff experience has deteriorated include staff intention to leave jobs and the Impact of health and well-being on ability to perform work or daily activities. A particular focus for the coming year is Key Finding 34 – Recommending the Trust as a place to



work and receive treatment and the Trust's overall staff engagement levels. The 'You said... we did' campaign will continue to ensure staff are aware the Trust continues to listen to what has been said, the Trust will continue with the Health & Wellbeing Strategy Implementation Plan, Divisional Action Plans will be monitored through the Divisional Quarterly Performance Reviews and Focus Groups will take place in May

and June 2011. Other actions include the continuation of the management development programme and continued availability of coaching and resilience training for all managers.

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

#### *Top four ranking*

Key Finding	Trust Score 2010	National Average	Difference on 2009
KF 12 – Percentage of staff appraised in last 12 months	88%	78%	+ 6%
KF19 – Percentage of staff saying hand washing materials are available	75%	67%	- 3%
KF21 – Percentage of staff reporting errors, near misses or incidents	99%	95%	+ 3%
KF22 – Fairness and effectiveness of incident reporting procedures	Scale Summary 3.60	Scale Summary 3.45	Scale Summary -0.01

#### *Bottom four ranking*

Key Finding	Trust Score 2010	National Average	Difference on 2009
KF1 – Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	71%	74%	- 3%
KF23 – Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	10%	8%	-
KF31 – Percentage of staff able to contribute towards improvements at work	57%	62%	- 2%
KF33 – Staff intention to leave jobs	Scale Summary 2.63	Scale Summary 2.53	- 0.16

## **Resilience Training**

Following training arranged through the North West Strategic Health Authority the Trust has three members of staff who deliver training sessions on Resilience, coping with stress and adversity. Managers and those who supervise staff have been targeted to attend this training which includes completing a psychometric profile on their current levels of resilience. The course aims to help staff build personal resilience in order to maintain high performance and positive well-being and how to help recognise and manage pressure in staff.

## **Coaching**

The Trust launched its internal coaching framework in January 2011 after thirteen staff had successfully completed the EMCC (European Mentoring & Coaching Council) Foundation Certificate in Coaching through I-Coach academy.

The Trust believes that by instigating a coaching culture it can help to develop a person's resilience, engagement, creativity, ability to deal with ambiguity and change, develop strategic thinking and leadership capacity.

The internal coaches will work on a one to one basis with individuals, to support them in developing their careers, to use reflection as a learning tool, deal with ambiguity and the changing pace and complexity of the NHS environment. Overall the Trust hopes that coaching will enable people to be empowered to make the right decisions at the right level and at the right time. As well as one-to-one coaching the Trust is also delivering a Coaching Essentials programmes to all managers to develop a strengthened coaching culture.

## **Leadership Development Programmes**

The Trust has a number of in house programmes:

*Bands 1 to 4* – National Vocational Qualification programmes

*Bands 5 and 6* – Becoming a Mid Cheshire Hospitals NHS Foundation Trust Manager. A twelve month programme covering a wide range of management and leadership topics, accredited by the Institute of Leadership & Management (ILM) and recognised by Manchester Metropolitan University (MMU) as one unit of a Masters Programme. The programme is now in its third year and there are plans to update the content and review the process for gaining a place on the programme for 2011/12.

*Bands 7 and 8a* – Managers Moving On. Similar to the Becoming a Mid Cheshire Hospitals NHS Foundation Trust Manager, the Managers Moving On programme is a twelve month programme, accredited by ILM and recognised by MMU as one unit of a Masters Programme. The programme is also in its third year and similarly there are plans to update the content and review the process for gaining a place on the programme for 2011/12.

*Ward Manager programme* – A seven month programme launched this year with twenty five attendees. It is planned to run the programme during 2011/12 for aspiring ward managers. The content of the programme covers leadership development and also considers issues raised within the Mid Staffordshire report in how the ward manager seeks assurance in respect of quality, safety and patient experience.

*Senior Leaders Programme* – This two year programme was launched in April 2010 and is facilitated by the

Advisory Board Company. The aim of the programme is to :

- Strengthen the collaboration and effectiveness of 'leadership partners' at both the Divisional and sub-divisional levels of the Trust
- Inspire leaders within the Trust to adopt a strong sense of the Trust vision and values for their own area of influence and the Trust as a whole and how they translate and communicate it
- Build the confidence and assertiveness of leaders within the Trust in order to improve both the making of and implementation of decisions
- Instil a powerful sense of ownership, accountability and responsibility for the larger interests of the Trust.

All of the above programmes (with the exception of the Ward Managers programme which is solely clinical) have both clinical and non-clinical attendance.

### ***Vocational Learning Skills for Life***

The Trust has divided the Skills for Life programme into 3 strands:

- **National Vocational Qualification (NVQ) Induction** – The Trust's NVQ Centre alongside the Trust's NVQ Training Provider undertake initial skills screening to determine learners who may have a literacy or numeracy need and to identify learners who would benefit from further assessments.
- **Induction** - The Trust's Welcome Day (induction day) for new staff involves an assessment of numeracy and literacy (paper based). Feedback is given to staff on an individual basis following the results. This is delivered and funded by a Training Provider and followed up with flexible courses for staff who wish to take up further development.

- **Skills Challenge** – a fun and motivating Skills Challenge was run by the Trust encouraging all members of staff to take up the Challenge. This intervention has acted as an excellent diagnostic tool to assess the numeracy and literacy needs of the Trust.

### ***National Vocational Qualification (NVQ)***

The Trust has a City and Guilds NVQ accredited Centre. Within the Centre there are 3 Internal Verifiers, 30 Assessors. The Trust has candidates who are progressing with the following programmes:

- Health and Social Care
- Health.

The Trust works alongside 2 training providers who deliver the following NVQ programmes:

- Business Administration
- Customer Service
- Leadership
- Team leading.

### ***Apprenticeships***

Apprenticeships are integrated work-based development programmes which reflect the application of knowledge and competencies required of the modern day multi skilled workforce, leading to nationally accredited qualifications. Apprenticeships are made up of three elements:

- National Vocational Qualification (NVQ)
- Technical Certificate – recognition of on-the-job development of competence, skills and knowledge
- Key skills – including Literacy, Numeracy and Computer skills.

The Trust has Apprentices who are successfully working towards the end of their apprenticeships with Knowsley



Community College. The apprenticeship programmes are:

- Business and Administration
- Health and Social Care
- Customer Services
- Team Leading and Management

### ***Work Experience***

During 2010 the Trust hosted 105 work experience students who were placed within various wards and departments across the Trust. Evaluations that have been received from the students show that students are motivated and enthusiastic about applying for positions within the NHS once they have completed their studies.

### ***Mandatory & Essential Training***

The Trust has seen a change in the way that the Mandatory and Essential Training Programme has been delivered since April 2010. The Trust has categorised the training, developed clear matrices which describe which pathway staff need to follow, as well as sending out individual training letters to staff advising which training courses they must attend during that year.

The booking procedures have also changed to allow key staff within each division to book their own staff onto a training course rather than having to contact Learning & Development to do so.

As a result of the change in procedures the Trust has achieved 'green' in the internal audit based around Mandatory Training.

### ***Health and Wellbeing***

The Trust is a host for a collaborative with East Cheshire NHS Trust to run the Cheshire Occupational Health Service. This service provides to a number of NHS, private and public sector organisations.

The Cheshire Occupational Health Service Model has been included as a case study of good practice in both regional and national publications of the future direction of Occupational Health. During 2010/11 a review has been undertaken of counseling services which has led to a decision to move to tender for a 24/7 Employee Assistance Programme Service.

The past year has also seen a significant step forward in the Trust's commitment to improving staff health and wellbeing. This progress reflects a genuine desire to offer opportunities for staff to improve their wellbeing and recognises the importance that good health plays in delivering improvements in the quality of patient care.

The Trust's approval of the Health and Wellbeing Strategy early in the year signalled the start of activity within this field. The Strategy document set out the vision for improving the physical and psychological wellbeing of the workforce and how this was to be achieved, following closely the key recommendations contained within the Boorman Report and the NHS Operating Framework.

The Director of Workforce and Organisational Development was identified as the Executive Lead to champion Health and Wellbeing and the Occupational Health Service Manager was acknowledged as the Senior Manager to lead on the implementation of the strategy. A Health and Wellbeing Steering Group has been established comprising a diverse range of staff from different groups and areas of the Trust. The purpose of this Group is to co-ordinate and plan activity in line with the Strategy and to evaluate its success.

The following strands were identified as core projects for the Group to focus on and project leads have been assigned to each area:

- **Emotional Wellbeing** - concerned with the psychological wellbeing of staff including work related stress and bullying & harassment in the workplace
- **Physical Wellbeing** - taking a proactive approach to help minimise musculoskeletal issues within the workforce
- **Nutrition** - providing advice on a healthy and balanced diet
- **Workplace Design** - concerned with addressing issues around workplace design (e.g. learning & development opportunities, coaching and addressing issues raised in annual staff survey)
- **Health Partnerships** - building on external links and network associations to improve learning and share best practice
- **Communications** - a core area concerned with raising the profile and awareness of activity in all of the above strands



The Steering Group launched a Health & Wellbeing logo as it was considered important to have a brand identity that brought the various strands of work together. There was already a good deal of work being implemented across the

Trust in relation to Wellbeing (e.g. a Green Travel Plan, Celebration of Achievement, Coaching, Lunch with the Chief Executive, etc.) and the introduction of a Wellbeing brand enabled all of this activity to be harnessed under one identity, making it easier for staff to relate to.

February 2011 also saw the launch of a Trust wide Health and Wellbeing Survey designed to gauge direct feedback from staff on what wellbeing initiatives are important to them and to give staff the opportunity to influence future activities. The survey closed at the end of March and the results will be analysed by members of the Steering Group in April.

The Steering Group is also planning a formal launch of Health and Wellbeing, scheduled for 18 May 2011. Staff across the Trust will be invited to come and find more out about how the Trust is supporting plans to improve staff Health and Wellbeing.

### ***Sickness Absence***

In the year ending 31 March 2011 the Trust set itself a target percentage attendance rate of 95.67% reflecting an annual sickness absence of 4.33%. The Trust is able to report that cumulative performance for the year was 95.64 %, reflecting an annual sickness absence rate of 4.36%.

### ***Equality, Diversity, Inclusion and Human Rights***

The Trust prepares a separate Annual Report on Equality, Diversity, Inclusion and Human Rights. The report for 2010/11 is scheduled to be published in September 2011. In outline, the year has been one of considerable progress. Amongst other things, the Trust has consulted upon and agreed its new Single Equality Scheme, undertaken audits on disability

access and on equal pay and received awareness training from people with learning disabilities, from trans people and from Gypsies and Travellers. The Trust's Customer Care Programme also highlights how staff can gain information and insight from groups in the community. The Trust has also reviewed the majority of its services for equality impact with the remainder to be assessed in 2011/12. Equality, Diversity, Inclusion and Human Rights has been the subject of a Board of Directors development event and the Board of Directors has confirmed its commitment to working with others to reduce health inequalities.

### ***Policies in relation to Disabled Employees & Equal Opportunities***

The Trust has an Equality Diversity and Human Rights Strategy which sets out the Trust's strategic direction for this agenda. During 2010/11 an Equality, Diversity and Human Rights in Employment Policy was developed and implemented to provide a framework within which the Trust will ensure that it fully meets legislative and regulatory requirements in Equality Diversity & Human Rights in employment and work 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.

The Trust's Mandatory and Essential Learning Policy and the Study Leave

Policy applies to all staff including disabled staff. Equality opportunity information including disabled staff is available on the Trust's website and is monitored through the Trust's Equality, Diversity and Human Rights Committee.

### ***Consultation with Employees***

The formal consultation and negotiation arrangements in place are the Joint Consultative and Negotiation Committee and the Joint Local Negotiation Committee. These committees meet regularly in accordance with their terms of reference and are attended by both management and trade union colleagues. For changes that take place in particular departments or services, consultation takes place in accordance with the Trust's Managing Organisational Change Policy.

The Trust has a 'Suggestives Scheme' which enables staff to put their ideas forward for consideration. Workshops were held during 2010/11 with both trade union colleagues and staff to ask for ideas for improvement and how these can be implemented. For more sustainable change, the Quality Matters Programme and the Productive Ward Programme have involved colleagues from across the Trust in designing and implementing changes to make improvements in the quality of services and general performance of the Trust.

Briefing sessions were held at the beginning of the 2010/11 financial year and an email was sent to all staff outlining the financial challenges ahead. This is included as part of the Trust Welcome Induction Day to encourage all new colleagues to play their part.

The Trust has a monthly Team Brief which is led by the Chief Executive or another member of the Executive Team. This



includes both 'need to know' and 'nice to know' items. In addition, the Trust intranet is used to post key news items for staff. There is also a quarterly newsletter for staff. Executive briefing sessions are held if there is an urgent communication for the Trust.

### ***Retention***

In the year ending 31 March 2011 the Trust set itself a target percentage retention rate of 91.68% reflecting an annual turnover rate of 8.32%. The Trust is able to report that cumulative performance for the year was 90.55%.

### ***Health and Safety***

In the financial year 2010/11 there were 32 reportable incidents to the Health and Safety Executive (HSE) as required by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). One incident was investigated further by the HSE who gave positive feedback in relation to management of health and safety in general and gave some recommendations where risk assessments could be improved.

The Trust is currently undergoing a major asbestos removal programme of work which is linked to work being carried out across the Trust regarding improvements to the building infrastructure in relation to fire protection. This improvement programme will continue until at least 2019.

In 2010/11 the Trust took part in the HSE's 'Safe and Sound at Work' campaign which included a number of training sessions delivered to staff and management representatives across the Trust. The sessions were delivered by Premier Partnerships and were designed to improve worker involvement in the development of a positive health and safety culture within the Trust.

### ***Emergency Preparedness***

The Trust has a Head of Emergency Planning who supports the Executive Director responsible for Emergency Preparedness. The Emergency Planning Group works with all divisions in the Trust to ensure the Trust is prepared in the event of a major incident.

### ***Local Resilience Forum***

Cheshire, Halton & Warrington Local Resilience Forum (LRF) was formed to ensure compliance with the requirements of the Civil Contingencies Act 2004. Senior representatives attend the Forum from all Category 1 responder organisations. Western Cheshire Primary Care Trust is the identified lead Primary Care Trust for Emergency Planning and represents all health sector organisations in Cheshire, Halton and Warrington.

There are a number of sub groups of the LRF and the Governance Manager from the Trust regularly attends the Health and Risk Assessment Groups. In addition to these groups, task groups established to manage particular risks including decontamination, heat wave and hospital evacuation are also regularly attended.

Local Health Economy Emergency Planning meetings were also initiated during 2010/11. The monthly meetings were attended by the Emergency Planning Officers from East Cheshire Trust, Central and Eastern Cheshire Primary Care Trust and Mid Cheshire Hospitals NHS Foundation Trust. The meetings have focused predominantly on the impending transfer of Cheshire East Community Health services to East Cheshire Trust from Central and Eastern Cheshire Primary Care Trust and the implications of these changes to Mid Cheshire Hospitals NHS Foundation Trust.

## **Major Incident Plan**

The Trust's emergency preparedness arrangements were audited by the Lead Primary Care Trust for Emergency Planning, Western Cheshire Primary Care Trust. The Head of NHS Resilience in Cheshire assessed the Trust's Major Incident Plan, the associated Action Cards, resource allocation, the staff involved, the command and control arrangements and the way in which emergency preparedness is monitored at the Trust. The Trust scored 96% against the assessment tool indicating that there are robust arrangements in place to maintain emergency preparedness and that the Trust is well placed to respond to any major incidents. Any deficiencies identified during this audit will be incorporated within the next review of the Major Incident Plan.

The Major Incident Plan was reviewed following the lessons learned during the command and control situation over the previous year in relation to swine flu and winter pressures. The latest version reflects the changes made to the Trust's out of hours management arrangements. The plan also now includes the Trust Road Fuel Shortage Plan which provides links to the National Emergency Plan for Fuel. The national heatwave guidance has been adapted for Trust use and now forms part of this version of the plan. Following this review the Plan was approved by the Board of Directors in December 2010.

A training strategy was developed and approved by the Emergency Planning Group. Training requirements were identified for all staff who may be involved in the Trust's response to a major incident. The training will be delivered by the Governance Manager in an ongoing programme.

## **Business Continuity Management**

The Trust is required to comply with the Civil Contingencies Act in relation to business continuity. A Corporate Business Continuity Plan has been developed that provides a framework for the Trust to respond to any incident that may result in an interruption of any of its services. The plan focuses on those services that are deemed essential by the Board of Directors. The Plan defines the commitment of the Trust and also details the process to be followed in order that local operational Business Continuity Plans can be developed.

The Corporate Business Continuity Plan was the subject of review by the Lead Primary Care Trust for Cheshire in November 2010 prior to a full audit in February 2011. The Plan was reviewed by the Head of NHS Resilience for Cheshire in line with the British Standards Institute BS 25999. Measured against these criteria the Corporate Business Continuity Plan performed well with a total score of 78%. An action plan was developed to address any deficiencies identified during this process. The full audit in February 2011, which assessed the Corporate Business Continuity Plan and also reviewed divisional, financial and information technology preparations gave a final score of 92%.

The Trust carried out its first Business Continuity Exercise in line with the Civil Contingencies Act and associated guidance. In attendance were representatives from Western Cheshire Primary Care Trust and Central and Eastern Cheshire Primary Care Trust in an advisory/ observational capacity. The Exercise met its objectives in identifying areas for improvement in both Divisional and Corporate Plans and in identifying weaknesses in the interconnectivity between Trust wide plans. The lessons

learned from the Exercise have been incorporated within the post audit action plan which will be monitored through the Integrated Governance Structure.

### ***Pandemic / Seasonal Influenza***

The Trust's response to the H1N1 Influenza Pandemic continued until August 2010 when the World Health Organisation declared an end to the pandemic. The Trust's experience of the H1N1 Influenza leads the Trust to believe that robust arrangements are in place which will allow the organisation to deliver both a flexible and proportional response, based on the needs of the local population.

During December 2010 seasonal flu cases began to escalate to previously unanticipated levels. As a result of this, and the anticipated winter pressures, the regional command and control structure was implemented led by Western Cheshire Primary Care Trust.

The majority of the impact of this outbreak was focused on the Trust's critical care areas and resulted in the implementation of both the Regional and Local Critical Care Escalation Plans. During December 2010/ January 2011 the situation was escalated to Stage 2 for Critical Care which meant that Trusts were requested to cancel all elective surgery except for urgent cancer patients and life threatening surgery.

## ***Fit for Purpose Infrastructure***

### ***Trust Premises***

In last year's Annual Report the challenges faced by the Trust in removing asbestos from the site, to enable developments to take place and the impact this had in complying with Cheshire Fire and Rescue improvement notices, were highlighted. Significant progress has been made in year with £1.4m of corridor refurbishment and £1.3m of further refurbishment covering two wards, which have dealt with the removal of asbestos and provided improved fire controls, at the same time as improving the ward environment for both patients and staff.

During the year there have also been a number of other investments in the Trust's premises including:

- Improvements in CT Scanning and Breast Screening facilities
- Conversion of side rooms into clinical areas
- Repair of gas mains to residential accommodation.

The Trust has also updated and replaced over £500,000 of Medical Equipment through leasing arrangements, key items include:

- Orthopaedic power tools
- Infusion pumps for administering medicines
- Scanner and retinal camera
- New ultrasound machines
- Blood gas analyser, allowing faster turnaround for diagnostic tests.

From 2011/12 the Trust will continue to progress its Hospital Corridors and Ward Refurbishment Programme and improve the facilities for the Fracture Clinic. However, the challenging economic



environment is likely to restrict the level of investment available which will still leave a number of areas requiring development in future years, in particular:

- Main theatres accommodation and intensive care
- Outpatient accommodation
- Neonatal critical care.

The main theatre development is currently being progressed to business case level and with intention to fund through long term borrowing.

The Trust plans to develop a charitable fundraising appeal to support the development of the Neonatal Intensive Care Unit.

### ***Information Management and Technology (IM&T)***

The Trust recognises the need to invest in modern information technology, which is key in such an information rich environment. During the year the Trust has implemented a fully integrated management information system and patient level costing system. This will allow faster, improved access to all information regarding a patient's visit in one place including the costs associated with the treatment.

Alongside the information about activity and cost, the next stage is to develop a joined up understanding of the quality of services to ensure the Trust can measure the cost and effectiveness of delivery in one place.

During the year there have also been a number of other IM&T investments, including:

- New maternity information system
- Improved resilience for business continuity

- Hardware replacement for the main Trust patient administration system
- Upgrade to the operational systems to deliver improved functionality.

### ***Fire Safety***

In October 2009 the Trust was issued with four enforcement notices from Cheshire Fire and Rescue Services (CFRS). In 2009/10 the Trust complied with two of the four notices. The two remaining notices require a programme of work to improve the fire integrity of wards departments and walkways over a number of years to meet modern day building standards. A programme of work has been in place throughout 2010/11 where a number of wards and walkways have been completely refurbished in compliance with the requirements of this notice. These works will continue over the coming years and will not be complete until 2019 at the earliest. Regular update meetings are held with CFRS to report and consult on progress made against the existing notices and to review the planned work schemes.

### ***Sustainability***

#### ***Introduction***

The Trust has a commitment to sustainability and presents below the general aims and principles of what is an extensive agenda for continuous development.

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 NHS Sustainability Unit provides leadership and support for NHS organisations to meet the challenge set.

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 continuous improvement in 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 2009/10	Tonne 2010/11	Disposal Cost 2009/10	Disposal Cost 2010/11
Total amount of waste produced by the Trust	1,635 #	1,080	£278,036	£273,574
Method of disposal (Landfill)	452	437	£47,572	£50,504
Method of disposal (Heat treated then deep landfill)	427	418	£160,323	£158,698
Method of disposal (Incinerated then deep landfill)	58	66	£34,935	£40,112
Method of disposal (Recycled)	696 #	159	£35,204	£24,260

# Includes circa 500 tonnes of abnormal one-off disposal.

## Finite Resource

Definition	Consumption 2009/10	Consumption 2010/11	Cost 2009/10	Cost 2010/11
Water	118,063 M <sup>3</sup>	117,301 M <sup>3</sup>	£388,598	£293,572
Electricity	7,013,611 kWh	6,237,792 kWh	£593,957	£536,983
Gas	24,835,000 kWh	26,263,911 kWh	£553,737	£663,126
Oil	215,556 kWh	816,278 kWh	£10,193	£43,070

## Summary Position

- Waste going to Landfill has reduced by 3.4%
- Heat treated waste has reduced by 2.2%
- Incinerated waste has increased by 13.8%
- Water usage reduced by 0.6%
- Gas consumption has increased by 5.8%
- Electricity consumption has decreased by 12.4%
- Oil usage due to additional testing of emergency preparedness capacity, has increased significantly.

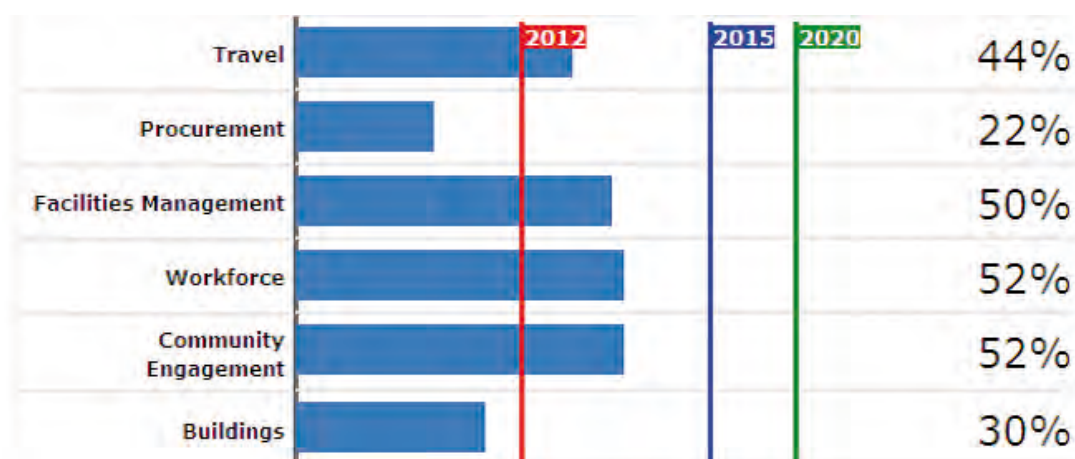
- Travel
- Procurement
- Facilities Management
- Workforce
- Community Engagement
- Buildings

Each section has three levels and the Trust scores its progress on a range between 0 to 10.

There are two target dates for partial compliance and a final compliance date of 2020. The Trust continues to make good progress towards complying with the 2012 targets and is well on the way to meeting the 2015 targets in four of the six categories.

## Good Corporate Citizenship

The NHS Good Corporate Citizenship Assessment Model Allows individual trusts to assess their organisations progress on sustainable development. The test is divided into six sections:







## Chapter 4

# Council of Governors

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. Our Council of Governors was formed with effect from 1 April 2008. As at 31 March 2011 our Council of 30 Governors consists of 23 elected Governors representing membership constituencies (10 Public Governors, 7 Staff and Volunteer Governors, 6 Patient and Carer Governors) and 7 appointed Governors.

Our appointed Governors represent a range of lay partner organisations that were selected to enhance the Foundation Trust's ability to contribute more widely to the public and social benefit. Terms of office for Governors is three years. Those Governors appointed to replace existing Governors where an election was not held, will hold the post for the remainder of the original term only, whilst those Governors appointed by means of election will hold the post for a term of three years from their elected date.

The term of our inaugural Council of Governors came to an end on 31 March 2011. In this regard, the Trust invited members from the Public, Patient & Carer and Staff & Volunteer Constituencies to stand for election. (Elections took place in 2010 for a Staff Governor – Non Clinical Support and Carer Governor – Carer of a Patient aged 16 years or more and so those Governors elected will be in post for three years from their elected date i.e. July 2010). Correspondence was also issued to our partner organisations, who in line with the Trust's Constitution appoint a Governor to Council, advising them the term of the existing Council was coming to an end and

inviting them to nominate a Governor. The newly elected and appointed Governors will be elected with effect from 1 April 2011.

The composition of the Council of Governors, as at 31 March 2011, is set out in Appendix 1 with a description of the constituencies as shown in the Membership section.

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:

- develop the membership of the Trust and represent the interests 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

A table summarising the Governor appointments and the constituencies they represent can be found at Appendix 1 on page 195.

General meetings of the Council are held in public. Since the 1st April the Council of Governors has met formally on 4 occasions. A summary of attendance is presented below with Governor Attendance continuing to be strong at Council meetings.

The number of meetings of the Council of Governors and individual attendance by Governors:

Name	29 April 2010	29 July 2010	21 October 2010	27 January 2011
Ames, Tracey	Yes	Yes	Yes	Yes
Amson, Derek	Yes	Yes	Yes	Yes
Baynham, Michael		Yes		
Blount, Betty		Yes		
Bowles, Brian	Yes	Yes	Yes	Yes
Cannon, David (1)	Yes	Yes	Yes	Yes
Carr, Susan			Yes	
Cooper, Christine	Yes	Yes	Yes	Yes
Dibben, Nigel			Yes	Yes
Dunning, John	Yes		Yes	Yes
Fairhurst, Gill	Yes			Yes
Gardner, Brian	Yes		Yes	Yes
Gray, Stuart		Yes	Yes	Yes
Hadfield, Michael	Yes	Yes	Yes	
Hopkins, Colin	Yes		Yes	Yes
Keenay, Lynne		Yes	Yes	Yes
Lakey, Lorna	Yes	Yes	Yes	Yes
Lyons, John	Yes	Yes	Yes	Yes
Macaulay, Brenda		Yes	Yes	Yes
Mawdsley, Harry	Yes	Yes	Yes	Yes
Nimmo, Peter		Yes	Yes	Yes
Parkinson, Charlie	Yes		Yes	
Paul, Neil	Yes	Yes	Yes	
Pordes, Philippa	Yes	Yes		
Ritchings, Andrew	Yes			Yes
Smart, Jane (2)	Yes		n/a	n/a
Stalker, Pat (3)	n/a	Yes	Yes	Yes
Walton, Brian (4)	n/a	Yes	Yes	Yes
West, Hazel	Yes	Yes	Yes	Yes
West-Burnham, Joss	Yes		Yes	Yes
Yates, Diane	Yes		Yes	Yes

## Notes :

(1) Cllr David Cannon was appointed to the Council of Governors as the Governor representative for Cheshire East Council following the resignation of Cllr Betty Howell. This appointment was effective April 2010.

(2) As a result of the winding up of Cheshire Community Voice, Mrs Jane Smart resigned from the Council of Governors effective September 2010. Cheshire Community Voice was subsequently removed from the Trust's Constitution as a partnership organisation from which a Governor was to be appointed.

(3) Mrs Pat Stalker was elected to the Patient & Carers Constituency – Carer of a Patient aged 16 years or more. This appointment was effective July 2010.

(4) Mr Brian Walton was elected to the Staff & Volunteers Constituency – Non Clinical Support Staff. This appointment was effective July 2010.

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.

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

### ***Membership of Council Committees as at 31 March 2011***

<b>Committee</b>	<b>Current Members</b>	<b>Meeting Dates</b>
Membership & Communications Committee	Mrs Betty Blount Mr Brian Bowles Mr John Lyons Mr Peter Nimmo Mrs Diane Yates	10 May 2010 14 June 2010 12 July 2010 9 August 2010 13 September 2010 11 October 2010 8 November 2010 17 January 2011 14 February 2011 14 March 2011
Nominations & Remuneration Committee	Ms Tracey Ames Mr John Dunning Mr John Lyons Mr Michael Hadfield	5 October 2010
Strategy Committee	Mrs Christine Cooper Mr Nigel Dibben Mr Stuart Gray Mr John Lyons Mrs Diane Yates	22 April 2010 2 June 2010 14 July 2010 29 September 2010 9 February 2011

## Governor Involvement

Please find below details of the Governor Membership of Council of Governor (CoG) and Trust Committees with Governor representation (TC), as at 31 March 2011:

• Ms Tracey Ames	Nominations and Remuneration Committee (CoG)
• Mrs Betty Blount	Membership and Communications Committee (CoG)
• Mr Brian Bowles	Patients Experience Committee (CoG)
	Membership and Communications Committee (CoG)
• Mrs Christine Cooper	Strategy Committee (CoG)
• Mr Nigel Dibben	Strategy Committee (CoG)
• Mr John Dunning	Nominations and Remuneration Committee (CoG)
• Mr Brian Gardner	Equality & Diversity Committee (TC)
• Mr Stuart Gray	Infrastructure Development Committee (TC)
	Strategy Committee (CoG)
• Mr Michael Hadfield	Nominations and Remuneration Committee (CoG)
• Ms Lynne Keenay	Patients Experience Committee (CoG)
• Mrs Lorna Lakey	Patients Experience Committee (CoG)
• Mr John Lyons	Executive Workforce Committee (TC)
	Strategy Committee (CoG)
	Membership & Communications Committee (CoG)
	Nominations & Remuneration Committee (CoG)
• Mr Harry Mawdsley	QuEST Committee (TC)
• Ms Brenda Macaulay	Patients Experience Committee (CoG)
• Mr Peter Nimmo	Membership and Communications Committee (CoG)
• Dr Neil Paul	QuEST Committee (TC)
• Mrs Phil Pordes	Patients Experience Committee (CoG)
• Ms Hazel West	Strategic Integrated Governance Committee (TC)
• Mrs Diane Yates	Charitable Funds Committee (TC)
	Membership and Communications Committee (CoG)
	Strategy Committee (CoG)

Governors were also given the opportunity to become more involved in a number of other areas across the Trust as follows:

- |                              |   |
|------------------------------|---|
| • Clinical Services Strategy | • Patient Safety Walkrounds                   |
| • Complaints Review Panel    | • Patient Representatives on Divisional Board |
| • Labour Ward Forum          |   |
| • Health Promotion Group     |   |

## Lead Governors

Ms Tracey Ames was appointed as Lead Governor effective from 31 March 2010. In her role as Lead Governor, Ms Ames attended a number of Board of Directors meetings and there was a formal arrangement in place for her to meet with the Chairman following the Board of Directors meetings where there is the opportunity to raise any issues of concern. Ms Ames also met with the Chairman to discuss how the role of Governor could be enhanced within the Trust.

- 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, in particular equality groups
- Governors have attended, at the invitation of members, local community groups to meet and discuss activity of the Trust

## General engagement with Governors and Members

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

The key focus for 2011/12 will continue to be membership engagement with a full review of the Membership Strategy having been completed.

Attendance of the Members of the Board of Directors at the Council of Governor meetings is as set out below:

## Attendance of Board Members at Council of Governor Meetings

Name	29 April 2010	29 July 2010	21 October 2010	27 January 2011
<b>Executive Directors</b>				
Mr P Morley	Yes	Yes	n/a	n/a
Mrs R Alcock				
Mrs T Bullock		Yes	Yes	Yes
Dr P Dodds				Yes
Mrs D Frodsham	Yes		Yes	
Mr M Oldham				Yes
Mrs J Smith	n/a	n/a	n/a	n/a
<b>Non Executive Directors</b>				
Mr J Moran	Yes	Yes	Yes	Yes
Mr M Chandler	Yes	Yes	Yes	Yes
Mr W Craig	Yes	Yes	Yes	Yes
Mr D Dunn	Yes		Yes	Yes
Mrs V Godfrey		Yes	Yes	Yes
Mr D Hopewell		Yes		
Dr A Wood	Yes	Yes	Yes	Yes



Attendance at Council of Governor meetings is not obligatory for the Executive Directors. Executive Directors attend as and when requested either by Council or the Chief Executive.

At the end of the public open meeting, the public and members of the Board of Directors leave the Council of Governors who then have a private meeting with the Chairman.

### ***Nominations and 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:

- Appoint the Chairman and Non Executive Directors of the Trust
- Consult and advise the Council on their proper level of remuneration and allowances
- Approve the appointment of the Chief Executive.

The Committee met once during 2010/11 on 5 October 2010. The meeting was held to discuss the outcome of the Annual Appraisal of Non-Executive Directors. The Committee were satisfied that all Non Executive Directors are operating to the required standard and encouraged the Chairman to continue to have interim appraisal meetings with Non Executive Directors and conduct a year end appraisal as soon as possible after the Trust financial year end in March 2011. The Committee also considered the skills analysis of the Non Executive Directors and are satisfied that a good balance of necessary skills exists within the Non Executive Director team.

The Council of Governors were also involved in the appointment of Mrs Tracy Bullock as Chief Executive Officer. Veredus were appointed to assist in the selection process with the short-listed candidates participating in round table discussions and presenting on a set topic on the evening of Thursday, 7 October 2010, followed by a formal interview on Friday, 8 October. One of the members of the Committee was included on the Interview Panel for the short-listed candidates and subsequently details of the recruitment and selection process, was provided to the Council of Governors as a whole for ratification.

### ***Attendance at the Committee meetings:***

	5 October 2010
Mr J Moran (Chairman)	Yes
Ms T Ames	Yes
Mr J Lyons	Yes
Mr J Dunning	
Mr M Hadfield	Yes

## Chapter 5

# Board of Directors

The Board of Directors comprises seven Non Executive Directors, including the Chairman and six Executive Directors with voting rights, including the Chief Executive.

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

A profile of Board Members as at 31 March 2011 is at Appendix 2.

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 4 and Appendix 1).

The Board meets monthly throughout the whole year. The Board 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 – set out in a letter of understanding. 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 of the Council and in setting of their agendas. The Chairman is also responsible for ensuring the Board and the Council work together effectively. The Chairman also ensures effective and efficient communication channels exist with patients, members, clients, staff, partner organisations and key stakeholders. The Chairman also 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 Chief Executive is accountable for executing the Foundation Trust's strategy as agreed by the Board 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 full list of skills and experience can be found in Appendix 2.

The Board also has a development programme for the year which is critical to its continuous learning and development. This was developed by the Chairman and Chief Executive.

The Board recognises the value of a regular performance review and has a bespoke half yearly review of its performance against key roles. 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 also appointed a Senior

Independent Director who leads the process of appraising the Chairman. The appraisal process for the Chief Executive is conducted by the Chairman. A review of the Board will be completed in the coming year by conducting a 360 degree appraisal by the Council of Governors and a cross section of staff within the Trust. The Board review will take place using a revised version of the Board Effectiveness Model which was developed by the NHS Institute for Innovation and Improvement in 2010. The model describes 3 core roles of a highly effective Board: (1) gaining insight; (2) defining expectations; and (3) holding to account. The assessment will be used to determine the development needs of the Board and it is anticipated that a program of further development will be in place by June 2011.

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 31 March 2011 are set out below:

Name	Position	Term of Contract	Date of Appointment	Unexpired Term	Notice Period	Liability for Early Termination
Moran J	Chairman	4 year Term	1 July 2008	1 year 3 months	None	None
Craig WD	Non Executive Director	3 year Term	1 February 2006	1 year 10 months	None	None
Chandler M	Non Executive Director	4 year Term	1 August 2007	4 months	None	None
Dunn D	Non Executive Director	3 year Term	1 May 2009	1 year 1 month	None	None
Godfrey V	Non Executive Director	3 year Term	1 May 2009	1 year 1 month	None	None
Hopewell D	Non Executive Director	4 year Term	1 December 2007	8 months	None	None
Wood A	Senior Independent Director / Deputy Chair	3 year Term	1 March 2002	1 year 7 months	None	None

Name	Position	Term of Contract	Unexpired Term	Notice Period	Liability for Early Termination
Bullock T	Chief Executive	Permanent	N/A	6 months	6 month's salary
Alcock R	Director of Workforce & Organisational Development	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	Director of Performance & Service Planning	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
Smith J	Director of Nursing & Quality	Permanet	N/A	6 month	6 month's salary

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

### ***Attendance of Members***

The membership and attendance at Board Committees can be found in Appendix 3 on page 203.

## ***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, the Non Executive Directors and the Chief Executive. Meetings will be held with the Chairman of the Board and at least two Non Executive members in attendance.

The Chief Executive shall not be present at any meeting of the Committee where the Chief Executive's appointment or remuneration is under discussion.



The Remuneration Committee met four times during the year, the members and attendance are shown below:

Member	Attendance
<b>Non Executive Directors</b>	
Mr. J Moran (Chair)	4
Mr. M Chandler	4
Mr. W Craig	4
Mr. D Dunn	3
Mrs V Godfrey	4
Mr. D Hopewell	4
Dr. A Wood	4
<b>Executive Director</b>	
Mr. Phil Morley (as Chief Executive)	2
Mrs Tracy Bullock (as Chief Executive)	2

### ***Remuneration of Senior Managers Policy***

Executive and Associate Directors receive a fixed salary established at the beginning of each year, and are determined using a job scoring system linked to average public sector salaries for similar job scores. The levels of pay for Executive and Associate Directors were set by the Board as recommended by the Nominations and Remuneration Committee at the meeting of 2 August 2010.

At this meeting, it was agreed that Executive Directors would not receive any cost of living increases for the financial year 2010/11.

In 2010/11, 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. However, each Executive will have agreed objectives and their performance will be 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 and Associate Directors has a permanent contract and a notice period. At 31 March 2011, the termination period for all Executive and Associate Directors was six months. If a decision were made 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 (A to C) in the accounts on page 168-170. Benefits in kind relate to the provision of lease cars.



Tracy Bullock  
Chief Executive

### **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 Executive Assistant acting in the role of Trust Secretary. The following interests were recorded for 2010/11:

Director	Interest	Seeking to do business with health authorities	Has business dealings with the Trust
Mr. M Chandler	Director of Too Young Co Ltd. Owner of Chandler Associates Chairman of Environment Africa Trust	*	
Mr. D Dunn	Pro Vice Chancellor of Manchester Metropolitan University	*	
Mrs V Godfrey	Member of the Local Management Committee of Sandiway Manor	*	
Mr. D Hopewell	Finance Director of Charitable Trust, Retrak	*	
Mr. J Moran	Director of F Squared Limited Director of Moran Business Advisory Services Ltd	*	

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

### **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 Overview and Scrutiny Committee at least once a year, concerning 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.

The Trust maintains regular contact with local GPs, with the Primary Care Trusts and with the NHS North West Strategic Health Authority. More recently the Chief Executive and Deputy Chief Executive, Medical Director have formed a senior leaders meeting with the Consortia Chairs to establish a strategic direction for the health economy. The Trust worked closely with Cheshire East Council and Cheshire West & Chester Council departments responsible for child care and social care.

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.

### **External Auditor**

Deloitte LLP is the Trust's appointed external auditor. There are no known conflicts of interest that need to be addressed by the Auditor or the Audit Committee.

### **Audit Committee**

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

During 2010/11 the Committee met on these occasions with the following attendance:

### **Attendance at Audit Committee Meetings**

Name	19 April 2010	1 June 2010	9 August 2010	11 October 2010	13 December 2010	14 February 2011
Mr. M Chandler	Yes	Yes	Yes	Yes	Yes	Yes
Mr. W Craig	Yes	Yes	Yes	Yes	Yes	Yes
Mr. D Dunn	Yes	Yes	No	Yes	Yes	No
Mrs V Godfrey	Yes	Yes	Yes	Yes	Yes	Yes
Mr. D Hopewell (Chair)	Yes	Yes	Yes	No	Yes	Yes
Dr. A Wood	Yes	Yes	Yes	Yes	No	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
- 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 a Statement of Internal Control. 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.



A & E  
Department  
**NHS**  
Mid Cheshire  
Hospitals



## Chapter 6

# Membership

### *Membership commentary*

The membership in total has grown by 12.2% over the year in all constituencies and whilst the Trust has growth plans for 2011/12 the key focus for the year remains engagement with members.

The table overleaf shows the membership size and movement with estimates for 2011/12. In 2010/11 the Trust increased representation in all Constituencies.

A key focus for Council of Governors for the year 2011/12 will continue to be ensuring proportional representation in all areas, age ranges and constituencies and active engagement with members. An Equality Impact Assessment of the Membership Office has been completed and a number of actions identified to ensure there is effective engagement across the local community as a whole.

The Trust has a range of measures that engage our members throughout the year, these include:

- i) Staff Governor surgeries
- ii) Member meetings on specific clinical issues
- iii) Regular newsletters
- iv) Website
- v) Annual General meeting
- vi) Governor meetings to which members are invited
- vii) Trust consultation events
- viii) Recruitment drives

Governors are actively involved in out-reach to their members, and run specific initiatives to recruit new members at events held in the region.

Regular reports on membership and plans for developing recruiting and engaging members, go both to the Board of Directors and the Council of Governors.

Members can contact the Board of Directors and Council of Governors by means of 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 public catchment area of the Congleton part of Cheshire East, the area of the Crewe and Nantwich part of Cheshire East or the area of the Vale Royal part of Cheshire West & 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 5 years preceding the application for membership.

**Staff & Volunteers Member:** Staff automatically become staff members unless they choose to opt-out. An individual may become a Volunteer member if they are registered with the Trust to undertake voluntary work at the Trust's premises, or in services managed by the Trust, 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.

**Membership size and movements**

Public constituency	Last year	Next year (estimated)
At year start (1 April)	3,629	4,022
New members	483	200
Members leaving	90	100
At year end (31 March)	4,022	4,122

Staff constituency	Last year	Next year (estimated)
At year start (1 April)	2,596	2,748
New members	415	75
Members leaving	263	50
At year end (31 March)	2,748	2,773

Patient constituency	Last year	Next year (estimated)
At year start (1 April)	976	1,309
New members	351	125
Members leaving	18	50
At year end (31 March)	1,309	1,384

The Trust attained its membership target of 8,000 and in this regard the key focus for the coming year will be on engagement with the existing membership, sustaining existing membership numbers, rather than recruitment of new members.

**Analysis of current membership**

Public constituency	Number of members	Eligible membership
Age (years):		
0 - 16	19	4,188
17 - 21	203	17,344
22 +	3,624	236,756
Undisclosed	176	
Ethnicity:		
White	3,521	254,944
Mixed	10	1,643
Asian or Asian British	27	489
Black or Black British	18	756
Other	4	276
Undisclosed	442	



Public constituency	Number of members	Eligible membership
Socio-economic groupings:		
ABC1	2,803	136,570
C2	959	39,224
D	149	42,105
E	111	36,635
Gender:		
Male	1,780	125,102
Female	2,088	133,005
Undisclosed	154	
Patient constituency	Number of members	Eligible membership
Age:		
0 - 16	1	n/a
17 - 21	24	n/a
22 +	1,212	n/a
Undisclosed	72	

### ***Analysis of election turnout***

Two by-elections took place over the year 2010/11. One within the Staff & Volunteers Constituency – Non Clinical Support Staff and the other, Patient & Carers Constituency – Principal Carer of a patient aged 16 years or more.

Within the Staff & Volunteers Constituency the candidate was elected unopposed whilst in the Patient & Carer Constituency, two candidates stood for election with the following voting report received:

Number of Eligible Voters	14
Total number of Votes Cast	7
Turnout	50%
Number of votes found to be invalid	0
Number of votes blank or spoilt	0
No declaration forms received	0
Total number of valid votes to be counted	7

The by-elections were hosted by the Electoral Reform Service.

The inaugural term of the Council of Governors came to an end on 31 March 2011 and the election results for the Council of Governors appointed, effective 1 April 2011, will be reported in the Annual Report 2011/12.





## Chapter 7

# Quality Account 2010/11

### Part 1

#### *Summary Statement on Quality from the Chief Executive*

I was appointed to the position of Chief Executive in October 2010, having been the Deputy Chief Executive and Director of Nursing at the Trust for the previous 5 years, and I am delighted to present our second published Quality Account for the period of April 2010 to March 2011.

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

As an organisation, we strive to deliver the best possible service and quality of care to our patients and carers, whilst consistently looking for areas of further improvement.

During 2010/2011, we have continued to make significant progress against our five year “10 out of Ten” Quality and Safety Improvement Strategy which was launched in 2009. The priorities in the Strategy are focussed around the four domains of quality and are intended to improve outcomes, experience, safety and effectiveness. In particular, we have agreed baseline data for our top ten criteria and embedded these principles in the appraisal process so that all staff are actively involved in processes to reinforce the importance of quality for our patients.

This message is reinforced to our staff through the promotion of our values and behaviours which are made available at training sessions and during appraisals. The values and behaviours that we ask our staff to embrace are:

#### Values

- Commitment to quality and safety
- Respect, dignity and compassion
- Listening, learning and leading
- Creating the best outcomes together
- Every1Matters

#### Behaviours

- I will act as a role model
- I will take personal responsibility
- I will have the courage to speak up and make my voice heard
- I will value and appreciate the worth of others
- I will play my part to the best of my ability

I am particularly proud of the Trust's performance in a number of key quality areas such as having zero MRSA bacteraemias over the past 12 months. This is a commendable achievement for all clinical areas within the Trust. The Trust's mortality rates have previously been higher than the national average. However, over the last 12 months we have seen a rate of improvement that has been faster than the national average and for the past two consecutive months, we have performed better than the peer average. We have continued our implementation

of initiatives as part of the Patient Safety First Campaign and the Leading in Patient Safety Programme which includes the introduction of patient safety walkrounds with Trust Board Members and Governors.

As part of our Quality Matters programme we have redesigned the way our operating theatres work to improve productivity and patient experience. This has been a huge undertaking and I am grateful to all the staff who have been part of making this happen, whether through providing leadership and direction or through cooperation and embracing the significant change process.

In January 2011 we launched our coaching framework and currently have thirteen qualified coaches available to support our staff. Coaching is fundamental to the development of our staff especially during times of significant transition and will ensure that, as an organisation, we have invested in our staff to enable them to give their best.

The work we have undertaken over the past year to improve the care offered to adults and children with a learning disability was recognised recently when the Trust won a Northwest Positive Action Award for Excellence in Clinical Care. This is something that we are particularly proud of and the learning from this will be rolled out to improve services for other vulnerable groups of patients such as those with Alzheimer's and other forms of Dementia.

We were also highly commended by the Northwest Stroke Collaborative (Stroke 90:10) for improvements in care we delivered for patients following a stroke. This included undertaking specific treatment and investigations within 24 hours of admission. As a result of this work our overall national performance in relation to stroke care has improved significantly from the lower quartile to the

middle quartile. Within some key indicators recorded, we are performing within the upper quartile. We recognise there is still work to do and believe we have the right calibre of dedicated staff to ensure this important service for our patients continues to progress.

I would like to take this opportunity to thank and congratulate all our staff in their achievements over the past year. 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  
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## **Statement of Directors' Responsibilities in Respect of Quality Accounts.**

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.

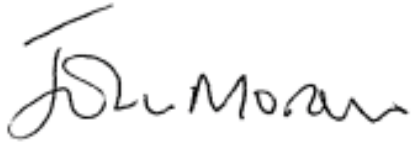
Monitor has also issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010-2011
- The content of the Quality Report is consistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2010 to March 2011
  - Papers relating to Quality reported to the Board over the period April 2010 to March 2011
  - Feedback from the commissioners (Central & Eastern Cheshire Primary Care Trust) dated 04/05/2011
  - Feedback from governors dated 17/05/2011
  - Feedback from LINKs dated 05/05/2011
  - Feedback from Overview and Scrutiny Committee dated 23/05/2011
- The Trust's complaint report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, and was laid before Parliament dated 19/05/2011
- The 2010 national patient survey
- The 2010 national staff survey
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 01/06/2011
- Care Quality Commission (CQC) quality and risk profiles dated 26/04/2011
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review. The Quality Report has been prepared in accordance with Monitor's annual reporting guidance

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

A handwritten signature in black ink that reads "John Moran". The signature is written in a cursive style with a large initial 'J'.

Chairman  
Mr John Moran  
June 2011

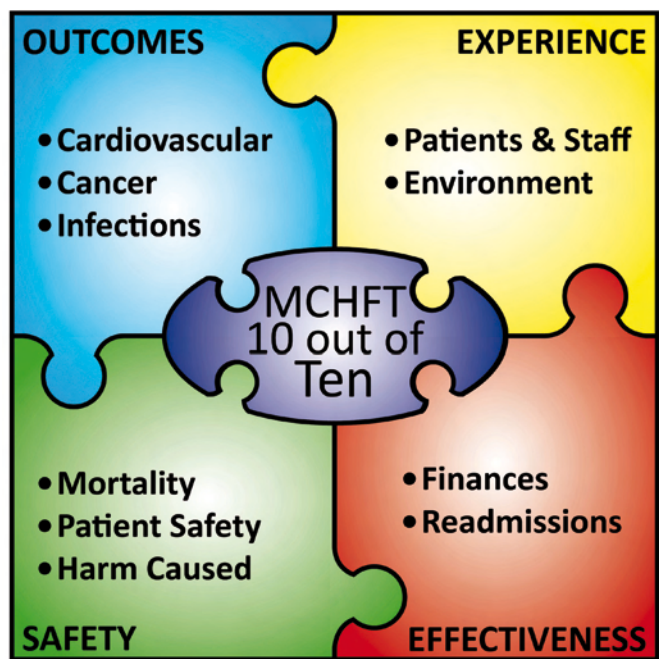
A handwritten signature in black ink that reads "Tracy Bullock". The signature is written in a cursive style with a large initial 'T'.

Chief Executive  
Mrs Tracy Bullock  
June 2011

## Part 2

### **Priorities for improvement in 2011/12 and Statements of Assurance from the Board**

The Trust has continued to be involved in many quality and safety improvement initiatives, which will all help achieve the key priorities for 2011/12. The Quality & Safety Improvement Strategy has mapped out the priorities of improvement for 2010/14 and is largely focused around the 10 out of Ten programme. These priorities are based on the four domains of quality and are intended to improve outcomes, experience, safety and effectiveness.



The Trust aims to be in the top 10% of all secondary care providers in England in ten agreed indicators of quality by 2014. Year two of the 10 out of Ten programme has successfully achieved the following objectives:

- Identify the Trust top ten metrics with baseline data
- Set stretch targets where baseline data was available
- Embed individual objective setting as part of the appraisal process
- Publish the Quality & Safety Improvement Strategy

Year three of the programme intends to progress plans to improve outcomes against the ten criteria identified which were previously agreed following a public and staff consultation.

## **Safety**

### **Mortality**

#### **Aim:**

To reduce mortality rates by 10 points in patient groups where death is not expected.

#### **Monitored:**

A Hospital Mortality Reduction Group has been established which is 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 the 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) to identify the low mortality healthcare resource groups (HRG's). Any HRG with less than 0.05 probability of death is used for calculation purposes. This system provides monthly information so that the Trust can closely monitor mortality rates with the aim of seeing a 10 point reduction by 31 March 2011.

### **Patient Safety**

#### **Aim:**

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

**Monitored:**

The episodes are monitored through the Integrated Care System (ICS) which is a patient management system used by the Trust.

**Measured:**

The number of patient moves during each emergency or unplanned admission will be measured using the Trusts Management Information System. The clinical divisions monitor this information on a monthly basis.

**Harm Caused**

**Aim:**

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

**Monitored:**

The Patient Safety Team review 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.

**Measured:**

The Trust's incident reporting system is used to determine the number of patients who suffer avoidable harm. In addition to learning from the National Leading Improvement in Patient Safety (LIPS) programme the Trust is considering reviewing healthcare records using the Global Trigger Tool to determine if avoidable harm was caused.

**Effectiveness**

**Readmissions**

**Aim:**

To reduce the number of patients who are readmitted to hospital within 7 days of discharge.

**Monitored:**

Readmissions to hospital within a 7

day period following discharge as an emergency admission are being monitored by the clinical divisions on a monthly basis.

**Measured:**

Readmission rates have previously been monitored on a monthly basis for patients who were readmitted as an emergency. The Trust now monitors readmissions within a 7 day period and 30 day period.

**Finance**

**Aim:**

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, compared with available benchmarking data with the intention of 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 total actual expenditure.

**Experience**

**Patients & Staff**

**Aim:**

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

**Nursing**

2010/11 – 60% of wards to be within required establishment.

2011/12 – 75% of wards to be within required establishment.

2012/13 – 90% of wards to be within required establishment.

2013/14 – 100% of wards to be within required establishment.



## Doctors

By 2014 the ratio of doctors to each patient bed will be in line with the Royal College recommendations for each clinical speciality.

### 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.

The European Working Time Directive (EWTD) and data from Doctor Foster has been used in the monitoring of medical staff. This is being used as the safety assessment in calculating the ratio of medical staff to inpatient beds.

### Measured:

The Nursing and Midwifery Acuity Group reviews the results of the Association of UK University Hospitals (AUKUH) acuity/dependency monitoring tool which is used to assess the numbers of nursing staff required in adult inpatient wards. The monitoring process is undertaken every 6 months. Similar tools for nurses and midwives working in other areas of the Trust and for medical staff will be reviewed, implemented and evaluated.

\*acuity - a description of how unwell a patient is.

## Environment

### Aim:

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 bi-monthly and reports to the Patient Experience Committee.

### Measured:

The DSSA group reviews incident reports and patient feedback (via surveys, complaints and the Patient Advice and Liaison Service). 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 in conjunction with progress against the privacy and dignity care indicator results.

## Outcomes

### Cardiovascular

#### Aim:

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

#### Monitored:

The data relating to the mortality in AMI within 30 days is collated by the Trust using CASPE Healthcare Knowledge Systems (CHKS) on a monthly basis.

#### Measured:

CHKS currently measures these mortality levels and benchmarks the Trust against its peer organisations.

### Cancer

#### Aim:

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

#### Monitored:

The baseline data for acute admissions and length of stay has been established.

#### Measured:

The Acute Oncology Unit measures reasons for acute admissions and ensures achievement of preferred place of care for

patients diagnosed with cancer.

### **Infections**

#### **Aim:**

To reduce the rates of healthcare acquired infections:

- Methicillin-Resistant Staphylococcus aureus (MRSA) – zero blood stream bacteraemias
- Clostridium difficile – to perform better than the nationally agreed target.

#### **Targets**

2010/11 MRSA - 5

2010/11 Clostridium difficile - 106  
(National targets are agreed annually).

- Urinary tract infection – Following receipt of National guidance it has been agreed that the Trust will monitor the incidence of urinary catheter insertion.

#### **Monitored:**

MRSA and Clostridium difficile are monitored on a monthly basis and reported to the Strategic Infection Control Committee and Central and Eastern Cheshire Primary Care Trust. The Trust is currently developing a methodology for collecting appropriate information in relation to urinary tract infections.

#### **Measured:**

The rates of MRSA and Clostridium difficile are measured and benchmarked nationally by the Health Protection Agency (HPA). There is currently no nationally recognised measure for urinary tract infections.

### **Monitoring & Reporting of 10 out of Ten via the Quality, Effectiveness & Safety Committee**

In recognition of the priority given to quality and safety, the Board of Directors has established an Executive Committee known as QuEST (Quality, Effectiveness and Safety). This Committee meets bi-monthly, reports to the Board of Directors and is chaired by the Chief Executive.

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

QuEST oversees the quality of patient care across the organisation. It provides the strategic direction and vision for the provision of quality and safety improvement across the Trust. It lends support and guidance to all staff to improve quality and safety.

Patient safety incidents and actions taken/planned are also reported to the Board of Directors by the Medical Director. All patient safety incidents are reported in the Integrated Governance Quarterly Assurance Report which includes lessons to learn and changes in practice. The report is discussed at the Operational Integrated Governance Committee which has representation from all of the divisions.

The priorities for 2011/12 were arrived at through a number of mechanisms:-

- Those outlined in the quality and safety improvement strategy
- Those mandated or suggested by Monitor and the Department of Health
- Those identified in the Quality Account published in 2010/11.

The views of relevant stakeholders, public and staff were taken into account when deciding the areas for inclusion.

The extent of this consultation is included within the section on the Consultation on Quality.

### ***Statements of Assurance from the Board***

The following statements relate to; the review of services, participation in clinical audits and research, commissioning for quality and innovation framework, the Care Quality Commission and data quality. The aim is to offer assurance to the public that the Trust is performing to essential standards as well as providing high quality care to patients.

### ***Review of Services***

During 2010/11, the Trust provided and / or sub-contracted 39 NHS services.

The Trust has reviewed all the data available to them on the quality of care in 100% of these NHS services.

The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by the Trust for 2010/11.

The review of services takes place through the development of the Trust's clinical service strategy which reviews all services in respect of:

- Service dimensions: such as population demographics, trading account position and whether or not the service is essential
- Service delivery: which looks at aspects relating to meeting performance

standards and targets / quality standards

- Service design: which reviews where the service is located, for example: centrally or in the community
- Service development: which explores planned changes to services over the next five years
- Service decisions: which considers, based on the above, if the Trust is best placed to deliver the service in its current form

### ***Participation in Clinical Audits***

#### ***Clinical audit***

The Trust is committed to embedding clinical audit throughout the organisation, as a process for improving the quality of healthcare provided. In order to achieve this, during 2010/11, the Trust developed a Clinical Audit Strategy (2010/13) and adopted the Good Governance Institute Self Assessment Maturity Matrix. This was developed in conjunction with the Healthcare Quality Improvement Partnership (HQIP) to address clinical audit at Board level.

The Trust has a comprehensive programme of national and local clinical audit projects that is supported through a central clinical audit department. The Effective Clinical Practice Group reports quarterly to the Operational Integrated Governance Committee, with escalation to Strategic Information Governance Committee as necessary. The majority of national comparative audit projects in which the Trust participates are part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP) which is funded through HQIP. Local clinical audit projects are supported by the central clinical audit function and form an essential part of the Trust's governance structure.

During 2010/11, 41 national clinical audits and 1 national confidential enquiry covered NHS services that the Trust provides. This equates to 70% of the national clinical audits and 100% national confidential enquiries of the total number in which the Trust was eligible to participate.

The full list of national clinical audits and national confidential enquiries is shown in Table 1

Table 1 also shows the audits and confidential enquiries the Trust participated in and the percentage of cases submitted as required by the terms of reference for each audit or enquiry.

Table 1: National clinical audits and confidential enquiries undertaken 2010/11

Audit Title	Participation	Data Submission (%) / Non-Participation Reason
<b>Peri- and Neonatal</b>		
Perinatal Mortality (CMACE)	Yes	100
Neonatal Intensive and Special Care (NNAP)	Yes	100
<b>Children</b>		
Paediatric Pneumonia	No	Participation planned 2011/12
Paediatric Asthma	No	Participation planned 2011/12
Paediatric Fever	Yes	100
Childhood Epilepsy (Epilepsy12)	Yes	Recently registered
Diabetes	Yes	100
<b>Acute Care</b>		
Emergency Use of Oxygen	No	Resource implications
Adult Community Acquired Pneumonia	No	Resource implications
Non Invasive Ventilation	Yes	Recently registered
Pleural Procedures	No	Resource implications
Cardiac Arrest	Yes	Recently registered
Vital Signs in Majors	Yes	100
Adult Critical Care	Yes	100
<b>Long Term Conditions</b>		
Diabetes	No	Currently under review
Heavy Menstrual Bleeding	Yes	Recently registered
Chronic Pain	Yes	Recently registered
Ulcerative Colitis & Crohn's Disease	No	Resource implications
COPD	No	Resource implications
Adult Asthma	No	Resource implications



Audit Title	Participation	Data Submission (%) / Non-Participation Reason
Elective Procedures		
Hip, Knee and Ankle Replacements (NJR)	Yes	82
Elective Surgery (PROMs)	Yes	93
Peripheral Vascular Surgery (VSGBI)	No	Resource
Carotid Interventions	Yes	100
Cardiovascular Disease		
Familial Hypercholesterolaemia	Yes	100
Acute Myocardial Infarction and Other ACS (MINAP)	Yes	98.5
Heart Failure	Yes	28
Acute Stroke (SINAP)	Yes	98
Stroke Care (Sentinel Stroke)	Yes	65
Renal Disease		
Renal Colic	Yes	100
Cancer		
Lung Cancer	Yes	n=67*
Bowel Cancer	Yes	n=101*
Head and Neck Cancer	Yes	100
Trauma		
Hip Fracture (NHFD)	Yes	44
Severe Trauma (TARN)	Yes	>65
Falls and Non-Hip Fractures	Yes	65
Blood Transfusion		
O Neg Blood Use	Yes	100
Platelet Use	Yes	100
NCEPOD		
Cardiac Arrest Procedures	Yes	100

\* refers to submission numbers not rates as data submission was commenced part way through the audit.

The reports of 18 national clinical audits were reviewed by or on behalf of the Trust in 2010/11. Table 2 highlights some of the actions taken to improve the quality of healthcare provided as a result of national clinical audits.

Table 2: Action taken following national clinical audit reports

National Diabetes Audit: Paediatric (NDA)	<p>Investment in skills and resources to improve the quality of care and outcomes for diabetic children highlighted in the audit include:</p> <ul style="list-style-type: none"> <li>• The purchase and use of continuous home subcutaneous glucose monitoring, to help families understand how and why blood glucose varies and to self-manage better.</li> <li>• New multimedia educational tools used in practice at diagnosis and follow-up, to improve understanding and awareness of pathophysiology and management.</li> <li>• Increased numbers of children on basal bolus insulin regime and insulin pumps</li> <li>• More children attending Diabetes UK holidays, introducing a greater acceptance of diagnosis and necessary management.</li> </ul>
Adult Critical Care (Case Mix Programme)	<p>Improvements have been made through comparative data on infection rates which has informed tightening of infection control measures including a revised antibiotic policy.</p> <p>Cooling of cardiac arrest patients has been instigated, which has been shown to improve outcome in out of hospital cardiac arrest and enable more patients to survive to go home.</p>
Elective Surgery (PROMS)	<p>First publication of PROMS data in September 2010.</p> <p>The questionnaire completion and return rate are above the national average. The majority of respondents reporting an improvement in their health following surgery. The PROMS reports are reviewed quarterly by the Lead Physicians in each of the specialist areas.</p>
National Sentinel Stroke Audit	<p>The National Sentinel Audit organisational and clinical was published in February 2011. The report demonstrates significant improvement from the 2008 audit results. For further information on stroke care please refer to the outcomes section of this report.</p>
College of Emergency Medicine: Pain in Children	<p>Along with training on patient group directives for triage nurses, the following measures are being implemented to improve the promptness of analgesia administration and re-evaluation of pain scores:</p> <ul style="list-style-type: none"> <li>• Implementation of dosing tables for analgesia</li> <li>• Alteration to Emergency Department notes format to include pain re-evaluation</li> <li>• A prompt for carers to ask for re-evaluation following analgesia included on triage leaflet and plasma screens</li> </ul>
College of Emergency Medicine: Fractured Neck of Femur	<p>To improve standards for x-ray times and pain scoring, re-education/training sessions for triage staff are being implemented together with a process for prioritisation of x-ray for patients with a suspected fractured neck of femur.</p>

The reports of 71 local clinical audits were reviewed by or on behalf of the Trust Board in 2010/11. Table 3 highlights some of the actions taken by the Trust as a result of local clinical audits to improve the quality of healthcare provided. The Trust have taken the following actions to improve the quality of healthcare provided

Table 3: Actions taken following local clinical audits

Re-audit of the Use of the Liverpool Care of the Dying Pathway (LCP)	The audit identified variation in the uptake of the LCP across Clinical Divisions, although there was evidence of best practice in use even where LCP documentation was not used. A training programme is being introduced and implemented by the MacMillan Nurses to rollout the use of the LCP throughout the Trust, in line with the continued roll out of Prognostic Indicator Guidance.
Audit of Intravenous Urogram (IVU) Radiograph Series in Medical Imaging	The audit recommended CT Scan and X-ray of Kidneys, Ureters and Bladder for patients with renal colic to reduce unnecessary radiography in Intravenous Urogram. Patients are now referred for this alternative non-invasive investigation within the capacity of the CT scanner.
Audit of Length of Hospital Stay after Mastectomy	The audit highlighted a length of stay after mastectomy of between four and nine days (the national average is five days). As drainage of mastectomy wounds is an important determinant of length of stay, ward protocols are being amended to shorten the length of drainage time associated with longer hospital stay post mastectomy and further training has been provided for ward nurses in removing drains and discharging patients following mastectomy.
Re-audit of Coding and Payment by Results in Fractured Neck of Femur	Improvements have been made in coding diagnosis (91%) and procedure (96%). Further changes are being made to the Fracture Neck of Femur Pathway, in conjunction with the Orthopaedic Unit and Clinical Coding for codes to be included in the pathway and coding information to be completed by the relevant surgeon.
Audit of Obstetric Early Warning Score	The re-audit showed improved rates for recording Obstetric Early Warning Scores, particularly in areas where there is a higher staff/patient ratio. Recording of pulse and blood pressure were very good but respiratory rate and oxygen levels require improvement.. Phase Two of the electronic record system for maternity patients (SIGMA) has been adapted to incorporate all indicators for Obstetric Early Warning Scores.

## Research

### Participation in Clinical Research

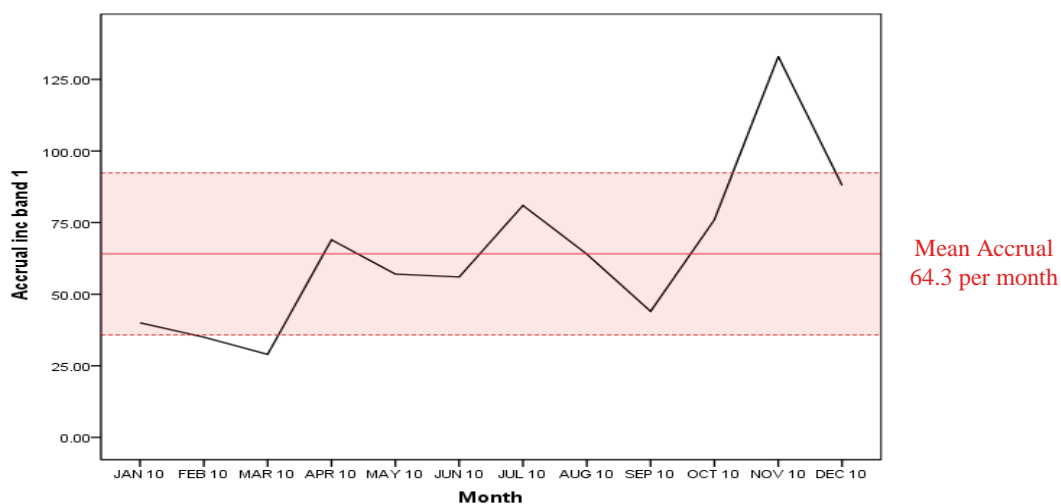
Participation in clinical research demonstrates the Trust's commitment to improving the quality of care offered and making a contribution to wider health improvement.

The number of patients receiving NHS services provided or sub-contracted by the Trust between April and December 2010 that were recruited during that period to participate in the National Institute of

Health Research (NIHR) portfolio research, which was approved by a research ethics committee was 668.

This is a 108% increase since the previous reporting period (March 2009 to February 2010). However, it should be noted that one study: Fungal Infection Risk Evaluation (F.I.R.E) accounts for nearly all of this increase.

Graph 1: Number of Patients Recruited to NIHR Portfolio Clinical Trials - Jan 2010 to Dec 2010



The Trust was involved in conducting 139 active clinical research studies during 2010/11 including, but not limited to, the following areas:

Areas of Clinical Research 2010/11	
Cancer	Medicines for Children
Cardiovascular	Mental Health
Congenital Disorders	Musculoskeletal
Diabetes	Oral and Gastrointestinal
Generic Health Relevance and Cross Cutting Themes	Reproductive Health and Childbirth
Infection	Primary Care
Inflammatory and Immune System	Skin
Injuries and Accidents	Stroke



There were 9 (7.45 Whole Time Equivalent) clinical research staff participating in research approved by a research ethics committee at the Trust during the 2010/11. The Trust was involved in conducting 2 clinical research studies in cardiovascular medicine during 2010/11. The treatment of high cholesterol levels to reduce the incidence of vascular events has been recruiting and treating patients since 2007. Over the same period, mortality amenable to mortality rates from causes considered preventable in cardiovascular medicine changed from the previous year and Cardiology improved its risk adjusted mortality index by 28.5%.

Two particular examples of how research can benefit patients are described below and demonstrate the link between the Trust's participation in research and drive to continuously improve the quality of services provided.

### ***Reducing Blood Tests for Children***

A research study on Early Morning Salivary Cortisol (EMSC) from the Medicine for Children Research Network (MCRN) took place on the Paediatric Unit. When patients have been on one type of asthma medication for some time, one of the side effects can be a reduction in the production of a hormone called cortisol. Cortisol is important in helping the body fight infection and heal itself after injury. The aim of the study was to identify patients who are at risk of low levels of cortisol and to treat prior to it becoming a problem. Normally this is done through blood sampling but the study is trying to determine whether this can be done by a saliva test instead. Clearly the saliva test would be much more acceptable to parents and children.

One patient, who had been treated with inhaled steroids (ICS) for asthma for many years, was enrolled in the study. At the time of the saliva test he was an apparently

a well child without any symptoms. The test revealed a very low level of available cortisol. As he and his family were about to leave for a holiday it was imperative that he was seen by his asthma physician and oral corticosteroid therapy commenced. This was carried out and he and his family went on their planned holiday with a supply of the necessary medication. Without such treatment the consequence may have been a severe adrenal crisis that could be life threatening. This specific example is highlighted to show that our local research can benefit our local patients.

### ***Portable Ultrasound Scanner***

A clinical audit of inpatient echocardiograms was undertaken in August 2009 by the Emergency Care Division. It was identified from the results that there was delay for patients who were too unwell to be transported to the Ultrasound Department.

The Research Department purchased a portable ultrasound scanner which is being used to treat patients in clinical areas as well as to conduct further research studies.

The portable ultrasound scanner is also currently being utilised in a stroke trial. This trial is a study of patients diagnosed with stroke, of which 10% will develop blood clots in the veins in their legs. The clots can be dangerous if they travel up the vein to the heart or lungs. Normal care can involve treatment with aspirin or other blood thinning drugs or stockings to reduce the risk of clots forming but the study is trying to find out if a new treatment, Intermittent Pneumatic Compression (IPC) helps to reduce the risk further. In this treatment, inflatable sleeves are wrapped around the legs and are inflated intermittently. This gently squeezes the legs and increases the blood flow in the veins. As part of this trial the dedicated mobile ultrasound scanner, necessary for the trial work, is also shared

with clinical routine service to reduce delays.

### ***Commissioning for Quality & Innovation Framework (CQUIN)***

A proportion of the Trust's contracted income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and its Commissioners through the CQUIN payment framework. This equates to a total of £1.9 million over the year. Further details of the 2010/11 agreed goals and those agreed for 2011/12 are available on request from the Deputy Director of Performance & Quality.

These are also available electronically via the Trust Internet site: [www.mcht.nhs.uk](http://www.mcht.nhs.uk).

Two of the agreed CQUINs related to improving the discharge arrangements for patients leaving hospital and improving the use of emergency theatres.

### ***Development of an Integrated Discharge Team***

The Integrated Discharge Team is a combined health and social care team which aims to support wards to commence the discharge planning process at the earliest opportunity after the patient is admitted to hospital. The team focuses on patients with the most complex discharge needs which require by their nature, more integrated working between care agencies.

The Integrated Discharge Team provide:

- Early referral to social services
- Named health and social care links per ward
- A case link allocated to each patient
- A case manager to actively manage particular cases due either to delays or complexity
- Support to the wards to allow them to do

achieve the days planned tasks.

It is anticipated that these improvements should reduce the unnecessary time patients stay in hospital and better plan for their care after they leave hospital.

### ***New Emergency Process in the Operating Theatre***

The purpose of this revised process is to ensure optimum utilisation of the emergency theatre facility and staffing, performing appropriate patient procedures within an agreed timeframe. Effective information transfer ensures the protection of patients and minimises clinical risk. Continuity of information underpins all aspects of a seamless service providing continuity of care and patient safety.

Benefits of the new process include:

- A core group of theatre staff led by the Emergency Theatre Co-ordinator to ensure a smooth seamless service and continuity of patient care
- Use of a central area in the main theatre suite with IT access
- Clinical discussion and input from all members of the multi-disciplinary team to agree on the patients prepared and the order of priority for that session, based on National Confidential Enquiry into Patient Outcome and Death (NCEPOD) coding.
- Priority sessions/timeslots identified for all specialities
- Timeslots allocated to each patient booked onto the Emergency List which will allow medical teams plan the work for that day.

### ***What others say about the Trust***

#### ***Care Quality Commission (CQC)***

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is unconditional.

The Care Quality Commission has not taken enforcement action against the Trust during the period April 2010 to March 2011

The Trust has participated in special reviews and investigations by the Care Quality Commission relating to the following areas during April 2010 to March 2011.

- CQC Review of support for families with disabled children
- Responsive review of the Trust following a number of breached safety alerts and a complaint relating to Maternity Care. A responsive review is a review of services that is undertaken when the CQC has received a complaint or has concerns in relation to compliance with the essential standards of quality and safety. The review at the Trust looked into:
  - Outcome 4 - Care and welfare of people who use services (in relation to maternity services)
  - Outcome 9 - Management of Medicines
  - Outcome 17 - Complaints.

The Trust has taken the following action to address the conclusions or requirements reported by the CQC, and has provided:

- The Maternity Action Plan includes the development of care pathways for women who were in high risk groups. These are updated monthly with all outstanding actions within the allocated timescales.
- The Pharmacy Staffing action plan was completed in February 2011 with all vacancies being filled.
- All breached safety alerts are closed and future alerts monitored monthly to ensure timescales are not breached

The CQC were satisfied with the Trust's arrangements regarding complaints management and agreed no further actions were required.

## **Quality and Risk Profiles**

The CQC plans to keep a constant check on all information that is available for each organisation. This intelligence is collated into a Quality and Risk Profile (QRP) which will be published for each organisation on a monthly basis. The QRP aims to gather all the information known about a provider in one place. This will enable the CQC to assess where risks lie and prompt front line regulatory activity such as inspection.

Following a meeting with the Regional Manager in February 2011 it has been agreed that the Director of Nursing and Quality and the Governance Lead will meet with the CQC to review the information held in the QRP on a quarterly basis. This will give the Trust an opportunity to provide information for any areas of concern and provide assurance to the CQC. Following this meeting a report will be submitted to Strategic Information Governance Committee (SIG) outlining the discussion and any progress made. This report is to provide assurance internally that the Trust is progressing against areas of concern as some of the data is collected from annual audits such as the patient and staff survey.

## **Data Quality**

The overall responsibility for the accuracy and completeness of data quality is held by the Chief Executive of the Trust. The Data Quality Policy has been updated in the past year and is available on the Trust Intranet.

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

- The Trust's Quality Committee meets bi-monthly and reports to the Information Governance Committee
- Completeness, validity and accuracy audits of non-clinical patient data
- Annual clinical coding audit
- Training and annual updates for all staff



responsible for entering patient data on to operational systems. All junior coders are trained by the Cheshire and Merseyside Clinical Coding Academy and are required to achieve the Foundation qualification. All qualified coders receive mandatory refresher and specialty workshops annually.

The Trust is currently specifically targeting the following areas to improve data quality:

- Completeness and validity of the recording of patient's ethnic groups
- Completeness and validity of patient's NHS number
- Improving the timeliness of the recording of patient events, particularly in Accident & Emergency and for admissions, transfers and discharges.

### ***NHS and General Medical Practice Code Validity***

The Trust submitted records during 2010/11 to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics.

The percentage of records in the published data which included the patient's valid NHS number was:

99.78% for admitted patient care  
99.91% for out patient care  
99.26% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

99.99% for admitted patient care  
100% for out patient care  
99.97% for accident and emergency care

### ***Information Governance Toolkit Attainment Levels***

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 Version 8, 2010/11 was 44% and the Trust was graded Unsatisfactory .

The reduction in score when compared with the 2009 – 2010 assessment can be attributed to the changes made to both the requirements of Version 8 of the Information Governance Toolkit and the way in which evidence is now evaluated and submitted to Connecting for Health.

To ensure compliance is achieved in future assessments, the Trust has implemented comprehensive action plans for all unsatisfactory rated requirements which are to be monitored by the relevant Trust committees. The Information Governance Toolkit Action and Annual Plan was passed by the Operational Integrated Governance Committee in March 2011.

### ***Clinical Coding Error Rate***

Accurate data quality and clinical coding are imperative to support patient care and to ensure the information is used for improving health care and ensuring more effective management.

The Trust was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.



### Part 3

#### Review of Quality Performance

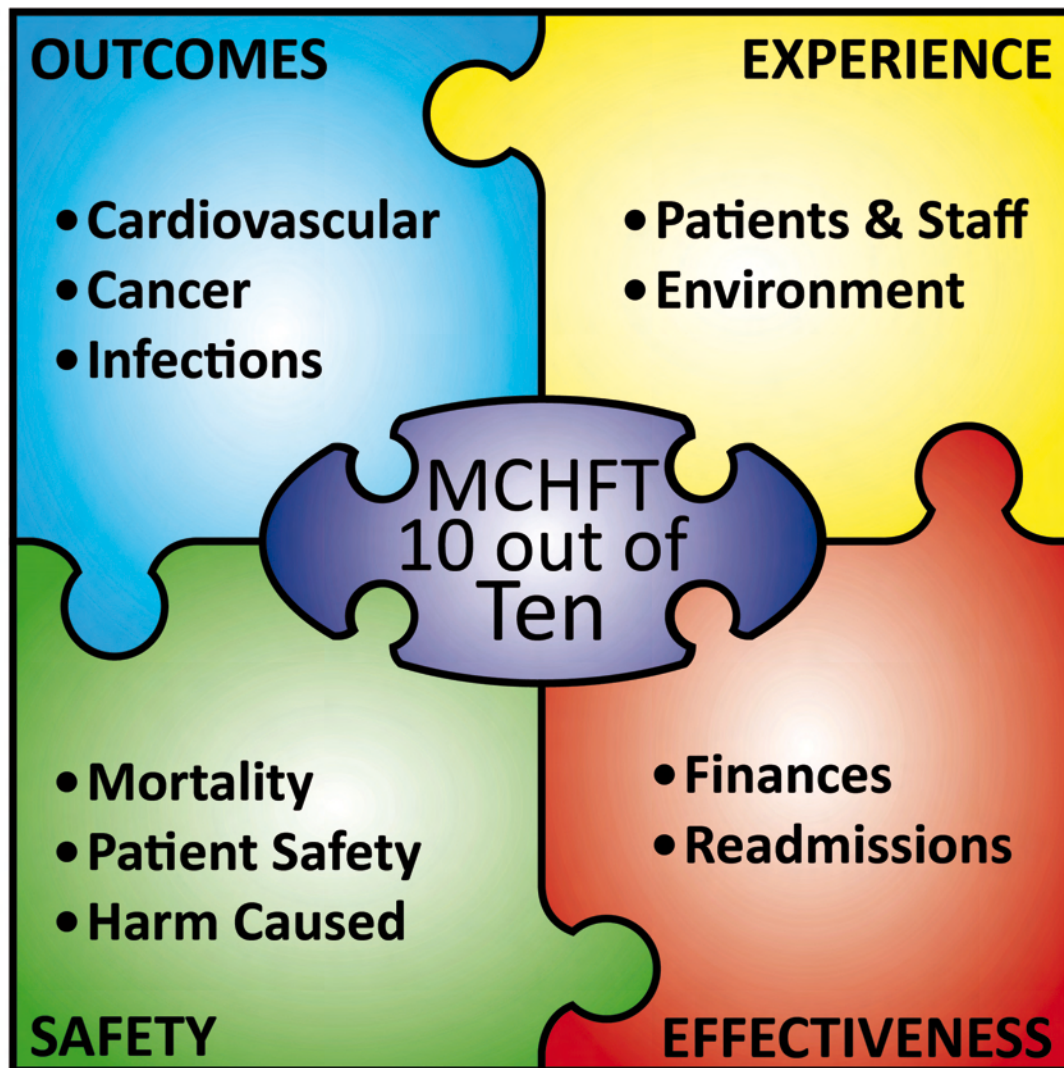
The 2010/11 Quality Account specifically details the progress against the Trust's 10 out of Ten strategy together with performance against areas of public interest or those recommended by other bodies such as Monitor and the Department of Health. These have been detailed under the following domains of:

- Safety
- Effectiveness
- Experience
- Outcomes

#### 10 out of Ten Strategy

The Trust aims to be in the top 10% of all secondary providers in England in ten agreed indicators of quality by 2014.

The key indicators for this strategy are shown below:

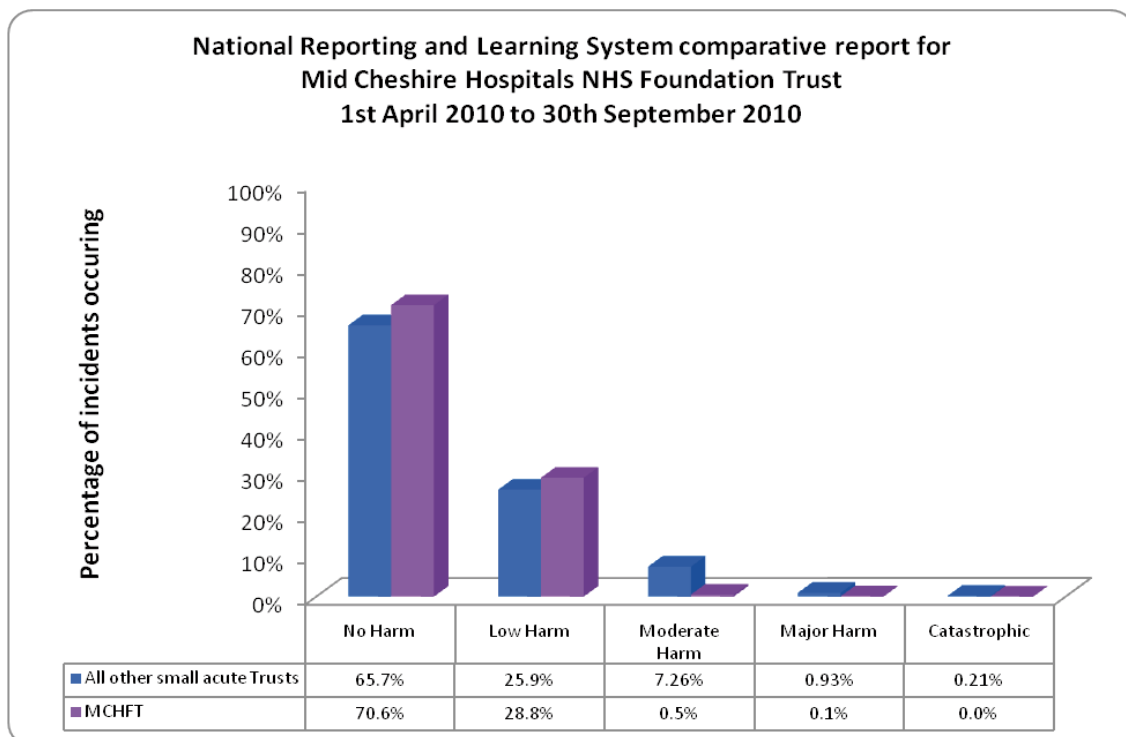


## Review of Performance in relation to Safety

### Reduce Avoidable Harm

All patient safety incidents are downloaded to the National Patient Safety Agency (NPSA) via the National Reporting and Learning System (NRLS) on a weekly basis. Every 6 months the NRLS produce a comparative report comparing the Trust with 30 similar sized, acute Trusts. This data is published on the NPSA's website. Graph 2 is the latest comparative reporting rate summary which provides an overview of incidents reported by the Trust to the NRLS between April 2010 and September 2010. This data is the most recent available, published in March 2011. In comparison to previous data received April to September 2009 the Trust has made significant improvements in reducing harm in the severe harm categories i.e. moderate and above.

Graph 2: Incident Reporting April 2010 to September 2010



Period	No Harm	Low Harm	Moderate Harm	Major Harm	Catastrophic
1 April 2010 to 30 September 2010	70.6%	25.9%	0.5%	0.0%	0.0%
1 October 2009 to 31 March 2010	86.8%	10.7%	2.4%	0.0%	0.1%
1 April 2009 to 30 September 2009	80%	11%	8.5%	0.5%	0.0%

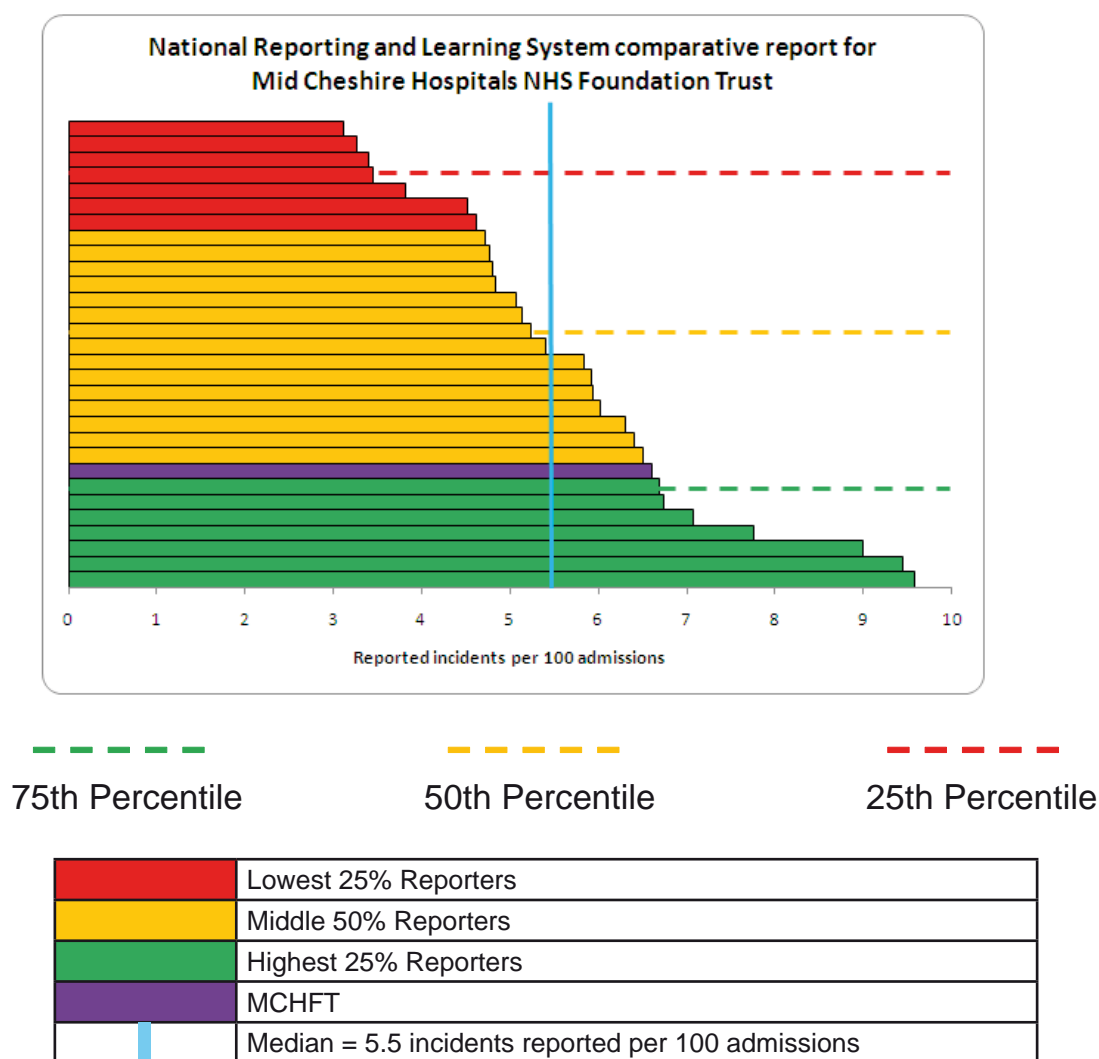
Please refer to Chapter 3 of the Annual Report to see changes in practice following the serious incidents.

### Maintain the Trust's Safety Culture

The data on harm caused to patients is collated from the Trust's incident reporting system. Staff report patient safety incidents in order for the Trust to learn from experience and share lessons learned to prevent a reoccurrence. To encourage staff to report patient safety incidents the Trust has adopted a 'Just Safety Culture'. A just safety culture is both attitudinal as well as structural, relating to both individuals and organisations. Adverse personal attitudes and corporate style can enable or facilitate the unsafe acts and conditions that are the precursors for accidents and incidents. It requires not only actively identifying safety issues but responding with appropriate action

In October 2009 to March 2010 the Trust was in the middle 50% of the reporting Trusts. The Trust is now in the upper 50% illustrating an improvement in incident reporting. Graph 3 demonstrates this.

Graph 3: Reported Incidents per 100 Admissions



Period	No of incidents reported per 100 admissions
1 April 2010 to 30 September 2010	6.61
1 October 2009 to 31 March 2010	6.00

## **Implement National Patient Safety Initiatives**

The Trust has taken part in two national patient safety initiatives with the aim to ensure that the Trust has the capacity and capability to eliminate avoidable harm to patients.

### **Patient Safety First Campaign**

The campaign has now finished but work continues with the implementation of interventions. The Patient Safety First website continues to deliver up to date information and interventions to reduce harm caused to patients.

### **Deterioration**

- The Early Warning Score (EWS) and Escalation Guidelines have been revised and re-implemented, this has resulting in an increase to the calls made to the Critical Care Outreach Team. This team provides expert advice and support in the management of the critically ill patient
- The Situation, Background, Assessment and Recommendation (SBAR) Communication Tool is in the progress of being rolled out across the Trust. This enables staff to provide clear and concise information to escalate the deteriorating patient
- The Trust has an established Mortality Reduction Group which undertakes case reviews. Lessons are learned and shared and actions taken to reduce mortality

### **Leadership**

- *Becoming a Manager* and *Managers Moving On* development programmes continue to be well subscribed to. These courses ensure staff have the skills to become effective and efficient managers
- Patient Safety Walkrounds have been reviewed and are recommenced in

January 2011. The Patient Safety Walkround ensures that the Trust leaders are seen to be committed in both word and visibility to the primary aim of 'first, do no harm'

### **Pre Operative Care**

- The World Health Organisation (WHO) checklist is now being used in every theatre. This ensures that theatre staff are prepared for the expected procedure and also prepared for any un-expected events

### **NHS Institute of Innovation and Improvement**

The Leading in Patient Safety Programme has now been completed with twice yearly updates from the Institute of Innovation and Improvement. Following the programme the Medical Director was invited by the NHS Institute of Innovation and Improvement to attend the Patient Safety Executive Development programme in the United States of America.

- Plan Do Study Act (PDSA) cycles of change are now frequently used when implementing a change in process or introducing new documentation. This ensures that small steps of change can be implemented before moving to the next area of implementation
- Statistical Process Charts (SPC) are now used to plot improvements. These charts identify visible areas of improvement and are supported by narrative



## Safety

### Priority 1: Mortality

#### **To reduce mortality rates by 10 points in patient groups where death is not expected**

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 patient conditions and displays this as an index (100 being the expected rate).

In general terms, the rationale for calculating death rates in hospital is so they can be used as a measure of hospital quality.

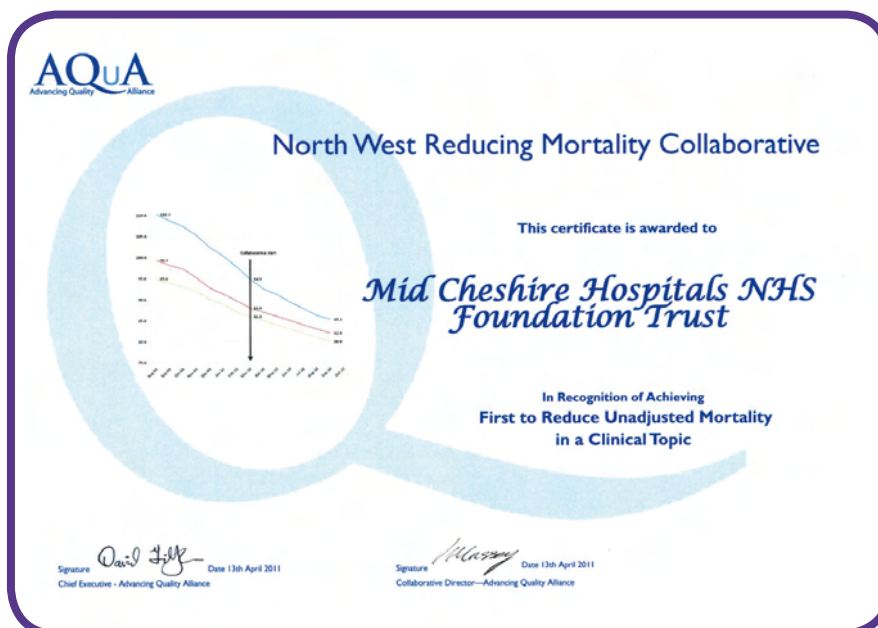
Mortality was chosen as a local priority by:

- The Council of Governors
- Consultation for the Trust's 10 out of Ten objectives, in particular focusing on patient groups where death is not expected.

**To date, there have been no unexpected patient deaths from these groups.**

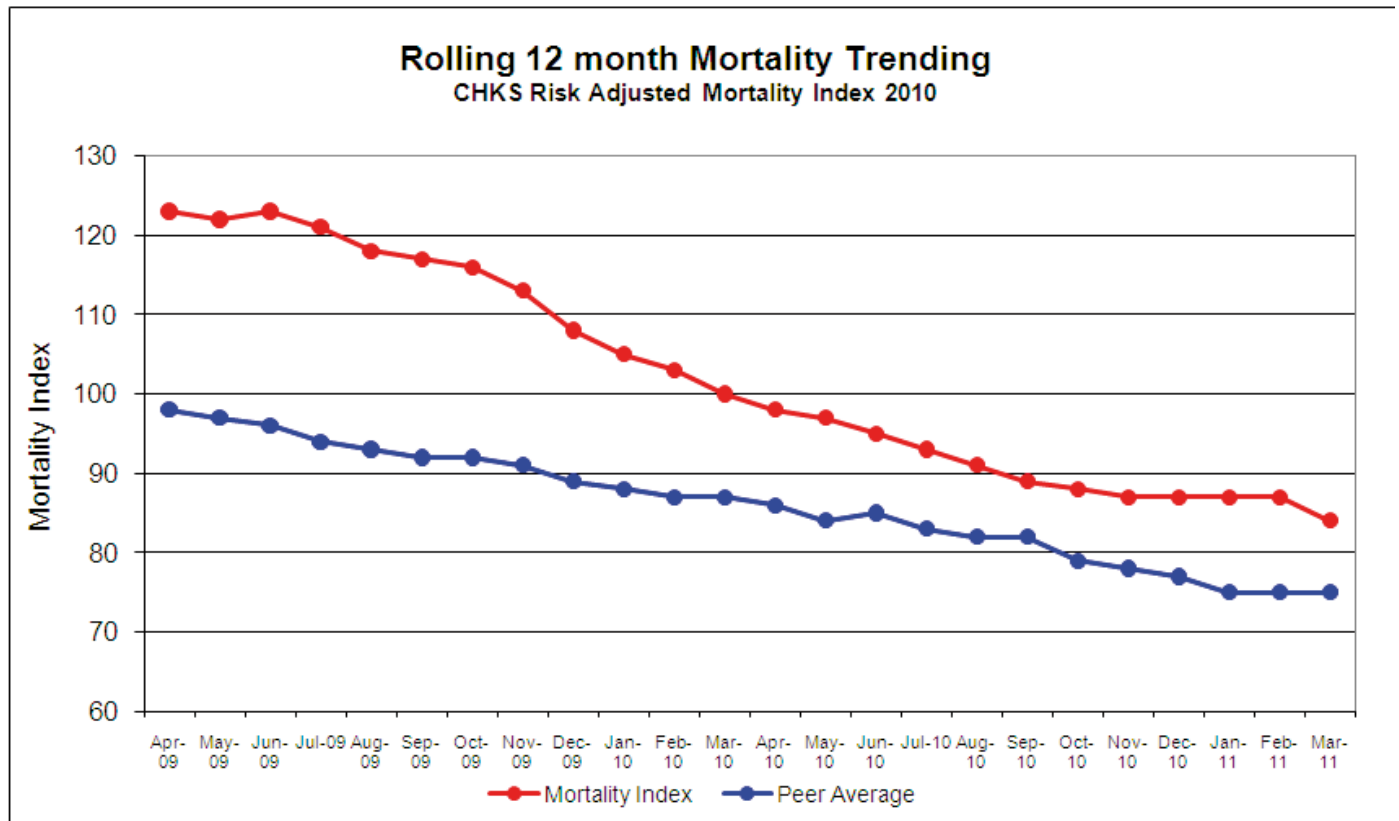
In 2010/2011, the Trust participated in the North West Reducing Mortality Collaborative facilitated by the North West Advancing Quality Alliance (AQuA). The collaborative was a 12 month improvement programme for a group of nine regional Trusts, who found they had a higher than expected Hospital Standardised Mortality Ratio (HSMR), to come together to reduce their HSMR score by 10 points. A frontline team in the Trust has been delivering improvement work in clinical areas to improve safety and reduce mortality.

**The Trust has exceeded the aims of the North West Collaborative by reducing its RAMI by 16 points** (from 100 in the 12 months to March 2010 to 84 in the 12 months to March 2011). At the North West Reducing Mortality Summit in April the Trust received an award for being the first Trust in the collaborative to reduce its unadjusted mortality amongst patients with sepsis.



Graph 4 demonstrates the Trust Risk Adjusted Mortality Index (RAMI) which shows the ongoing reduction in the Trust's RAMI.

Graph 4: RAMI 12 month rolling mortality trending April 2009 – March 2011



(Source: CHKS Signpost 2011)

The Risk Adjusted Mortality Index (RAMI) developed by Caspe Healthcare Knowledge Systems (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 the CHKS signpost to calculate the Risk Adjusted Mortality Index (RAMI).

The mortality index is the ratio of the observed number of deaths to the expected number of deaths in a particular population.

## Safety

### Priority 2: Patient Safety

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

Patients are rightly moved as part of their care pathway or if the patient's diagnosis has changed and care is being 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 a longer length of stay.

In the Quality and Safety Improvement Strategy the Trust stated it would establish a method of monitoring this quality indicator, gather the historical data and set a target for improvement, this is presented in graph 5.

It can be seen that progress has been made and the Trust has started to reduce the numbers of unnecessary patient moves over the past year

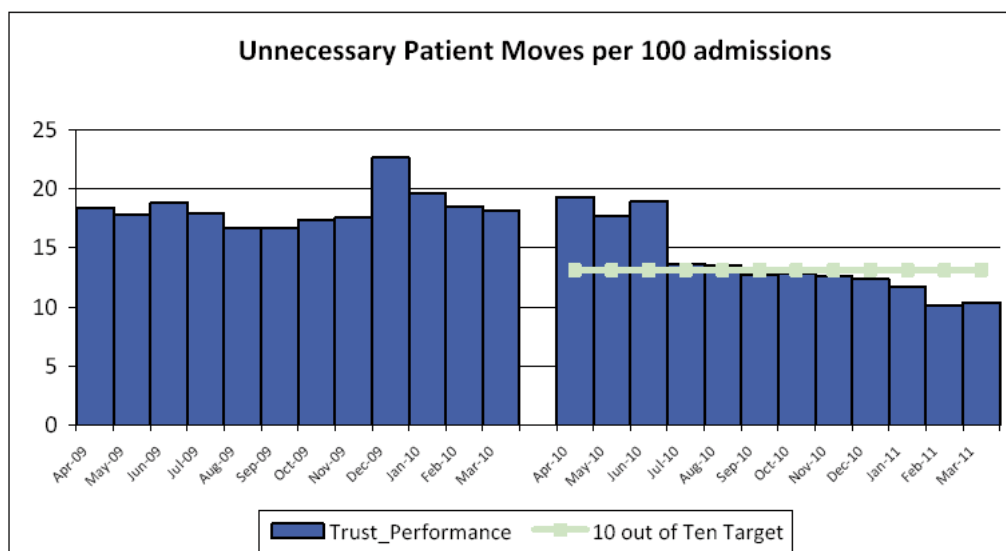
Having established a methodology and target for improvement the Trust intends to

reduce the number of unnecessary patient ward moves by:

- Ensuring patients are admitted first time to the right specialty / ward to care for their needs
- Monitoring / investigating the care of patients who have moved frequently in their hospital stay
- Ensuring the bed configuration matches the demand for each specialty
- Reducing the time a patient spends in hospital and therefore the opportunity for them to be moved unnecessarily.

Graph 5 below shows the average number of unnecessary patient ward moves per patient since April 2009. The green line shows the target the Trust would like to achieve to improve this quality indicator by 2014. The Trust has achieved the target set for reducing the number of unnecessary patient moves in 2010/11.

Graph 5: Unnecessary Patient Moves per 100 admissions



## Safety

### Priority 3: Harm Caused

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

The National Patient Safety Agency (NPSA) has emphasised that:

'Trusts with the highest level of reported incidents tend to be the safest because staff are encouraged to report incidents openly and learn from them. You can't learn and improve if you don't know what the problems are' (NPSA 2011).

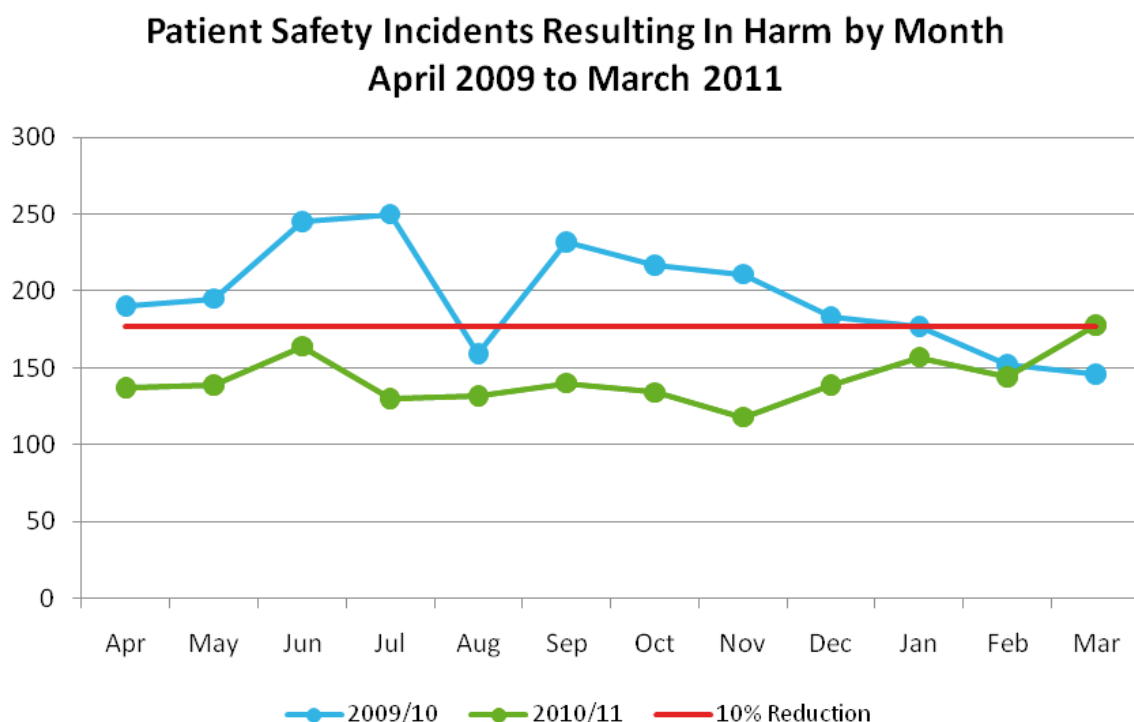
This financial year, the Trust has reduced avoidable harm by 10%.

The Trust's incident reporting system is used to determine the number of patients who experience avoidable harm. All patient safety incidents are reported in

the Integrated Governance Quarterly Assurance Report which includes lessons to learn and changes in practice. The report discussed at the Operational Integrated Governance Committee which has representation from all of the divisions. All serious patient safety incidents and actions taken/planned are reported to the Board of Directors by the Medical Director on a monthly basis. Serious patient safety incidents are also monitored and reported to the QuEST Committee. Central and Eastern Cheshire Primary Care Trust receive a monthly serious incident report which provides assurance on the management of these incidents.

Graph 6 demonstrates the reduction in harm caused to patients over the past 12 months.

Graph 6: Patient Safety Incidents Resulting in Harm





## ***Review of Performance in relation to Effectiveness***

### ***Quality Matters***

All patient safety incidents are downloaded. The Quality Matters programme is now into its third year using “Lean” methodology to review Trust wide services and is aimed at:

- Improving patient care
- Improving staff morale
- Improving efficiency.

After a successful one year pilot phase the programme progressed with a two year plan where the emergency care pathway, theatre efficiency and gynaecology outpatients were reviewed.

### ***Improving theatre productivity, patient experience and staff morale***

A revised theatre template was introduced in October 2010 with progression to four hour theatre sessions and forward planning for elective sessions to be undertaken 50 weeks of the year. The workforce redesign permitted creativity when job planning within clinical teams, creating speciality teams which allowed improved co-ordination and planning of emergency theatres. This revised template also allowed for a dedicated children's theatre.

### ***Improve the patient flow through the Emergency Department, Emergency Admissions Unit & Core Wards***

The Quality Matters team undertook a review of the emergency patient pathway from front door to discharge: The implementation of information systems enabled the staff to examine the overview of a patient's journey, which led to the patient flow policy with additional targets for discharges.

Overall, the average length of patient stay

was reduced by one day. Patients with complex discharge needs are managed by the Integrated Discharge Team which includes partnership working with external agencies. As part of the improved patient flow it is hoped that patient experience will improve along with a reduction in unnecessary hospital stays.

### ***Improving Outpatient efficiency, process flow and patient experience***

The review of Gynaecology Outpatients in 2010 was aimed at improving the flow of patients through the Trust and improving patient experience for service users. As part of this review the referral process was redesigned as was the service provision for hysteroscopy. Nurse led clinics were introduced, along with a review of all follow up appointments.

### ***Coaching for Quality & Organisational Development***

The Trust officially launched its Coaching Framework on 19 January 2011. Thirteen coaches have now received certification from the European Mentoring and Coaching Council (EMCC) following the training programme with i- Coach Academy.

The Trust has developed a two-pronged approach to developing a coaching culture in the organisation.

#### ***Part One***

Access to an accredited internal coach has been made available to all senior managers and to staff currently on development programmes. The initial offer is of four sessions with a coach with the option of a further two sessions if required. There may also be occasions where use of an external coach will be more appropriate. Staffs usually access a coach after discussions with their line manager.

## Part Two

The second element in developing a coaching culture across the organisation will be the delivery of an in-house one-and-a-half day “Essential Coaching Skills for Managers” programme, to which all line managers will be invited to attend. This programme is intended to develop a line manager’s capacity to use coaching skills in their conversations with their teams and across all levels of the organisation in their everyday interaction with each other and service users. It is not intended to develop them as internal coaches.

## Effectiveness

### Priority 4: Readmissions

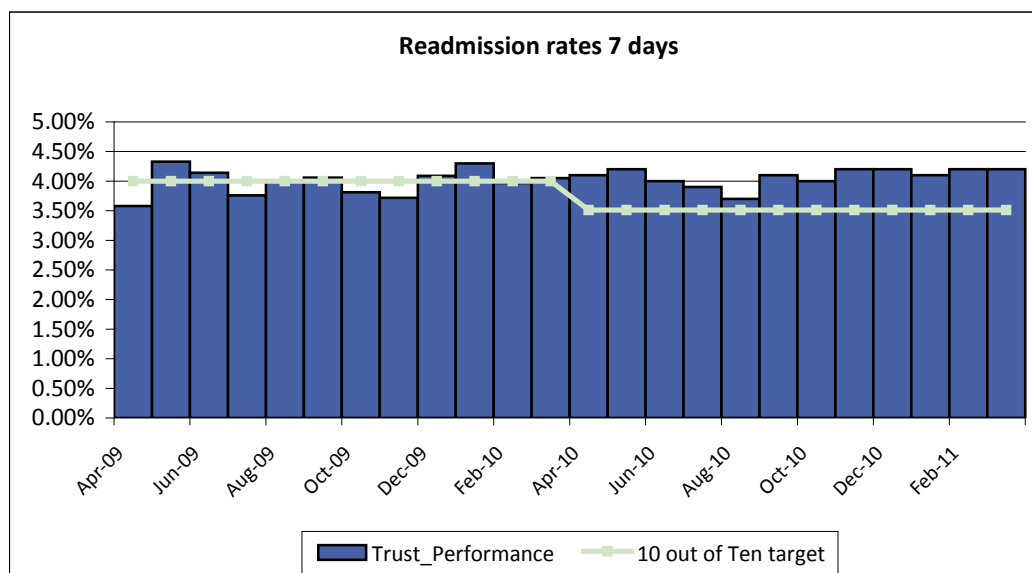
#### *To reduce the number of patients who are readmitted to hospital within 7 days of discharge*

The Trust’s Quality and Safety Improvement Strategy stated that the Trust would reduce the number of patients who are readmitted to hospital within 7 days to match the peer average. Overall, the Trust is planning to reduce readmissions by 22.5% by 2014.

The Trust has been working to do this by:

- Monitoring readmissions on a monthly basis and developing plans to remedy underlying problems, within clinical divisions
- Improving the advice / instructions given to patients on discharge
- Improving the planning of patient discharge by ensuring patients have a planned date of discharge, soon after admission, so all professionals, patients and relatives know the estimated date for leaving hospital
- Developing an Integrated Discharge Team with social care colleagues to ensure closer working and collaboration in planning patient discharges
- Introducing an electronic system for creating and delivering clinical discharge information for the patients, to improve the timeliness of information reaching the General Practitioner
- Working with primary care colleagues to ensure urgent referrals to hospital are managed in an appropriate setting, for example, urgent care centre to help avoid potentially unnecessary admissions to hospital.

Graph 7: Percentage of patients readmitted within 7 days since April 2009



The Trust did not achieve the target to reduce readmission rates during 2010/11. The ongoing improvement programme to promote effective discharges will see this overall rate improve.

## Effectiveness

### Priority 5: Finance

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

Under the NHS Operating Framework there is a requirement to reduce management costs allowing more income to be reinvested into NHS care for patients.

The Trust's priorities for improvements have echoed in reducing the percentage of the Trust's income spent on management costs.

Over the financial year, the Trust has been monitoring its management costs on a quarterly basis against its own pre-defined targets. The cumulative quarterly performance for 2010/11 is as follows:

Table 4: Cumulative Quarterly Performance 2010/2011

	Plan % of Income	Actual % of Income
Quarter 1	6.08	5.79
Quarter 2	5.86	5.62
Quarter 3	5.82	5.61
Quarter 4	6.04	5.61

The Trust's future target is presented opposite:

Table 5: Planned Percentage of Income 2011/2013

Year	Plan % of Income
2011/12	5.89
2012/13	5.74

In addition, the Trust has monitored its annual management costs in accordance with the Department of Health's definition. The Trust's performance was 5.1% of total income for 2010/11, compared with 5.2% of total income in 2009/10.

For 2010/2011, Quarter 1 to Quarter 3 the actual management costs as a percentage of income are lower than the 2010/11 Quarter 1 to Quarter 3 targets and also the future years targets. This is due to the Trust's income (up to December 2010) being significantly higher than initially forecast. Also there has been a recruitment freeze on a number of non clinical posts which has contributed to the lower percentage. However, the Trust anticipates that in 2011/12 and 2012/13 it will not generate these levels of surplus income above plan.

## Review of Performance in relation to Patient Experience

### Improve on the results of the National Patient Survey

To improve the quality of services, it is important to understand what patients think about their care and treatment. One way of doing this is by asking patients who have recently used their local health services to tell the Trust about their experiences.

The Trust participates in the NHS Survey programme co-ordinated by the CQC, which enables the Trust build up a picture of patient's experiences over time.

### National Inpatient Survey

The National Inpatient Survey is the main source for reporting the perception of our patients and is used in comparative performance tables and quality indicators. Unfortunately the most recent survey (2010) shows a general fall in patient satisfaction levels and, when compared to other Trusts,' responses were lower.

The seventh survey of adult inpatient involved 162 acute and specialist NHS Trusts. The Trust received questionnaires from 480 patients, a response rate of 52%. Patients were eligible for the survey if they were aged 16 years and older, had at least one overnight stay and were not admitted to maternity or psychiatric units.

Table 6: National Inpatient Survey 2010/11

Questions	2009	2010	Change →↑↓	Northwest
Were you involved as much as you wanted to be in decisions about your care and treatment?	67	64	↓	69
Did you find someone on the hospital staff to talk to about your worries and fears?	62	56	↓	60
Were you given enough privacy when discussion your condition and treatment?	77	77	→	79
Did a member of hospital staff tell you about medication side effects to watch for when you went home?	37	35	↓	41
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	40	41	↑	72

Based on a report by IPSOS Mori, key drivers are identified to focus on to improve overall patient satisfaction. The Trust monitors progress against key aspects of patient experience relating to care and services.



Table 7: Comparisons of results from National Inpatient Surveys

National Inpatient Survey - Mean Rating Scores	2009	2010	Change →↑↓
Cleanliness of hospital room or ward	96	94	↓
Cleanliness of toilets and bathrooms	88	87	↓
Getting answers to questions from doctors	82	81	↓
Involvement in decisions about care and treatment	88	84	↓
Amount of privacy when discussing treatment	89	90	↑
Amount of privacy when being examined or treated	98	98	→
Overall were you happy with respect and dignity	96	95	↓
Overall rating of care (excellent, very good and good)	93	89	↓

The areas listed below were identified as concerns by patients completing the National Inpatient Survey and the Trust has identified the following actions:

#### Reduce unnecessary noise at night

- Privacy doors installed at the end of each patient bay, and these are closed at night to assist with the noise reduction
- Patients have access to earplugs

#### Provision of information for patients

- Easy read patient information leaflets available
- Volunteers assist with the 'stocking up' to ensure leaflets are readily available

#### Reduce delays on discharge

- Established Integrated Discharge Team who assess the need of complex patients within 24 hours of admission
- Bedside folders to be available with recommended discharge information

#### Provide more information about medications

- Established Pharmacy Discharge Team
- Leaflets available with information regarding medication administration.

### National Maternity Survey

Over 25,000 women who had given birth in January and February 2010 responded to the survey nationally. All women aged 16 or over who received care from a Trust, and who had either given birth in hospital, or at home were eligible to take part. The Trust had a 60% response rate with 244 women responding.

Participants were asked about all aspects of maternity care, including the first clinician appointment and the quality of care provided in the community in the weeks following discharge from hospital.

Table 8: National Maternity Survey 2010/11

National Inpatient Survey - Mean Rating Scores	MCHT 2007	MCHT 2010	Change →↑↓	National 2010
At the start of pregnancy choice of where women could have their baby	90	84	↓	83
Choice of where antenatal checkups would take place	18	59	↑	25
Women having an episiotomy having stitches within 20 minutes	67	70	↑	60
Overall rating of care during labour and birth rated as excellent, very good and good	89	96	↑	93
Women given a copy of the Red pregnancy book	81	67	↓	78
Treated with kindness and understanding after the birth of their baby	86	89	↑	93
Women breast feeding in first few days	61	48	↓	59

**Women were also asked what was particularly good about their care with free text and comments included:**

*“The midwives and doctors that helped deliver my baby were brilliant. I felt completely safe and in control at all times. I cannot praise them enough, I was well looked after. The care I received in hospital was outstanding.”*



## **National Cancer Services Survey**

The survey included all adult patients with a primary diagnosis of cancer who had been admitted to an NHS Trust as an inpatient or as a day case and had been discharged between 1 January 2010 and 31 March 2010. 362 eligible patients from the Trust were sent a survey with 219 completed surveys returned.

The responses were from patients with a range of tumour groups seen here with the largest number of respondents being patients with breast, colorectal, urological and prostate cancer.

## **Areas of Concern**

The survey identified 3 questions where the Trust scored in the lowest 20% of trusts.

- Ward Nurses – ‘always / nearly enough nurses on duty’. The average % for the Trust was 56% with the national threshold for the lowest 20% being 57%
- Hospital Care and Treatment – ‘always given enough privacy when discussing condition and treatment’. The average % for the Trust was 79% with the national threshold for the lowest 20% being 80%
- Hospital Care and Treatment – always given enough privacy when being examined or treated. The average % for the Trust was 89% with the national threshold for the lowest 20% being 91%

*“Cancer care at the Macmillan Unit at Leighton Hospital is excellent. Doctors, nurses, all staff are professional, efficient, kind, caring and helpful in every way to make chemotherapy treatments as comfortable as possible”*

## **Patient Recommendation**

In 2010, nearly 4,000 patients were asked in local patient surveys if they would recommend the Trust to family and friends based on their experience as a patient:

91% of patients declared that they would recommend the Trust to others compared to 86% in 2009.

## **Improvements Achieved: Local Patient Surveys:**

### **Supporting patient needs**

A pager system was introduced to help patients with a hearing impairment to be made aware of their appointment in clinic when waiting in the out patient department.

### **Support group established**

A survey identified 94% of respondents expressed an interest in attending an Inflammatory Bowel Disease Support Group. A focus group has been held to establish what patients would like from a group and meeting dates have been set with the first topics on diet and a consultant led question and answer session.

### **Support for patients and visitors**

Signage has been improved from Out Patients to the Breast Screening Unit.

### **Waiting times**

Reception staff in the Treatment Centre advise patients regards waiting times on arrival and posters have been introduced to ask patients to report to reception if they have been waiting longer than 20 minutes.

## **National Staff Survey**

The national staff survey was undertaken from September – December 2010 and 57% of the 844 staff returned a completed survey. The results from Quality health were available to the Trust in early March 2011. The Care Quality Commission (CQC) benchmark results were made available shortly after.

The results are currently being analysed by each Clinical Division, and action plans will be produced and monitored to address specific areas of staff feedback.

The results and progress against patient surveys are available on the Trust's website.

### ***Privacy & Dignity***

The Trust continues to make patients' privacy and dignity a priority, understanding that being treated courteously and with compassion are what all patients expect and deserve. The Trust has particularly made progress during 2010/11 in the care it provides for patients with dementia and learning disabilities.

### ***Dementia Care***

Improving care for patients with dementia in the acute setting is a key focus of the Trust. The priority for 2009/10 was to improve training and education for staff, and enormous strides have been made in this area.

An active Dementia Care Link Nurse Group is now well established. The "*Double Ds*" – Dedicated to Dementia, now have representation across all wards and departments and have received specialist training from an Advanced Practitioner in Dementia.

There has been excellent attendance and evaluation of the Mental Health Awareness training provided by Cheshire East Council, and the Trust are working collaboratively with Cheshire Hospices' Education to improve the end of life care offered to patients with dementia.

The Trust has recently commissioned the Campaigns Officer / Dementia Care Trainer from The Alzheimer Society to provide specific training for health care assistants. This training will give advice on how to care for people with dementia from a very practical point of view. It is the health care assistants that provide much of the basic nursing care to many patients, so these training days help the provision

of excellent care by providing an increased understanding as to what it is like to have dementia.

The Trust was recently invited to a supper event at the Royal College of Nursing in London to support of their Dementia project which is focusing on improving the experience of care for people with dementia and their carers in general hospitals. The supper provided an important opportunity to bring people together in developing a shared approach and a lively discussion took place highlighting a number of key points:

- Making dementia a priority for **everyone** delivering care in these settings
- Sharing and disseminating innovative practice
- Delivering outcomes from the project that will enable staff to deliver good quality care; including considering staffing levels
- Linking dementia in with other quality improvement initiatives.

The Trust will be working with the Royal College of Nursing (RCN) to help deliver this important agenda.

### ***Learning Disabilities***

The work undertaken by the Trust over the past year to improve the care offered to adults and children with a learning disability was recognised recently when the Trust won a Northwest Positive Action Award for Excellence in Clinical Care.

The development of Learning Disability Guidelines (available on the hospital intranet), a hospital passport aimed at gathering key information to help staff understand patients with learning disabilities better and the development of picture pathways to make certain investigations less daunting for patients are all examples of the work that has been recently undertaken. The Trust continues



to work collaboratively with Cheshire and Wirral Partnership NHS Foundation Trust and Learning Disability Awareness training is being provided to all appropriate staff.

### ***Improve the handling of complaints***

Following implementation of the Local Authority Social Services and National Health Service Complaints (England) Regulations in April 2009, the Trust has continued to work towards ensuring that its complaints handling is more individualised and responsive to complainants' needs. Complainants are contacted within three working days, in line with the Regulations, and are offered the choice of a meeting or a written response. As a consequence, 79 meetings were held with complainants this year.

The Trust has clear procedures in place for complaints handling which comply with Outcome 17 of the Essential Standards of Quality and Safety by the Care Quality Commission.

The Trust complies with the National Patient Safety Agency (NPSA) guidance on Being Open and, where deficiencies in care have been identified, an apology and explanation is always offered.

Where action plans have been developed, these are shared with the complainant and updates are provided at a later stage for assurance that the Trust has learnt from the complaint. This improvement came about as a direct result of the Trust's annual complaints survey in 2009 where it was identified that only 39% of complainants felt confident that action would be taken to improve the areas about which they had raised concerns. Action plans are reviewed and monitored on completion.

A Complaints Review Panel meets bi-monthly and consists of a Non-Executive Director (Chair), the Director of Nursing

and Quality, the Medical Director, the Deputy Director of Nursing and Quality, a Governor representative, the Complaints and Legal Services Manager and a patient representative. The Panel is responsible for providing information and assurances to the Board of Directors through the Patient Experience Committee that the Trust is safely managing all issues relating to the management of complaints. The Panel reviews complaints data to identify trends and monitors the implementation of action plans resulting from complaints. The Panel also reviews outcomes of independent reviews by the Ombudsman.

A system has been introduced to ensure that complaints are linked in more closely to risk governance if serious untoward incidents are identified. Serious concerns raised in complaints are discussed at the Trust's monthly Risk Governance meeting. Since July 2010 a member of Integrated Governance now attends the Patient Experience Team's monthly operational meeting to enable issues and trends to be identified as soon as possible.

The following table 9 shows the Number of Complaints, Referrals to the Ombudsman and Response Times over the past 4 years:

Table 9: Number of Complaints, Referrals to the Ombudsman and Response Times over the last 4 years

	2007/08	2008/09	2009/10	2010/11
Number of Complaints received	261	268	245	260
Number of Independent Reviews undertaken	1	1	3	1
Number of Requests for Review to Ombudsman	0	0	9	3
Number accepted for Review by Ombudsman	0	0	0	0
Response Times within 25 Days (or agreed timescale with complainant)	84%	98%	96%	96%

Examples of changes made as a result of complaints:

- The Trust holds an annual Complaints Best Practice event where experience of handling complaints is shared across divisions to promote best practice. This year a complainant was invited to attend to share the experience of making a complaint
- All patients with dementia now have a capacity assessment and a dietician referral on admission
- Photographs of the matrons, service managers, ward managers and lead nurse are now available on the medical wards so that patients and relatives know who to contact if they have any

concerns

- Off duty rotas have been changed to ensure that there is a co-ordinator on duty on the late shift which is when the majority of visitors arrive and want information about their relatives
- A web cam service has been introduced on the Neonatal Intensive Care Unit so that all mothers who are separated from their babies are able to see them at any time.

To assess if patients making a complaint feel they have been treated fairly and not discriminated against, an annual survey of complainants is undertaken.

Table 10: Annual Survey of Complainants

Complaints Survey	Target	2009	2010
Respondents felt their complaint was resolved satisfactory	65%	48%	48%
Were offered a meeting	75%	47%	52%
Reassured that action would be taken to improve the concern to them	50%	38%	56%
Complainants received a copy of the Trust's complaints leaflet	90%	76%	76%
Number of people who felt they were treated differently as a result of making a complaint	0	2	1

## Experience

### Priority 6: Patients and Staff

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

#### Nurses

The Trust has introduced the AUKUH (Association of UK University Hospitals) adult acuity / dependency tool to help determine the optimum nurse staffing levels on the wards. The AUKUH tool has been developed to help NHS hospitals measure (patient dependency and / or acuity) and provide evidence based decision making about nurse staffing levels and workforce requirements. Acuity and dependency measurements traditionally take place twice yearly in January and July.

In 2009, assisted by the acuity / dependency results, it was agreed to provide an additional budget for 26 healthcare assistants and three qualified nurses.

In 2010/11, the results were collected in

July, October and January. Due to ward reconfigurations within the Trust, it was agreed that the Emergency Care Division would undertake their audits in July and October whilst the Surgery and Cancer Division would undertake audits in October and January.

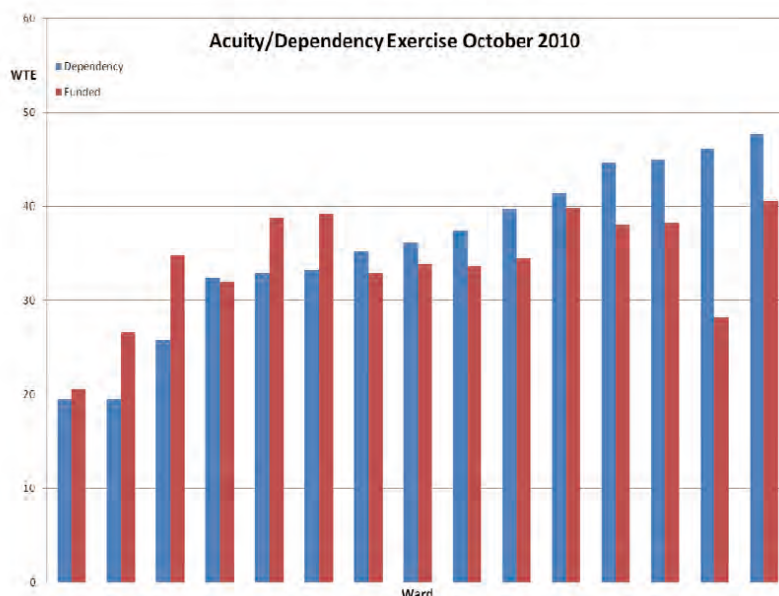
The aim for 2010/11 was that 60% of wards would be within range of their required establishment. In October 2010, 9 of the 15 wards reviewed were within range which means that this target has been achieved.

Work is currently ongoing within the Trust to review and trial alternative workforce tools for paediatrics, maternity, intermediate care and the assessment units.

Graph 8 represents the results from the acuity / dependency in October which shows that twelve wards are within range of their funded establishments.

The graph demonstrates an increase in patient acuity/ dependency against the funded staffing establishment for that ward.

Graph 8: Demonstrates the Acuity / Dependency results from October 2010





## Doctors

The Trust's Quality and Safety Improvement Strategy stated that the Trust would ensure the correct ratio of doctors to each inpatient bed to ensure the provision of safe, effective and compassionate care to all its patients.

The Trust has reviewed the available benchmarking tools to measure the skill mix of medical staff and has utilised Dr Foster Research to assist calculating a baseline. Dr Foster Research is a hospital marketing and measurement tool, used to provide comparative information on health and social care. Dr Foster Research has examined the ratio of doctors to 100 beds at each NHS Trust or Board in England.

This data is to be utilised by the Trust to calculate the appropriate numbers and skill mix of medical staff required for the 10 out of Ten. This Dr Foster ratio has been shown to have a strong link to mortality figures, in hospitals with high doctors per bed tend to have better than expected mortality ratios, and vice versa.

Trust performance against locally defined peers shows the Trust to be twelfth out of fifteen for numbers of doctors per 100 inpatient beds. The actual ratio of doctors per beds has to take into account the social and demographic profile of the community it serves. As such further investigation into the case mix is currently underway.

## Experience

### Priority 7: Environment

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

All wards within the Trust operate a "no-mixing" policy. There have been considerable changes to the environment and ways of working to ensure the Trust complies with the need to eliminate mixed sex accommodation.

The Trust has received positive comments with regards its coloured doors, signage and patient information leaflets.

The following improvements have been identified to help promote single sex accommodation:

- Mobile telemetry units
- Collaborative working with the patient placement team
- A process mapping exercise within the surgical assessment unit.

The Trust will be publishing a declaration of compliance of single sex accommodation in April 2011 following the approval of the Board of Directors.

Delivering same sex accommodation was highlighted at the National Dignity Day in March 2011 which was well evaluated by staff.



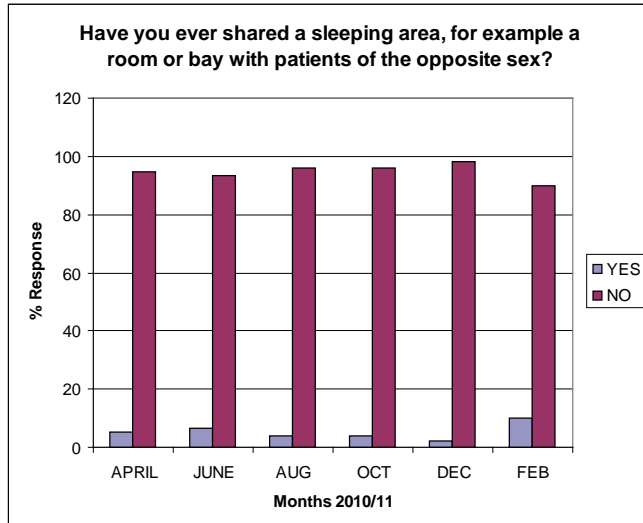
A survey of 100 patients takes place bi-monthly, which highlights patient experience in relation to same sex accommodation. As well as answering the specific questions it gives patients an



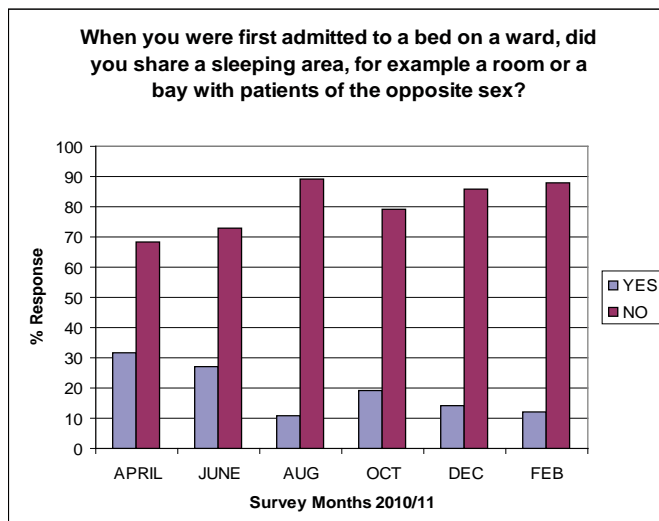
excellent opportunity to discuss any issues or comments they may have in respect of privacy and dignity at the Trust.

The results for these are shown in graphs 9, 10 & 11.

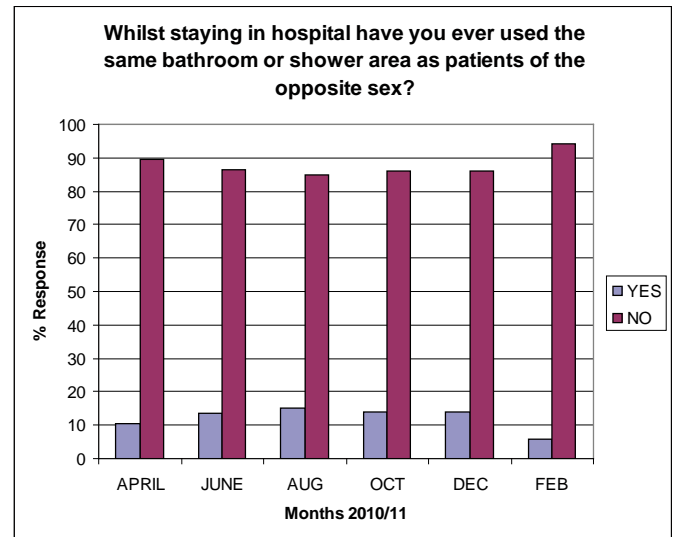
Graph 9



Graph 10



Graph 11



## Review of Performance in relation to Outcomes

### Advancing Quality (AQ)

Advancing Quality is a regional programme which was commenced in 2007, going live in 2008. The aim of the project is for Trusts to collect and report on a set of clinical measures for four patient groups.

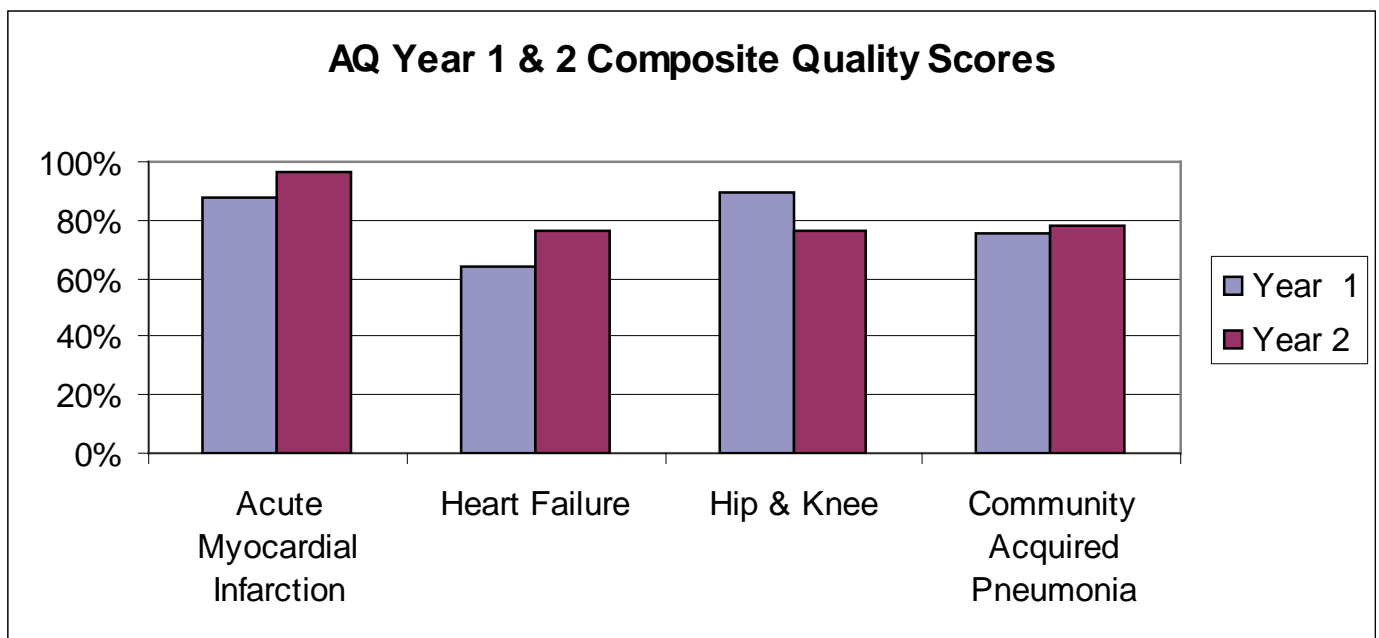
- Acute Myocardial Infarction (AMI)
- Heart failure
- Hip and Knee Replacement Surgery
- Community Acquired Pneumonia,

With continuous service improvement, the Trust aims to optimise patient care, improve clinical outcomes and reduce inpatient length of stay. The data is collected retrospectively and based on the final discharge diagnosis.

The Advancing Quality project entered its third year in April 2010, and for Year 3 has joined the CQUIN (Commissioning for Quality and Innovation) programme.

Year one saw the Trust in the top 50% of North West Trusts for Heart Failure and Community Acquired Pneumonia. In Year 2, the Trust improved in all but one of the focus groups, but only managed to achieve the Top 50% in Heart Failure. These results are shown in graph 12.

Graph 12: Composite Quality Scores for Advancing Quality Year 1 and 2



The composite scores measures the overall summary of care received. As can be seen, the Hip and Knee replacement surgery group failed to improve in year 2 and this was predominantly due to local practice within orthopaedics not meeting

the North West guidance. Practice has now been altered and the results for hip and knee replacement surgery are improving.

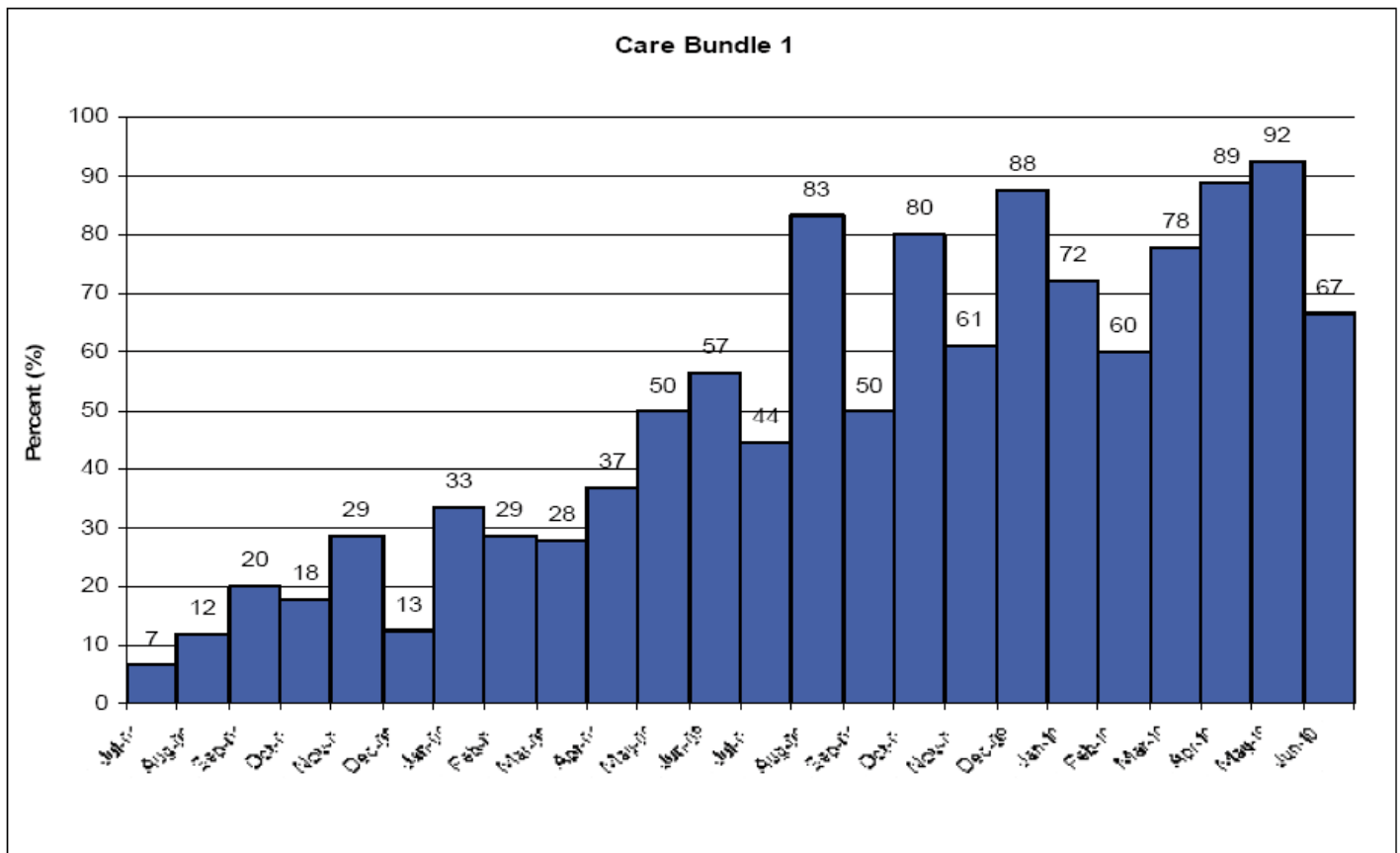
## Stroke

The Northwest Stroke Collaborative (Stroke 90:10) commenced in January 2009, with the aim of improving the care and management of patients who have suffered a stroke. The project was separated into 2 bundles of care, one focusing on acute care and the other on rehabilitation. A care bundle is a collection of interventions that may be applied to a particular condition.

The bundle aims to tie practice together into a cohesive unit that must be adhered to for each and every patient.

Stroke 90:10 held its summit meeting in November 2010, and the final data submission having taken place in July 2010. The final results from July 2010 for each care bundle are shown in graphs 13 and 14.

Graph 13: Care Bundle 1 Compliance July 2008 to July 2010



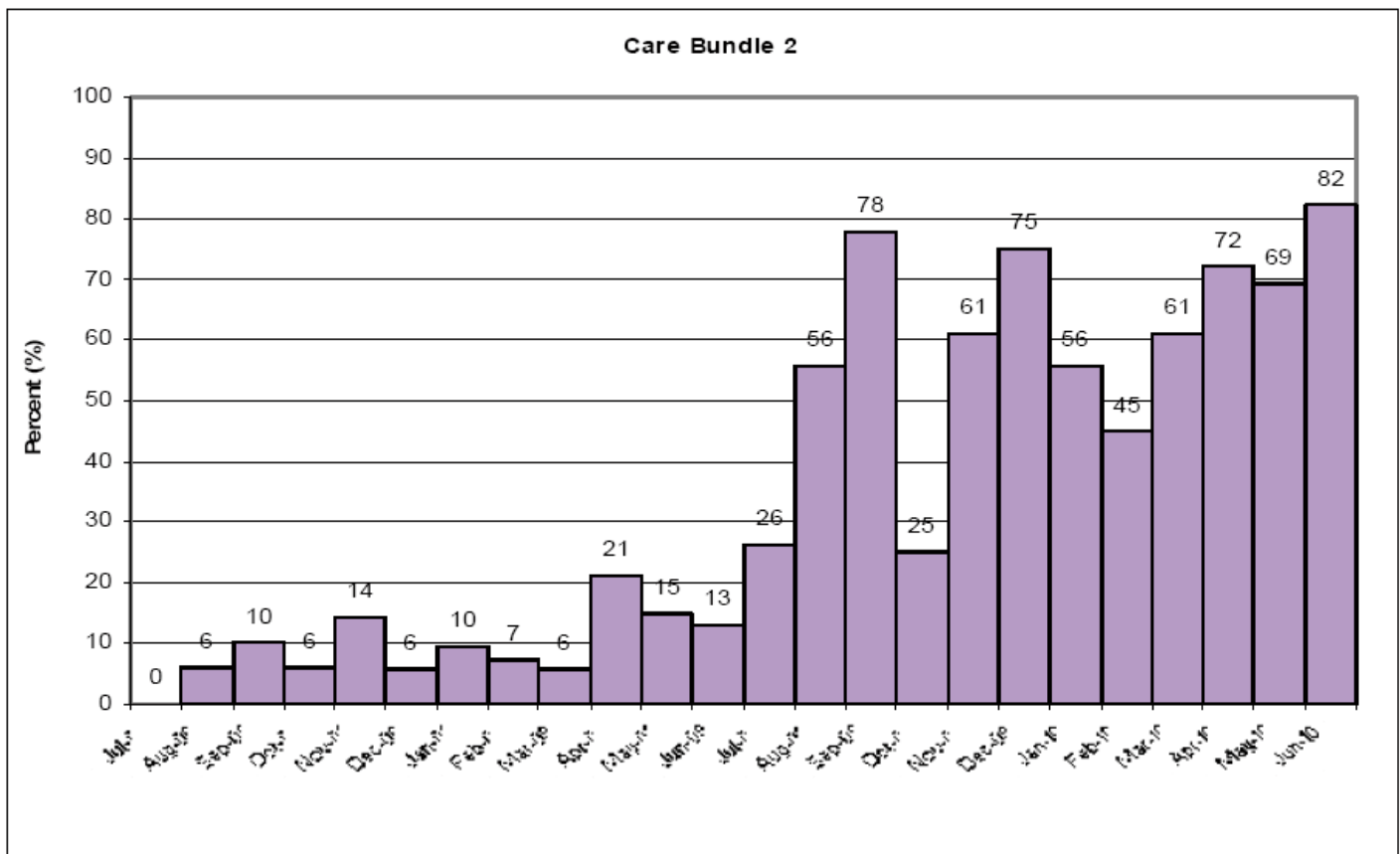
Graph 13 demonstrates the Trust's compliance with the acute care bundle.

The acute care bundle includes:

- Computed Tomography scan within 24 hours of admission

- Swallow assessment within 24 hours of admission
- Patient was weighed during hospital stay
- Aspirin therapy within 24 hours of admission.

Graph 14: Bundle 2 Compliance July 2008 to July 2009



Graph 14 demonstrates the Trust's compliance with the rehabilitation care bundle.

The rehabilitation care bundle includes:

- Physiotherapy within 72 hours of admission
- Occupational therapy within 7 days of admission
- Multidisciplinary goals set and reviewed weekly
- Mood assessment during hospital stay
- Stay on stroke unit.

### **National Sentinel Audit for Stroke**

The National Sentinel Stroke Audit is a bi-annual audit that is carried out by the Royal College of Physicians to measure the organisation of stroke care facilities at the Trust and the clinical care the patient who has had a stroke receives. This data is collected for an agreed number set of

patients admitted from 1 April to 30 June 2010.

The organisational score for 2010 was 61.62 moving up to the middle half from the lower quartile in 2008, showing great improvement in the Trust's processes and facilities to care for these patients.

The clinical audit results also show great improvements in the care of the stroke patient at the Trust. The nine key indicators of care showed the Trust to be performing in the upper quartile, above the national average. The overall Trust total domain scores moved from the lower quartile in 2008 into the middle half in 2010.

The Trust has implemented many service improvements as part of this project and was rewarded with a "Highly Commended Award" for improvement to Stroke Care by the Faculty of Stroke 90:10.



## Outcomes

### Priority 8: Cardiovascular

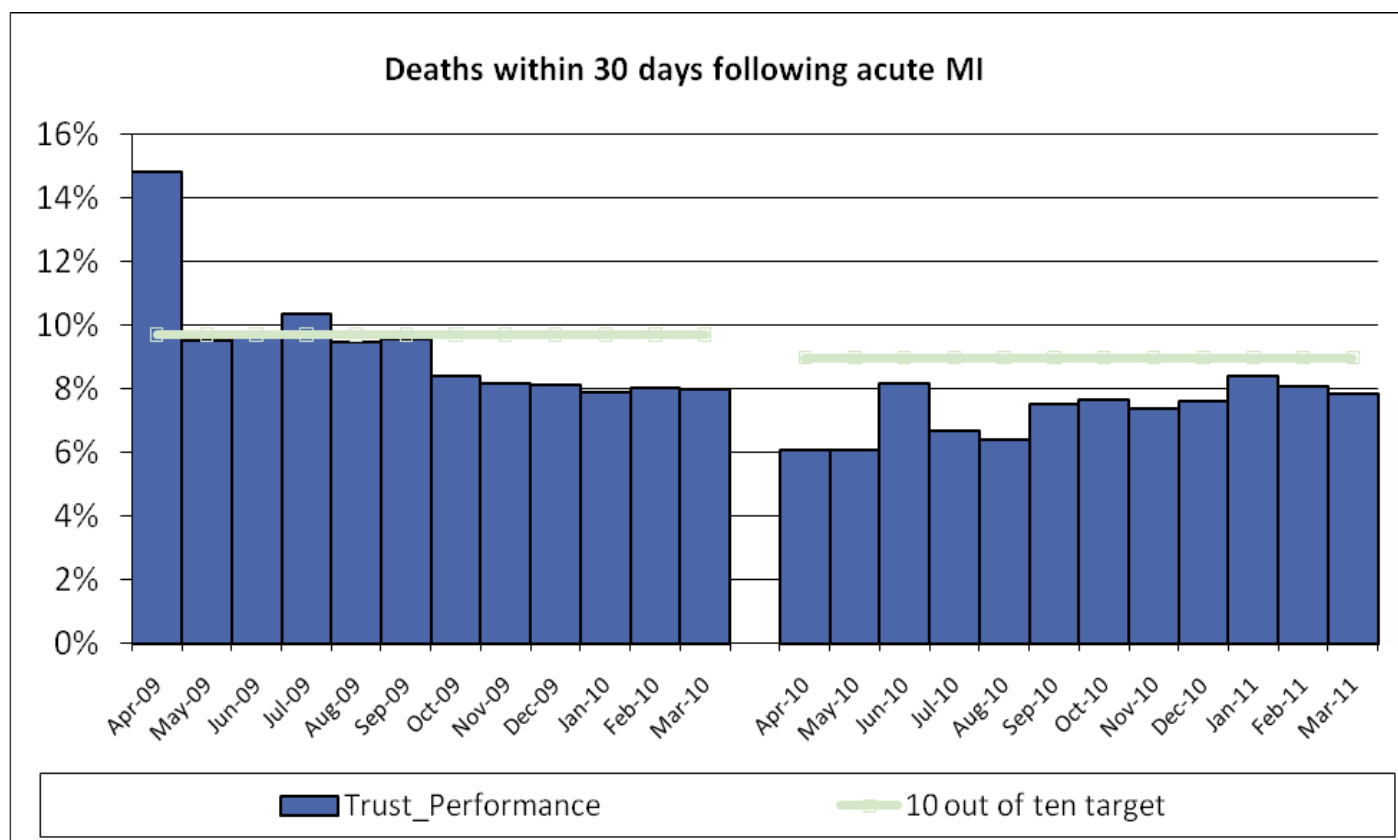
#### *To reduce the 30 day mortality rate in patients following Acute Myocardial Infarction (AMI)*

The aim for patients who have suffered an AMI is to return to a full and healthy life style as soon as possible. Following initial medical intervention patients are strongly encouraged to enter a cardiac rehabilitation programme which can help with lifestyle

change, including diet and exercise. Instances of death following an AMI can be reduced following these interventions and processes. Benchmarking this information against comparable peer information allows the Trust to direct its resources accordingly.

The Trust uses data from CHKS to monitor the mortality with 30 days following AMI.

Graph 15: Death within 30 days following AMI



The Trust has achieved the 10 out of Ten target to reduce deaths following acute AMI during 2010/2011.

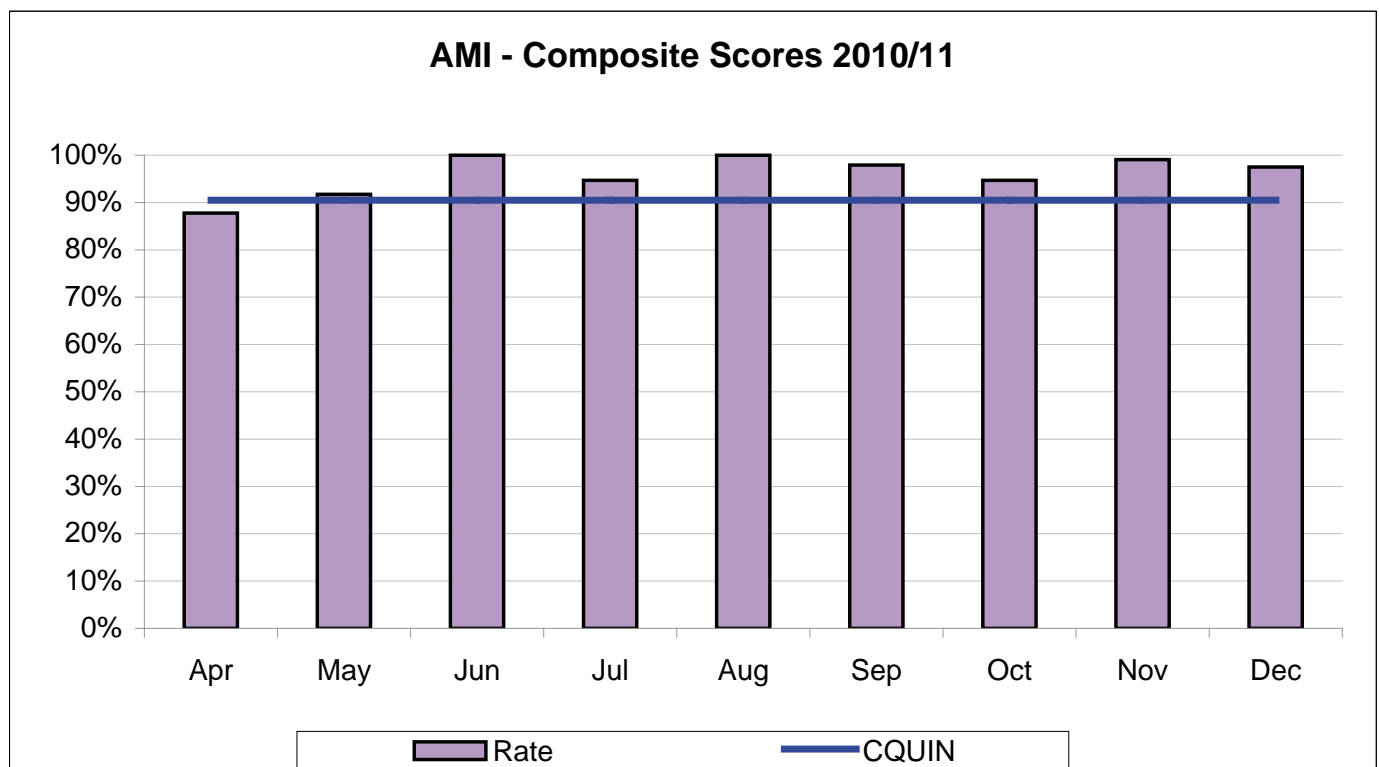
The outcomes of those patients who return to a normal healthy lifestyle as this is a true measure of success or failure of the AMI programme.

AMI is one of four conditions monitored by the Advancing Quality Programme. It was chosen due to its high prevalence in the North West of England. The aim of the programme is to record and report on a set of clinically agreed measures to improve outcomes for patients. The identification of the AMI population is based on discharge

diagnosis hence the lapse in available results.

Advancing Quality AMI Metrics	
•	Aspirin administered within the first 24 hours of admission
•	Thrombolytic treatment (if clinically registered)
•	Smoking cessation advice given
•	Discharge medications provided

Graph 16: The Trust's results for the delivery of appropriate care to the AMI patient group in 2010/11



Graph 16 shows the CQUIN was achieved.

The Trust has participated in Advancing Quality since 2008 and is continuously striving to improve the care patients receive whilst in hospital. Identification of patient who have been diagnosed with AMI is taken from the discharge diagnosis, hence there is a delay in the monthly reported scores

Following discharge from the Trust all AMI patients are entered into the Cardiac Rehabilitation Programme. This rehabilitation consists of a team of specialists who support the patient during their inpatient stay (phase 1) and throughout their journey back into the community. Cardiac Rehabilitation aims to reduce patient mortality and morbidity, to provide support for both patient and carer and enhance quality of life.

## Outcomes

### ***Cancer - To improve survival rates for patients diagnosed with cancer***

At present there is no available measurement tool to monitor or measure the survival rates for patients diagnosed with cancer. There are many data collection systems for patients diagnosed with cancer, but they are primarily measured on a national level. The Trust is part of the Central & Eastern Cheshire Primary Care Trust (CECPCT) all available data is presented as part of the return for the CECPCT and cannot be broken down to individual Trusts.

The data is further complicated as, following diagnosis, treatment for individual patients is often at other hospitals depending on the type of cancer. The stage at which the cancer is diagnosed contributes to the complexity of this outcome measure.

The Trust has met with the Greater Manchester & Cheshire Cancer Network and Merseyside & Cheshire Cancer Network with the aim of being able to collate data to enable measurement of this metric. Unfortunately the collation of data is not straight forward and due to the unavailability of local data the indicator has had to be altered.

The amended metric chosen will continue to encompass the patient diagnosed with cancer but will focus on reducing readmissions and length of stay in hospital following any complications of diagnosis / treatment.

## Priority 9: Cancer

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

In Year 2 of the 10 out of Ten strategy the original indicator for the cancer outcomes was changed due to the lack of available data. The baseline data for the revised indicator was established with stretch targets agreed until 2014. Overall the Trust is aiming to reduce admissions by 0.5-2.0 days per admission. The Acute Oncology Team has commenced the monitoring of acute admissions and length of stay in

hospital following early diagnosis and /or treatment of cancer. along with the reasons for admission.

It is hoped that the Greater Manchester and Cheshire Cancer Network will have purchased and installed the Recurring Admission Patient Alert (R.A.P.A) system throughout the Network in early 2011. This will allow the Acute Oncology Team to identify patients, intervene and manage patients at the 'front door', ensuring optimum healthcare treatment and advice are available.

Table 11: Actual number of Cancer Patients admitted as an Emergency and Length of Stay 2008-09 by Acute Trust

Acute Trust	Actual 2008-2009		Actual 2008-2009 Average length of stay (days)
	Patients per week	Patients per day	
Pennine Acute Hospitals NHS Trust	141	20	7.2
Wrightington, Wigan and Leigh NHS Foundation Trust	67	10	5.4
Christie Hospital NHS Foundation Trust	65	9	6.4
Central Manchester University Hospitals NHS Foundation Trust	64	9	8.2
Salford Royal NHS Foundation Trust	62	9	6.8
Mid Cheshire Hospitals NHS Foundation Trust	58	8	5.9
University Hospital of South Manchester NHS Foundation Trust	57	8	6.9
Stockport NHS Foundation Trust	51	7	10.7
Tameside Hospital NHS Foundation Trust	43	6	6.2
Bolton Hospitals NHS Trust	39	6	8.6
East Cheshire NHS Trust	36	5	6.8
Trafford Healthcare NHS Trust	21	3	7.2
<b>Grand Total</b>	<b>703</b>	<b>100</b>	<b>7.1</b>

NB These figures are based on patients admitted as an emergency who already had a cancer diagnosis or who were subsequently diagnosed with cancer during their admission. It is assumed that some (not all) of these patients would be seen by / benefit from the acute oncology service.

Data courtesy of Greater Manchester and Cheshire Cancer Network.

An audit of 30 sets of patient case notes was undertaken in November 2010 to measure the Trusts current position in respect of length of stay. It was found to be 5.2 days, which demonstrates improvement on the 5.9 days reported in 2008/09. It is recognised that this is a small sample of case notes that were reviewed by the Trust, but work will continue in this area over the coming year.



## Priority 10: Infections

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

#### Goal

To comply with national guidelines and annual targets for Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile infection rates. To establish a baseline for monitoring urinary tract infections (UTIs) and implement surveillance processes in 2010 and set a year on year improvement target.

#### Planned Target Outcomes

- Demonstrate an annual reduction in HCAI rates
- 2010/11 Clostridium difficile:  
Target: < 106      Actual: 105  
Achieved
- 2010/11 MRSA bacteraemia:  
Target: < 5      Actual: 0  
Achieved
- Establish baseline for UTI surveillance 2010
- MRSA screening for emergency admissions by December 2010

### Progress Made by March 2011

#### Clostridium difficile

Rates of Clostridium difficile infection (CDI) have fluctuated over the year and this has predominantly been linked to episodes of Norovirus within the Trust and seasonal activity. Rates of CDI were significantly lower from May to October 2010, with the highest number per month seen in November & December 2010; during which outbreaks and admission activity peaked. Whilst the Trust has not seen the reduction it would have like to, it has met its annual trajectory of less than 106 cases for the year. The final CDI rate for the twelve month period stands at 105. The objective for next year (2011/12) is 73 cases in a

twelve month period, which will provide the organisation with a significant challenge. To achieve this objective, CDIs must receive the same focus as MRSA bacteramias and divisional boards must review all cases of CDI reported on their wards.

#### MRSA bacteraemia

MCHFT has not reported any cases of MRSA bacteraemia over the past 12 months and this is a commendable achievement for the Trust. The Trust currently represents the best in class within England for small acute trusts in relation to MRSA bacteraemia rates. Last year 8 cases were reported; 6 hospital acquired and 2 community acquired. A number of measures have been implemented as part of overall infection prevention strategies and this includes focussing on ANTT (a standardised process for aseptic non touch technique), attempting to clear (or reduce the amount of) MRSA from patients carrying it (to reduce the risk of systemic infection) and revising cleaning methods within the Trust. The target for 2011/12 is 2 MRSA bacteramias and work will continue to ensure that avoidable infections are prevented within the organisation.

#### Urinary Tract Infections (UTIs)

Due to nationally changing requirements for the monitoring of UTIs, this goal has not been fully achieved. National guidance has reviewed the UTI surveillance criterion and recommends that the incidence of catheter insertion provides a more meaningful metric. The Trust has reviewed catheter insertion incidence three times over the last 18 months in the form of prevalence surveys and the following insertion rates (percentage of patients with a catheter) have been 12%, 11% and 14%. Establishing an improvement target is difficult, due to the lack of national data available for benchmarking. However, a recently published national document indicated that two Trusts who

had implemented change management strategies had initial catheter insertion rates of 21% and 24 % respectively. A Trust in the Northwest (of similar in size to MCHFT) reported a catheter insertion rate of 32%, reducing to 16% after proactive measures. This indicates that the Trust's insertion rate appears to be well below the national average. Further data will be collated next year in relation to catheter insertion, as this metric is also included in the Northwest's

patient safety initiative; Patient Safety Express Host.

### MRSA Screening

In December 2010, the Trust implemented MRSA screening for all emergency admissions, as required by the Department of Health. Compliance with screening requirements and positivity rates are detailed below:

Month	Numbers of patients screened			Numbers of patients MRSA positive (from screened patients)		
	Surgery and Cancer	Emergency Care	Overall	Surgery and Cancer	Emergency Care	Overall
January 2011	447	553	1000	2	10	12
February 2011	390	632	1022	5	11	16
March 2011	425	574	999	8	10	18

MRSA screening will continue as a proactive measure, as early detection allows timely suppression therapy (attempt to clear MRSA carriage) and this reduces the risk of the patient developing a bloodstream infection.

### External Assurance and Performance Indicators

The external assurance and performance indicators have been fixed by Monitor. The Trust will report on the following performance indicators:

- MRSA – this is reported in priority 10, as it is part of the 10 out of Ten Programme
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

Also included is the Trust's Governors' locally selected indicator which has been chosen as Mortality for 2010/11.

Maximum waiting time of 62 days from

urgent GP referral to first treatment for all cancers.

There has been considerable work within the Trust over the last 12 months to improve the timeliness of the 62 day pathway in all tumour groups:

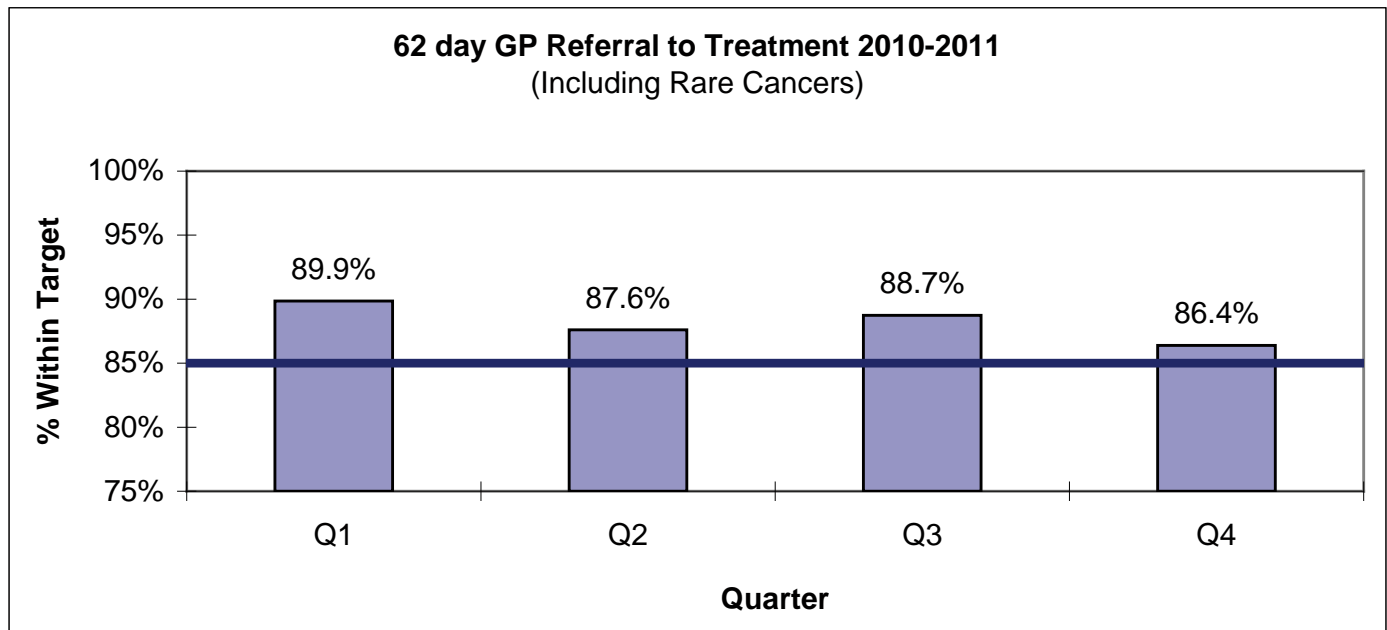
- Reorganisation of the cancer tracking team to enhance efficiency and allocate responsibility effectively.
- Appointment of a Cancer Data Manager to manage, monitor and report on current and predicted target performance.
- Weekly meetings with Divisional Manager to highlight and enable action on pathway delays.
- Meetings with clinical and service leads

to analyse suspected cancer pathways and identify required improvements.

This work is ongoing and further work is planned both at Trust and Greater Manchester & Chester Network level to ensure that pathways are efficient and also to ensure communication between Trusts is effective and within agreed protocols:

- Development of GP referral proformas to reduce inappropriate referrals and to enhance efficiency at the start of the 62 day pathway.
- Regular reporting of performance and breach reasons of individual tumour groups to clinical and service leads.
- Network led work to improve communication between Trusts and standardise transfer of care procedures.
- Reduction of average days to / from referral to first seen to 5 days as part of the Surgery & Cancer Division's 10 out of Ten.

Graph 17: 62 day GP Referral to Treatment 2010/11



Graph 17 demonstrates the GP referral to treatment rate on a quarterly basis within 2010/11. The figures for February and March contained within quarter 4 have not yet been validated, but all figures show the target has been achieved.

## Consultation on Quality

The consultation process for the Quality Account commenced on 21 September 2010 until 1 March 2011.

The objective of the Consultation was to:

- Ask local people and Members of the Foundation Trust for feedback on the 10 key priorities for the Trust
- Recruit new Members as Foundation Trust Members
- Ask local people how they would like to see the Trust grow and where interest lay for access Trust information.

Through partnership working, the Trust once again joined with the Cheshire Police Authority to participate in a joint consultation exercise. The Police

Authority aimed to directly consult with the community to gather views about public priorities. Members from the Trust also visited local supermarkets in Winsford and Crewe to gain public opinion on the importance of the Trust's 10 out of Ten.

Surveys were sent to members who receive regular news from the Trust to put forward their views on the Trust's 10 priorities as well as assisting in the mapping of the future.

The public were once again asked to prioritise the list of 10 key areas as well as give comments indicating which areas they felt were important. The overall number of responses received was 200 and the results below demonstrate the public's opinion of the importance of the Trust's 10 out of Ten.

Table 13

Indicator	Rank	Count	%
Infections	1	155	77.5%
Patient Safety	2	154	77.0%
Cancer	3	152	76.0%
Cardiovascular	4	145	72.5%
Patient and Staff	5	137	68.5%
Environment	6	127	63.5%
Readmissions	7	126	63.0%
Finance	8	124	62.0%
Harm Caused	9	123	61.5%
Mortality	10	116	58.0%

Graph 18

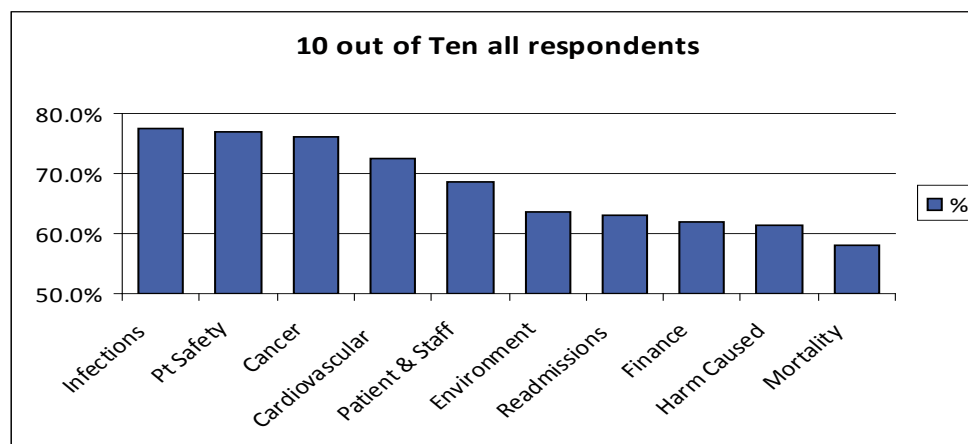
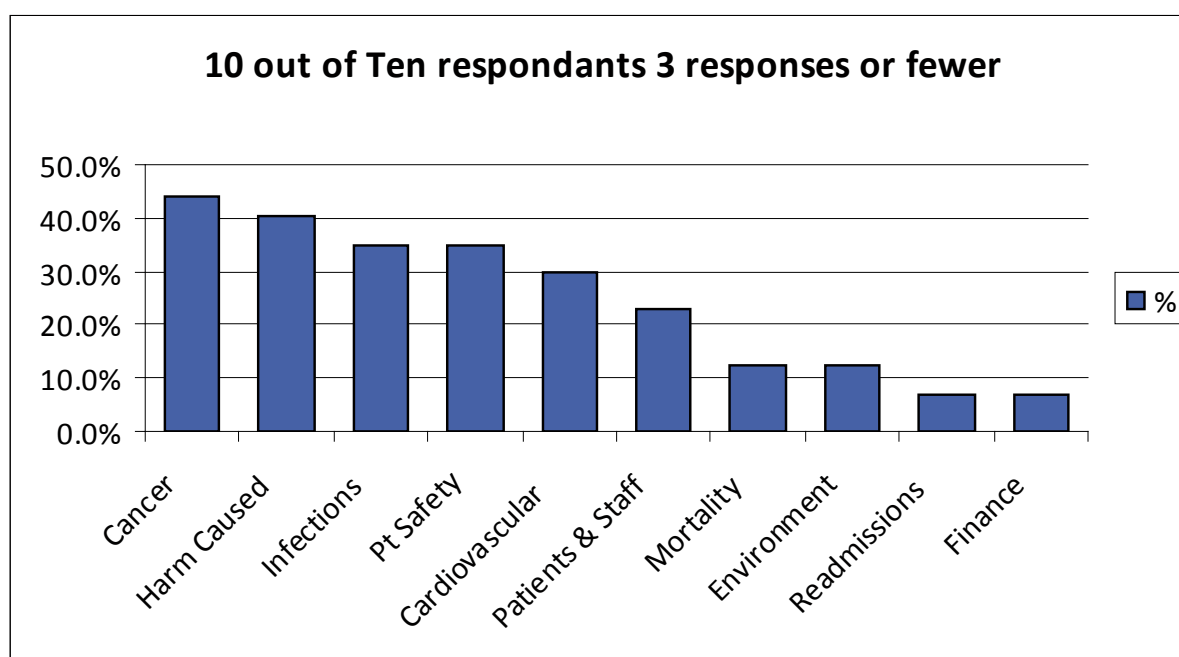




Table 14: Indicators where 3 or fewer chosen 2010/11

Indicator	Rank	Count	%
Cancer	1	25	43.9%
Harm Caused	2	23	40.4%
Infections	3	20	35.1%
Patient Safety	4	20	35.1%
Cardiovascular	5	17	29.8%
Patient and Staff	6	13	22.8%
Mortality	7	7	12.3%
Environment	8	7	12.3%
Readmissions	9	4	7.0%
Finance	10	4	7.0%

Graph 19



In 2009, Infections, Cancer and Mortality were the most important in people's minds equating to 53.95% of all the respondents. Infections were ranked the most important with 44 out of 215 responses (108 people) highlighting that area.

To clarify a person could choose one, two or three different groups and still be included in this sub-analysis, hence

why 108 people generated 215 different responses.

Overall it has been demonstrated that the 10 indicators chosen by the patients, public and staff in 2009 are still regarded as important when measuring quality.

***Statements from Local Involvement Network (LINK), Health & Adult Social Care Scrutiny Committee and Central and Eastern Cheshire Primary Care Trust (CECPCT) and Governors***

***Central and Eastern Cheshire Primary Care Trust***

**CECPCTs response to Mid Cheshire Hospital NHS Foundation Trust Quality Account**

CECPCT has reviewed the information contained in the Quality Account and can confirm the following is accurate:

- Commissioning for Quality and Innovation (CQUIN) framework
- Care Quality Commission (CQC)
- Cancer waiting times

**CECPCT has no comparative data to verify the following:**

- Priority 4 - 7 day readmissions
- Priority 6 – number of Doctors per 100 inpatient beds

**CECPCT is unable to validate the data as follows:**

**Safety**

**Priority 1: Mortality**

The information provided from Caspe Healthcare Knowledge Systems (CHKS) is not available nationally therefore CECPCT does not have access to this data.

CECPCT expects MCHfT, as a matter of high priority, to move over to systems which are published nationally, e.g. Dr Foster, to enable CECPCT to confidently validate this data in the future.

**Outcomes**

**Advancing Quality (AQ)**

CECPCT is able to validate Year 1 data from the AQ website, Year 2 data is not yet published so CECPCT is unable to validate.

**CECPCT would like to commend the following:**

**Safety Reducing Avoidable Harm**

The fall in the numbers of incidents resulting in significant harm to patients.

**Care Quality Commission (CQC)**

The actions taken by MCHfT following the CQC responsive review into compliance regarding patient safety alerts and the review of outcomes 4, 9 and 17.

**Complaints**

A decrease in the number of complaints received by MCHfT, and actions taken to assure complainants that lessons learned and actions taken are improving areas where concerns are raised. CECPCT would like to see the risk-rating of complaints for 2010/11 included in

the Quality Account.

**CECPCT would like to comment about the following:**

**Priority 1 – Mortality**

CECPCT acknowledges all the work that MCHfT have undertaken in reducing hospital mortality rates and welcomes the involvement with the North West Reducing Mortality Collaborative in 2010/2011.

**Information Governance (IG)**

CECPCT is concerned about the low score (41%) and is not confident that the information provided gives adequate reasons for this. Further assurance from MCHfT on actions to improve the standard is required.

**Patient Experience**

CECPCT is concerned about the results of the National Inpatient Survey and National Maternity Survey but welcomes the initiative proposed by MCHfT to improve the experience for patients. CECPCT requires assurance on the action plans put in place to improve standards.

**Experience**

**Priority 6: Patients and Staff**

Nurses – CECPCT commends the introduction of the Association of UK University Hospitals (AUKUH) Acuity and Dependency Tool. CECPCT requires assurance on patient safety and quality of care on wards where the establishment is significantly below the dependency requirements.

**Outcomes**

**Priority 9 Cancer – Improve survival rates**

The Somerset Cancer System, used by MCHfT, does provide detailed cancer intelligence, which populates the Cancer Registry. The Cancer Registry provides cancer incidence, survival and mortality data to Trust level.

Cancer Services are working with Greater Manchester and Cheshire Cancer Network to implement an acute oncology service by Autumn 2011.

CECPCT would have liked the information in the Quality Account to include the priorities agreed with the Cancer and End of Life Programme Board.



Michael Pyrah  
Chief Executive

## **Local Involvement Network (LINK)**

Thank you for inviting the Cheshire East LINK to comment upon the Trust's Quality Accounts

We understand that the Trust has consulted the public, its users and staff on the priorities they wish to see addressed and we welcome this initiative. We also welcome the intent to produce an easy read version of the Document. The Document is a much easier read this year.



The LINK welcomes and agrees with the emphasis placed upon the priorities in the four domains of Outcomes, Experience, Safety and Effectiveness.

In particular Safety focusing on:

- Mortality Rates
- Patient safety, particularly in the attempt to reduce the number of moves experienced during a patient's stay in hospital
- A reduction in avoidable harm caused to patients.

### **Experience, Patients and Staff**

We are concerned at this year's low target to ensure that 75% of the wards reach their required nursing establishment. However we understand that the Trust has a nurse recruitment problem which it is attempting to address. The work undertaken to identify patient dependency is to be commended but the vacancy factor must make the implementation of this extremely difficult.

### **Environment**

We congratulate the Trust on its compliance in eliminating Mixed Sex accommodation.

### **Infection**

We congratulate the Trust in meeting the nationally set targets and in particular in achieving zero numbers of MRSA bacteraemia.

We understand that the production of the Annual Report has mandatory elements in its structure and that it concentrates both on the previous year's performance whilst looking forward to the coming year but we do find the separation of these elements somewhat difficult.

We welcome the intent to improve upon patient experience as evidenced in the National Inpatient Survey and the National Maternity Survey but find it of concern that under the National Inpatient Survey performance has dropped in all but two areas. The National Maternity survey shows improvement in all but two areas.

The Trust is to be congratulated upon its work in Dementia care and Learning Disabilities.

The improvement in Stroke care as evidenced in the national Sentinel Audit is very welcome.



### **Care Quality Commission**

Cheshire East LINK is pleased to note there has been no enforcement action against the Trust during the past year.

We note that the Trust has participated in special reviews and investigations by the Care Quality Commission in relation to:

- Care Quality Commission review of support for families with disabled children
- A Responsive review in relation to a number of breached safety alerts. The LINK notes that the Review looked into
- Care and Welfare of people who use services (Maternity services)
- Medicine Management
- Complaints

We note and welcome the actions taken as a result of the Review.

Again thank you for the opportunity to comment.

### ***Health & Adult Social Care Scrutiny Committee***

Thank you for inviting the Health & Adult Social Care Scrutiny Committee to comment upon the Trusts Quality Accounts.

An overview of the Quality Account was presented to the Committee with an explanation of the 10 out of Ten Initiative, how it was established and monitored as part of a five year Quality & Safety Improvement Strategy. The Committee was pleased that the Trust ran a consultation each year to analyse whether or not the 10 priorities identified were still relevant and judged as being important by the public.

The Committee was invited to comment on aspects of the Quality Account

#### **Patient Experience**

The Committee queried why the satisfaction levels were so low. The Committee was satisfied that the Trust had set up a steering group to analyse the results and to develop subsequent actions.

#### **Readmissions**

The Committee questioned whether the Trust had confidence in meeting the target set when the current and lower target had not been achieved. It was explained that the development of the integrated discharge team should have a large impact on reducing the number of readmissions and therefore, the Trust were confident in meeting the revised target.

#### **Handwashing**

It was questioned whether the Trust felt that their hand cleaning policy was being enforced properly. It was confirmed that this was audited rigorously and that the message was constantly reinforced with staff.

It was suggested that for future versions of the Quality Account it would be useful if out-patients were surveyed in more detail. The Trust assured the Committee that this would be something that the Trust would consider.

The Chairman drew attention to a number of figures that were not yet available with regards to the Trust's performance against key national priorities. It was agreed by the Trust that these figures would be submitted to the Committee when available but Members were advised that the overarching aim of the Quality Account is to demonstrate the Quality provision, not as a performance monitor.

The Committee welcomed the planned 'easy read' version of the Quality Account.

## **Governors**

The Quality Account 2010/11 was presented to the Board of Governors in March 2011. The comments received following this meeting are summarised below:

Overall the Quality Account was reported as interesting and informative.

The 10 out of Ten Initiative was praised for its continuous improvement within the financial reality of the current healthcare economy. Areas commended include the improvements made within the Trust in Stroke care and the promotion of patients' privacy and dignity.

The Quality Account 2010/11 was described as 'an excellent platform for going forward with confidence'.

## **Readers' Panel**

The Quality Account 2010/11 was circulated to the Trust's Readers' Panel with a questionnaire for completion. The questionnaire asked for comments about the usefulness of the account, the overall content and the labelling of the data presented.

The feedback that the Trust received suggested that the Quality Account was very useful and the summary of contents was 'about right' for public to understand. The presentation and labelling of data was described as being completely correct by the majority of respondents.

## Key National Priorities

Table 15: Quality Overview

Safety Measures Reported		2008-2009	2009-2010	2009-2010	Result	
Hospital Falls / injuries (falls / 1000 bed days) *		6.41	6.09	6.98	Improved (Higher reporting in no harm falls)	
Falls assessment risks completed within 24hrs *		83%	96%	95%	Reduced	
Waterlow tests completed within 24hrs of admission *		98%	93%	94%	Improved	
Nutritional assessment completed within 24hrs of admission		82%	99%	97%	Reduced	
Performance Indicators		2008-2009	2009-2010	2009-2010	Target	Result
A & E Waiting Times		98.1%	97.3%	97.3%	95%	Achieved
Access to Geniro-urinary medicine (GUM) clinics		99.9%	100%	100%	100%	Achieved
Cancelled Operations	% of cancelled operations	1.19%	1.46%	0.94%	0.8%	Achieved
	% of breaches of the 28 day guarantee	9.5%	14.4%	7.2%	< 5%	Underachieved
Ethnic coding data quality		84.1%	85.3%	87.5%	85%	Achieved
Inpatients waiting longer than 26 week standard		0%	0%	0%	0%	Achieved
Outpatients waiting longer than 13 week standard		0.14%	0%	0%	0%	Achieved
Rapid access chest pain clinic waiting times		100%	100%	100%	100%	Achieved
Patient Experience Measures Reported		2008-2009	2009-2010	2009-2010	Result	
Overall how would you rate the care you received **		93%	93%	89%	Reduced	
% of patients who felt they were treated with dignity and respect		97%	96%	95%	Reduced	
% patients who had not shared sleeping area with opposite sex		74%	75%	76%	Improved	

\*monitored monthly

\*\*patients rating their care as excellent,very good and good

Table 16: National Priority and National Core Standards

National Targets and Regulatory Requirements	2008-2009	2009-2010	2010-2011	Target	Result
MRSA Bacteraemias	15	8	0	5	Achieved
Clostridium Difficile Infections	142	117	105	106	Achieved
Smoking During Pregnancy	22.5%	19.5%	20.0%	15%	Underachieved
Breastfeeding Initiation Rates	59.5%	59.6%	61.5%	65%	Underachieved
18 week maximum wait from point of referral to treatment (admitted patients)	89.1%	92.8%	93.2%	90%	Achieved
18 week maximum wait from point of referral to treatment (non-admitted patients)	97.2%	97.6%	98.1%	95%	Achieved
Maximum wait of 31 days from diagnosis to treatment of all cancers	96.2%	98.4%	100%	93%	Achieved
Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals (note change of definitions and targets between 2008/09 and 2009/10)	98.7%	93.2%	93.6%	96%	Underachieved
Maximum waiting time of 31 days for subsequent treatment for all cancers	Target from 09/10	100%	100%	96%	Achieved
Maximum two month wait from RTT for all cancers (note change of definitions and targets between 2008/09 and 2009/10)	95.9%	85.6%	87.7%	85%	Achieved
Thrombolysis	74.5%	66.7%	67.9%	68%	Underachieved

NB. There were definitional changes to the cancer targets from 1 January 2009.



## Glossary & Abbreviations

Term	Abbreviation	Description
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.
Aseptic Non Touch Technique	ANTT	Aseptic Non-Touch Technique aims to prevent micro-organisms on hands, surfaces or equipment from being introduced to a susceptible site.
The Association of UK University Hospitals	AUKUH	A national tool used to measure patient dependency/acuity to help determine nurse staffing levels.
Care Quality Commission	CQC	The independent regulator of health and social care in England. It's aim is to make sure better care is provided for everyone, whether that's in hospital, in care homes, in people's own homes, or elsewhere. The CQC replaces 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.
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.
Global Trigger Tool	GTT	Uses internationally agreed triggers to identify adverse events during case note review to measure the overall level of harm in a health care organisation.
Healthcare Resource Group	HRG	Is a grouping consisting of patient events that have been judged to consume a similar level of resource

Term	Abbreviation	Description
Healthcare Quality Improvement Partnership	HQIP	The Healthcare Quality Improvement Partnership, HQIP, promotes clinical audit and healthcare quality improvement, managing the National Clinical Audit and Patient Outcomes
IPOS MORI		A leading market research company in the UK.
Liverpool Care Pathway	LCP	The LCP is a document which should be used to facilitate best practice and improve care of the dying patient. Adapted from the hospice model of care the LCP is a holistic, multidisciplinary and evidence based tool which focuses on the physical, psychological and spiritual needs of the dying patient (and their families) in the last few days of life
Leading Improvement in Patient Safety	LIPS	The Leading Improvement in Patient Safety (LIPS) programme is about building the capacity and capability within hospital teams to improve patient safety
Methicillin-Resistant Staphylococcus Aureus	MRSA	Staphylococcus aureus is a bacterium which is often found on the skin and in the nose of about 3 in 10 healthy people. An infection occurs when the bacterium enters the body through a break in the skin. A strain of this bacterium has become resistant to antibiotic treatment and this is often referred to as MRSA.
Mid Cheshire Hospitals NHS Foundation Trust	MCHFT	The organisation which runs Leighton Hospital, Crewe, Victoria Infirmary, Northwich and Elmhurst Intermediate Care Facility, Winsford
Monitor		Monitor authorises and regulates NHS foundation trusts and supports their development, ensuring they are well-governed and financially robust.
National Patient Survey		Co-ordinated by the CQC, it gathers 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.

Term	Abbreviation	Description
Patient Recorded 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.
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 Matters		The Trust's programme to look in detail at the clinical pathways and processes to progress quality, reduce waste and improve efficiency.
Re-admission Rate		A measure to compare hospitals which looks at the rate at which patients need to be readmitted to hospital after being discharged (leaving hospital). Readmission measures can use different time periods between leaving and being readmitted to hospital e.g. 14 and 28 days.
Risk Adjusted Mortality Rates		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.
Reporting & Learning System	RLS	National database that allows learning from reported incidents

Term	Abbreviation	Description
Safety First		E 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.
Sentinel Audit		A national audit that measures the care delivery provided for patients following the diagnosis of a stroke.
Situation, Background, Assessment and Recommendation	SBAR	A national tool to standardise handover of care between clinicians
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.
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.



## Chapter 8

# Chief Executive Officer's Afterword

I am delighted to be able to comment on the first Annual Report produced during my office as the Chief Executive Officer for Mid Cheshire Hospitals NHS Foundation Trust. This has been an exciting and yet difficult year for me personally; managing the transition into the Chief Executive role whilst delivering the level of care and experience that our patients deserve and all against a backdrop of real financial constraints, service reconfigurations and developments.

Chapters 2 and 3 of the report provide additional information on the principal activities of our Trust during the financial year. However, I am sure you will agree that despite the considerable challenges mentioned above, the Trust has performed remarkably well. I am particularly proud of the Trust's achievement of zero MRSA bacteraemias, where we are considered best in class for similar sized Trusts across the country, and exceeding our planned 10 point reduction in the Trust's mortality rates ; a 16 point reduction was actually achieved. Also, as a result of undertaking additional works on our estate and repositioning the Emergency Assessment Unit, we have been able to make a declaration of compliance in respect of delivering against the same sex accommodation criteria.

Once again, demand has increased over the year, but due to creating efficiency in how we deliver our services, such as reducing length of stay by a day during this financial year, we have managed to sustain delivery against all targets and standards.

As always, there have been challenges that have caused major operational difficulties, such as managing the exceptional demand created by the influx of patients with Swine flu over the winter months. Across the Northwest this led to the cancellation of all non-urgent and non-cancer surgery to ensure enough beds and critical care capacity for very poorly Swine flu patients. As a result of this, targets and standards pertaining to delivery against waiting times, such as 18 week referral to treatment time target, became increasingly difficult to achieve. However, due to the hard work and commitment of the many staff involved in delivering services to our patients, we were able to recover our position and we passed all our key targets and standards except for the Thrombolysis target which we underachieved.

Quality of care remains a number one priority and the Trust's Quality, Safety and Effectiveness Committee (QuEST), which is now in its second year of operation, was set up to enable a real focus on delivering quality initiatives, and evidence how this has improved clinical outcomes and the quality of experience for our patients. There have been some noticeable achievements reported through this committee to the Board of Directors.

Last year's Annual Report mentioned our low score in the 2008 Stroke Sentinel Audit, and measures we had taken to improve performance since then, such as doubling the number of acute stroke beds and appointing a new Stroke Consultant. Under the leadership of Dr Salehin I am delighted to say our performance in the 2011 stroke audit has significantly improved. As well as scoring better in the majority of areas we are proud to be in the top 25% of Trusts delivering the 9 key standards that form part of a care bundle to patients who have suffered a stroke. This is an extremely important achievement, as delivery

against these key standards will improve the clinical outcome for our patients. To support delivery of our achievements in stroke care the Trust was part of a regional initiative called Stroke 90:10. This initiative was instrumental in providing support and momentum to the stroke team at our Trust. Although the regional stroke 90:10 project has ceased we remain committed to delivering on these standards and further improving services for patients who have undergone a stroke, and QuESt will continue to monitor this progress.

Additionally our main efforts this year in improving the quality of care for patients has been through sustained delivery of the Trust 10 out of Ten, 5 year Quality and Safety Strategy. In year one staff, patients, public and other key stakeholders supported the Trust in selecting 10 key indicators where we aimed to be in the top 10% of performance by 2014. This year time was spent establishing our current performance and putting monitoring mechanisms in place where these did not currently exist. This allowed us to demonstrate measurable improvement or areas for further action. Chapter 7 gives a full account of performance against these 10 indicators, as these now form the foundation of the Trust's Annual Quality Account.

The Annual Report provides a business review of all aspects of the organisation. From these reports and accounts the public and users can see how well the Directors have performed in delivering the organisational objectives as outlined in the Annual Report. I am sure you will agree that, under the current economic climate, the operational and financial reviews demonstrate we have performed well. There have undoubtedly been disappointments within the year which have been covered in the body of the Annual Report. However, where these occur we

are committed to ensuring any issues highlighted are rectified and the appropriate learning takes place.

Finally, I would like to particular extend my thanks to the staff, Volunteers and Governors of the Trust who equally remain committed and work tirelessly to improve the quality of service that we deliver to our patients. Year on year I am impressed by their dedication and selflessness in enabling our patients, carers and families to achieve a better personal experience.



Tracy Bullock  
Chief Executive Officer

## Chapter 9

# Annual Accounts

### *Foreword to the accounts*

These accounts for the year ended 31 March 2011 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.

A handwritten signature in black ink, appearing to read 'TBullock', written in a cursive style.

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 accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed Mid Cheshire 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 NHS Foundation Trust and of its Statement of Comprehensive Income 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 him to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer's Memorandum.



Tracy Bullock  
Chief Executive

6 June 2011



## ***Statement on Internal Control of Mid Cheshire Hospitals NHS Foundation Trust***

### ***Scope of responsibility***

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer memorandum.

### ***The purpose of the system of internal control***

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can, therefore, only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Mid Cheshire Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Mid Cheshire Hospitals NHS Foundation Trust for the year ended 31 March 2011 and up to the date of approval of the annual report and accounts.

## ***Compliance with the NHS Pension Scheme Regulations***

As an employer with staff entitled to membership of the NHS Pension Scheme control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with, this includes ensuring that deductions from salary, employers 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.

### ***Capacity to handle risk***

The Corporate Governance Manual and Risk Management Strategy set out the comprehensive processes in place to manage risk. I provided leadership with support from the Trust's Medical Director during 2010/11 through the Integrated Governance framework, evidenced by the Risk Management Strategy and Integrated Governance Strategy. All management and staff have clearly defined responsibilities and receive the appropriate training. Risk Management training is provided through Induction and the mandatory training process. This is supplemented through the management development programme, which includes risk and governance training. Operational managers are supported by Competent Persons and other officers with particular risk management skills. 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.

### ***Annual Quality Accounts***

The directors of Mid Cheshire Hospitals NHS Foundation Trust are required to satisfy themselves that the Trust's Annual Quality Accounts are fairly stated. In doing

so we are required to put in place a system of Internal Control to ensure that proper arrangements are in place based on criteria specified by Monitor, the Independent Regulator of NHS Foundation Trust.

We have appointed a member of the Board, the Director of Nursing & Quality, to lead, and advise on all matters relating to the preparation of the Trust's Annual Quality Accounts.

To ensure the Trust's Quality Accounts present a properly balanced picture of its performance over the year, the Trust has put in place a monthly Quality Accounts meeting to review current performance and the status of the Quality Accounts. The meeting is attended by key internal staff and membership is available to the PCT. The meeting reports directly into a new developed sub-committee of the Board, QuEST (Quality, Effectiveness and Safety Committee) where the information is scrutinised for accuracy and outcome.

The Quality Account metrics are produced by the Trust's Information Department and Quality Department and are reviewed at the regular monthly meeting.

The Board of Directors, Council of Governors and relevant Stakeholders, including Local Involvement Network (LINK), Overview and Scrutiny Committee and Primary Care Trust have had the opportunity to review the Quality Account and to comment on whether the report is a fair reflection of the Trust's performance.

The Quality Account itself contains an assurance statement summarising the director's view of the Quality Accounts in terms of accuracy and robust systems and processes for production.

## ***The Risk and Control 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.

The Trust has an organisation-wide risk register. Staff are given risk management training and each division has a full-time risk and governance manager, supported by the central team. Staff are required to identify risks, and to score them in a standard way. Formal plans to eliminate or manage the risks are prepared. Risks are reviewed by the Integrated Governance Department and Board Committees. The Board is kept fully informed of all significant risks and the plans to manage and mitigate them.

The Trust has self assessed against the Information Governance Toolkit and scored 44% which is "unsatisfactory" against a target of 66%. The Trust has a robust action plan in place to attain the required standard which includes :

- A formal annual work-plan which will be monitored by the Information Governance Committee
- Formal Assignment of Leads for individual toolkit requirements
- A detailed action plan for each unsatisfactory key requirement with the aim of achieving level 2 in each prior to the 2012 Toolkit submission
- An action plan for all requirements in order to achieve satisfactory status prior to the 2012 Toolkit submission
- An action plan in response to internal audit findings
- Action plans will be monitored by the Information Governance Committee and the Operational Integrated Governance Committee

Incidents, claims and complaints are analysed, and reviewed by the Board. Serious untoward incidents undergo a thorough investigation and a review hearing 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.

A review of existing risks on the Board Assurance Framework highlights that there remains a number of risks that have a score of 20 or above, and where expected reductions in the risk have not been achieved in year.

These key risks are described below with the actions in place to mitigate them:

Objective Risk	Mitigation
Ensure the Trust is viewed as an equal player in the transition board in whole health economy discussions	<ul style="list-style-type: none"> <li>• Chief Executive on Pathway Group for long term conditions</li> <li>• Joint caring together programme board established</li> <li>• Membership of Regional QIPP board</li> <li>• Forums established to engage clinically with GP Consortia leads</li> </ul>
Implementation of the Trust's Clinical Services Strategy	<ul style="list-style-type: none"> <li>• Divisional management objectives and priorities aligned</li> <li>• Trust Board approval giving clear strategic direction</li> <li>• Focus the priorities of service development team to support key objectives</li> <li>• Executive lead for strategy</li> <li>• Progress monitored through Executive Management Board</li> <li>• All business cases reviewed in line with the Strategy</li> <li>• Whole health economy included information and sign off including GP Consortia leads</li> </ul>
Proactively seek quality relationships with key strategic partners	<ul style="list-style-type: none"> <li>• Formal governance arrangements for existing partnerships</li> <li>• Governor involvement through Governor Strategy Group</li> <li>• GP Consortia involved in developing Trust's Strategy</li> <li>• Regular executive meetings in place with key partnerships</li> </ul>

Objective Risk	Mitigation
Ensure sufficient capacity to deliver secondary care demand	<ul style="list-style-type: none"> <li>• Monthly monitoring of delivery against key performance indicators through Performance &amp; Finance Committee</li> <li>• Monthly contract meetings with commissioner to monitor levels of demand</li> <li>• Development programme of work with PbC to manage non elective demand</li> <li>• Review of internal processes in order to maximise capacity</li> <li>• 3 meetings per day to proactively manage flow of patients through the hospital</li> <li>• Development of programmes to avoid admission and reduce length of stay</li> <li>• Divisional review of capacity on an annual and weekly basis</li> </ul>
Deliver all local and national targets and standards	<ul style="list-style-type: none"> <li>• Monthly monitoring of delivery through Performance &amp; Finance Committee</li> <li>• 18 week project board in place to monitor actions required</li> <li>• Targets owned by all divisions and monitored through divisional boards</li> <li>• Weekly analysis of all activity with breaches standards</li> <li>• Escalation policy agreed and in place</li> </ul>
Ensure the workforce remains fit for purpose	<ul style="list-style-type: none"> <li>• Workforce planning process and clinical strategy aligned</li> <li>• Delivery against key performance indicators monitored through Performance &amp; Finance Committee and Executive Workforce group</li> <li>• Divisional ownership through Workforce Committees</li> <li>• Engagement in sub regional workforce planning and development network</li> <li>• Training needs analysis undertaken annually</li> <li>• Educational Governance framework in place</li> </ul>



Objective Risk	Mitigation
Implementation of Estates Strategy including compliance with Cheshire Fire and Rescue improvement notices	<ul style="list-style-type: none"> <li>• Executive Group in place to review Estates Strategy</li> <li>• Development control plan agreed</li> <li>• Contract in place for asbestos removal</li> <li>• Annual assessment of backlog maintenance programme</li> <li>• Fire action plan agreed with Cheshire Fire and Rescue monitored through Infrastructure Development Committee</li> <li>• Monthly meeting with Cheshire Fire &amp; Rescue representatives</li> <li>• 3 year annual financing plan in place</li> <li>• Ward and street refurbishment programme in place</li> </ul>
Ensure that the major incident plan is fit for purpose	<ul style="list-style-type: none"> <li>• Trust Governance lead represents Trust at local resilience forum</li> <li>• Approved emergency preparedness plan in place</li> <li>• Validation of plans through exercises</li> <li>• Additional staff trained in emergency planning</li> <li>• Emergency planning committee in place</li> <li>• Strategy for key staff training</li> </ul>
Ensure full compliance with Monitor's Terms of Authorisation	<ul style="list-style-type: none"> <li>• Annual plan and budget agreed delegated to divisions</li> <li>• Identified CIP schemes with delivery monitored through monthly meeting with divisions and Executive Director of Finance and Chief Operating Officer</li> <li>• Monthly meeting between management teams and finance team to monitor delivery and agree required actions</li> <li>• Job descriptions with clear financial accountability</li> <li>• Suite of key performance indicators in place</li> </ul>

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. Directors attend the meetings of the Local Authority Scrutiny Committees. Governors also sit on the Trust sub-committees where they have opportunity to

raise issues and inform the risk register.

The NHS Foundation Trust is unconditionally registered with the Care Quality Commission.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The key control measures in place include:

- a) Equality and Diversity lead officer in place providing specialist support
- b) Equality and Diversity steering group reporting through to Operational Integrated Governance Committee with a focus on monitoring progress against the Trust's single equality scheme
- c) Equality, Diversity and Human Rights Strategy in place
- d) All developments require an equality and diversity impact assessment.

The Trust's progress in this area has been recognised by NHS Employers as the Trust has been selected as a partner for 2010/11 in relation to this agenda.

The Trust has undertaken risk assessments and Carbon Reduction Delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

### ***Review of economy, efficiency and effectiveness of the use of resources***

The Board ensures that its Annual Financial Plan is set to produce an Income & Expenditure Account surplus. This ensures that costs are contained within the NHS National Tariff, rules set under the NHS Payment by Results (PbR) regime and prices for non PbR services demonstrated to be equitable and fair, which can be demonstrated through the Trust's reference cost score of 95. The Trust is implementing a Patient Level Costing system which will allow divisions to better understand the variances in cost in order to identify potential inefficiencies. The Trust's divisions are required to carry out a similar

exercise for each clinical specialty and to produce plans where a specialty is not expected to make the required surplus.

Non clinical services are benchmarked whenever this is feasible. During the year the Trust received benchmarking reports undertaken by CIPFA in conjunction with the Audit Committee on:

- Financial Services
- Information Management and Technology
- Human Resources
- Procurement.

These reports indicate in the main performance benchmarks favourably with peer groups.

During the year, a "Quality Matters" programme has been implemented, using "LEAN" principle and practices "right first time", with particular focus on :

- a) Theatre productivity, which has delivered financial savings of £340,000 whilst improving quality and safety in emergency theatres
- b) Reducing length of stay, where a reduction in length of stay of over 1 day has been delivered in emergency admission.

### ***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 and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework, and 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, Integrated Governance Framework, the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risk to the organisation achieving its principal objectives have been reviewed.

The Board reviews the Board Assurance Framework at each of its meetings for risks associated with its key strategic objectives on a rolling programme, and receives reports from the Audit Committee and other Board Committees and progress in managing these risks.

The Audit Committee gives independent assurance to the Board and comprises only non-executive directors. Its terms of reference are based on those recommended by the NHS Audit Committee Handbook, and 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.

Internal Audit has reviewed the effectiveness of internal control and given a positive opinion in the Head of Internal Audit report.

The Board has reviewed reports from various external inspection agencies such as the Care Quality Commission. These have provided further assurance.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Audit Committee, and other Board

Committees, through review of the minutes at Trust Board and any significant issues highlighted for the attention of the Board.

## Conclusion

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

Whilst Internal Audit reports in the year highlighted no significant risks to objectives being achieved, there is one area of limited assurance worthy of note.

- i) Data Quality against specific measures of Thrombolysis and Delayed Discharges;

Action plan is in place to address this issue is as follows :

- |  |   |
|--|---|
| Data Quality (Thrombolysis and Delayed Discharges) | <ul style="list-style-type: none"><li>• Local procedures have been agreed and published</li><li>• Introduction of more detailed reconciliation processes</li><li>• Utilisation of IT functionality to ease</li><li>• Faster and more accurate data collection</li></ul> |
|--|---|

I am confident that these risks are being carefully monitored and managed and do not regard them as significant risks.



Tracy Bullock  
Chief Executive, Mid Cheshire Hospitals  
NHS Foundation Trust  
6 June 2011



## **INDEPENDENT AUDITORS' REPORT TO THE COUNCIL 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 2011 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 The 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 non-financial 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 2011 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 matters prescribed by the National Health Service Act 2006**

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the 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 National Health Service Act 2006 requires us to report to you if, in our opinion:

- proper practices have not been observed in the compilation of the financial statements; or
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources

### **Certificate**

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.



Paul Thomson ACA (Senior Statutory Auditor)  
For and on behalf of Deloitte LLP  
Chartered Accountants and Statutory Auditor  
Leeds, UK  
6 June 2011

**STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED  
31 MARCH 2011**

	<b>Note</b>	<b>2010/11 £000</b>	<b>2009/10 £000</b>
Operating Income from patient care activities	<b>3</b>	<b>149,047</b>	148,320
Other operating income	<b>4</b>	<b>20,713</b>	16,182
Operating expenses	<b>5-7</b>	<b>(163,320)</b>	(158,739)
<b>OPERATING SURPLUS</b>		<b>6,440</b>	5,763
<b>Finance Costs:</b>			
Finance Income	<b>8</b>	<b>33</b>	37
Finance expense - financial liabilities	<b>9</b>	<b>(175)</b>	(226)
Finance expense - unwinding of discount on provisions		<b>(39)</b>	(30)
PDC Dividends paid	<b>22</b>	<b>(3,579)</b>	(3,586)
<b>NET FINANCE COSTS</b>		<b>(3,760)</b>	(3,805)
<b>SURPLUS FOR THE YEAR</b>		<b>2,680</b>	1,958
<b>Other comprehensive income</b>			
Impairments on property, plant and equipment		<b>(7,414)</b>	(4)
Revaluations gains on property, plant and equipment		<b>7,652</b>	27
Receipt of Donated Assets		<b>122</b>	97
Depreciations of Donated Asset		<b>(169)</b>	(127)
Asset Disposals		<b>(9)</b>	-
Other recognised gains and losses		<b>(1,143)</b>	-
<b>TOTAL COMPREHENSIVE INCOME FOR THE PERIOD</b>		<b>1,719</b>	1,951

The notes on page 150 to 194 form part of these accounts.  
All income and expenditure is derived from continuing operations.

**STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2011**

		31 March 2011	31 March 2010
	Note	£000	£000
<b>Non-current assets</b>			
Intangible assets	10	721	669
Property, plant and equipment	11	109,172	108,391
Trade and other receivables	14	373	416
<b>Total non-current assets</b>		<b>110,266</b>	<b>109,476</b>
<b>Current assets</b>			
Inventories	13	3,166	3,091
Trade and other receivables	14	8,374	6,938
Cash and cash equivalents	24	3,356	6,053
Non-current assets held for sale	12	31	3
<b>Total current assets</b>		<b>14,927</b>	<b>16,085</b>
<b>Current liabilities</b>			
Trade and other payables	17	(9,874)	(10,646)
Borrowings	19	(1,438)	(1,454)
Provisions	22	(308)	(577)
Tax Payable	17	(2,174)	(2,145)
Other liabilities	18	(390)	(434)
<b>Total current liabilities</b>		<b>(14,184)</b>	<b>(15,256)</b>
<b>Total assets less current liabilities</b>		<b>111,009</b>	<b>110,305</b>
<b>Non-current liabilities</b>			
Trade and other payables	17	(60)	(31)
Borrowings	19	(2,268)	(3,192)
Provisions	22	(1,248)	(1,368)
<b>Total non-current liabilities</b>		<b>(3,576)</b>	<b>(4,591)</b>
<b>Total assets employed</b>		<b>107,433</b>	<b>105,714</b>
<b>Financed by taxpayers' equity</b>			
Public dividend capital		49,946	49,946
Revaluation reserve	23	42,061	43,517
Donated asset reserve		2,374	2,071
Income and expenditure reserve		13,052	10,180
<b>Total taxpayers' equity</b>		<b>107,433</b>	<b>105,714</b>

The financial statements on pages 148 to 194 were approved by the Board and signed on its behalf on June 6, 2011.

  
Chief Executive

**STATEMENT OF CHANGES IN TAXPAYERS' EQUITY AS AT 31 MARCH 2011**

	Public dividend capital (PDC) £000	Retained Earnings £000	Revaluation Earnings £000	Donated asset Reserve £000	Total £000
<b>Taxpayers' Equity at 1 April 2010</b>	<b>49,946</b>	<b>10,180</b>	<b>43,517</b>	<b>2,071</b>	<b>105,714</b>
Retained surplus for the year	-	2,680	-	-	2,680
Impairments	-	-	(7,402)	(12)	(7,414)
Revaluations	-	-	7,281	371	7,652
Receipt of donated assets	-	-	-	122	122
Other recognised gains and losses	-	(6)	(1,137)	(169)	(1,312)
Other reserve movement	-	198	(198)	-	-
Asset disposals	-	-	-	(9)	(9)
<b>Taxpayers' equity at 31 March 2011</b>	<b>49,946</b>	<b>13,052</b>	<b>42,061</b>	<b>2,374</b>	<b>107,433</b>

**STATEMENT OF CHANGES IN TAXPAYERS' EQUITY AS AT 31 MARCH 2010**

	Public dividend capital (PDC) £000	Retained Earnings £000	Revaluation Earnings £000	Donated asset Reserve £000	Total £000
<b>Taxpayers' Equity at 1 April 2009</b>	<b>49,569</b>	<b>8,088</b>	<b>43,628</b>	<b>2,101</b>	<b>103,386</b>
Retained surplus for the year	-	1,958	-	-	1,958
Impairments	-	(4)	27	-	23
Receipt of donated assets	-	-	-	97	97
Other recognised gains and losses	-	-	-	(127)	(127)
Other reserve movement	-	138	(138)	-	-
Public Dividend Capital received	377	-	-	-	377
<b>Taxpayers' equity at 31 March 2010</b>	<b>49,946</b>	<b>10,180</b>	<b>43,517</b>	<b>2,071</b>	<b>105,714</b>



**STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2011**

	2010/11 £000	2009/10 £000
<b>Cash flows from operating activities</b>		
Operating surplus	6,440	5,763
<b>Non-Cash income and expense</b>		
Depreciation and amortisation	5,135	5,131
Impairments	495	8
Reversal of impairments	(1,619)	-
Transfer from donated asset reserve	(169)	(127)
Increase in trade and other receivables	(1,332)	(423)
Increase in Inventories	(75)	(510)
(Decrease) / Increase in trade and other payables	(1,014)	677
(Decrease) / Increase in other current liabilities	(44)	197
(Decrease) / Increase in provisions	(389)	708
Increase in tax paid	28	182
Other movements in operating cash flows	(46)	(70)
<b>Net cash generated from operations</b>	<b>7,410</b>	<b>11,536</b>
<b>Cash flows from investing activities</b>		
Interest received	33	37
Payments for intangible assets	(116)	(276)
Payments for property, plant and equipment	(4,851)	(4,794)
Sales of plant property and equipment	11	45
<b>Net cash used in investing activities</b>	<b>(4,923)</b>	<b>(4,988)</b>
<b>Cash flows from financing activities</b>		
Public Dividend Capital received	-	377
Capital element of finance lease rental payments	(1,478)	(1,995)
Interest element of finance lease	(175)	(226)
Public Dividend Capital paid	(3,653)	(3,573)
Cash flows from other financing activities	122	97
<b>Net cash used in financing activities</b>	<b>(5,184)</b>	<b>(5,320)</b>
<b>(Decrease) / Increase in cash and cash equivalents</b>	<b>(2,697)</b>	<b>1,228</b>
<b>Cash and Cash equivalents at 1 April</b>	<b>6,053</b>	<b>4,825</b>
<b>Cash and Cash equivalents at 31 March</b>	<b>3,356</b>	<b>6,053</b>

## Notes to the Accounts

### 1. Accounting Policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2010/11 NHS Foundation Trust Annual Reporting Manual 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 'discontinued' where they meet all of the following conditions:

- a. the sale (this may be at nil consideration for activities transferred to another public sector body) or termination is completed either in the period or before the earlier of three months after the commencement of the subsequent
- b. period and the date on which the financial statements are approved;
- b. if a termination, the former activities have ceased permanently;
- c. the sale or termination has a material effect on the nature and focus of the reporting NHS foundation trust's operations and represents a material reduction in its operating facilities resulting either from its withdrawal from a particular activity or from a material reduction in income in the NHS foundation trust's continuing operations; and
- d. the assets, liabilities, results of operations and activities are clearly distinguishable, physically, operationally and for financial reporting purposes. Operations not satisfying all these conditions are classified as continuing. Activities are considered to be 'acquired' whether or not they are acquired from outside the public sector.

#### 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 the financial year 2011/12.

##### 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 27th 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 is controlled in equal shares with Shropdoc, Central and Eastern Primary Care Trust and Mid Cheshire Hospitals NHS Foundation Trust through a limited liability partnership. 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 can not 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 for 2011 is £83,872.

**Employees' Expenses** At 31 March 2011 the accrual for outstanding holidays is £632,000 which has been based on a sample of employees outstanding holiday entitlement. This has been increased on a pro rata basis using the total employee numbers. The percentage of the sample represents 77% of the total permanent employees.

#### **1.6 Income**

The main source of income for the Trust is 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 yearend 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 under single managerial control; or
- form part of the initial equipping and



setting-up 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 value for existing use  
Specialised buildings – depreciated replacement cost

The Foundation trust has had its last full revaluation of the buildings as at 1st

April 2008 and an interim valuation as at 4th January 2011. 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 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 de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

### **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.

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.

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 ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

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 2 to 89 years.

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

- Plant and Equipment – 3 to 10 years
- Information Technology – 3 to 10 years
- Furniture & Fittings – 5 to 10 years

### **1.12 Borrowing costs**

Borrowing costs are recognised as expenses as they are incurred.

### **1.13 Donated assets**

Donated fixed assets are capitalised at their fair value on receipt, with a matching credit

to the donated asset reserve. Donated assets are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the statement of comprehensive income.

Similarly, any impairment on donated assets charged to the Income and Expenditure Account is matched by a transfer from the Donated Asset Reserve to the Income and Expenditure Reserve and matched with the sales proceeds and net book value to calculate a profit(loss) on sale of asset. On sale of donated assets, the value of the sale proceeds is transferred from the Donated Asset Reserve to the Income and Expenditure Reserve.

### **1.14 Government Grants**

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Grants from the Department of Health, including those for achieving three star status, are accounted for as Government grants as are grants from the Big Lottery Fund. Revenue grants are treated as deferred income initially and credited to the statement of comprehensive income to match the expenditure to which it relates. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to the statement of comprehensive income over the life of the asset on a basis consistent with the depreciation charge for that asset.

Assets purchased from government grants are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and

impairments are taken to the government grant reserve and, each year, an amount equal to the depreciation charge on the asset is released from the government grant reserve to the statement of comprehensive income.

### **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
- 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, donated asset reserve or government grant 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, 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.

#### 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 first-out 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 NHS foundation trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% in real terms. When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the

restructuring and not associated with ongoing activities of the entity.

### **1.21 Clinical Negligence Costs**

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS 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.

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 2010/11 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 they become due.

### **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 EU Emissions Trading Scheme

The Trust is exempt from participating in the EU emissions trading scheme.

#### 1.25 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 non-derivative financial assets that are designated as available for sale or that do 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 one 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.

### **1.26 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.

### **1.27 Value Added Tax**

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

### **1.28 Corporation Tax**

The Mid Cheshire Hospital NHS Foundation Trust is a Health Service body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the 17 exemption in relation to the specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of Corporation Tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000pa. 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 non-healthcare 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.

### **1.29 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.

### **1.30 Third Party Assets**

Assets belonging to third parties are not recognised in the accounts if, in the opinion of the directors,

- a) the Trust has no beneficial interest in them
- b) they are of significant value and therefore justify the administrative costs of maintaining separate bank accounts. In all other cases, third party assets are incorporated within the Trust's other asset and a corresponding liability is included in Creditors.

Details of Third party assets are given in Note 31 to the accounts.

### **1.31 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, 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.

### **1.32 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 is prepared on a cash basis.

### ***1.33 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 future financial years:

Change Published	Financial year for which the change first applies
IFRS 7 Financial Instruments: Disclosures - Amendments <ul style="list-style-type: none"> <li>Transfers of financial assets</li> </ul>	Effective date of 2012/13 but not yet adopted by the EU
IFRS 9 Financial Instruments <ul style="list-style-type: none"> <li>Financial Assets</li> <li>Financial Liabilities</li> </ul>	Uncertain. Not likely to be adopted by the EU until the ISAB has finished the rest of its financial instruments project
IAS 12 Income Taxes amendments	Effective date of 2012/13 but not yet adopted by the EU
IAS 24 (Revised) 'Related Party Disclosures'	2011/12

Change Published	Financial year for which the change first applies
Annual improvements 2010	2011/12
IFRIC 14 amendments	2011/12
IFRIC 19 'Extinguishing financial liabilities with Equity Instruments'	2011/12

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.

### ***1.34 Accounting standards, amendments and interpretations issued that have been adopted early***

The Trust has not adopted any new accounting standards, amendments or interpretations early.

## 2. Segmental Reporting

The Trust considers the Trust Board 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 Trust Board during its January 2011 meeting.

The Trust receives 86% 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:

	2010/11 £000	2009/10 £000
Elective Income	26,114	26,083
Non Elective Income	56,286	61,037
Outpatient Income	29,583	26,773
A & E Income	6,256	5,882
Other NHS Clinical Income	28,125	25,880
Income from activities (before private patient income)	146,364	145,655
Other non-protected clinical income	1,230	1,075
Private patient income	1,453	1,590
Total Activity Income	149,047	148,320

The elective and non elective income includes the levels of incomplete spells as at 31st March 2011. The calculation is based on all patients who are in a bed at midnight on the 31st March by specialty and point of delivery. This activity is then multiplied by the average spell income for the relevant specialty/point of delivery for that year. The calculation also takes into account any Payment by Results rules with regard to marginal rates and thresholds for non-elective activity. The movement in year impacting on the recognised income is a reduction of £304,020. A reduction of £108,550 is due to a change in price and a reduction of £195,470 is due to a change in volume.

Included in Other NHS Clinical Income is £352,735 which relates to the Trusts share of the income generated by the Central Cheshire Urgent Primary Care Consortium joint venture. It also includes direct access income for Pathology and Radiology, Community Service income, high cost drugs income and income for screening programmes.

Injury Cost Recovery income included in 'Other non-protected clinical income' is subject to a provision for doubtful debts of 9.6% 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

	2010/11	2009/10	Base Year 2002/03
	£000	£000	£000
Private patient income	<b>1,453</b>	1,590	1,194
Total patient income	<b>149,047</b>	148,320	79,862
%	<b>0.97%</b>	1.07%	1.50%

Section 44 of the National Health Service Act 2006, requires that the proportion of private patient income to the total patient related income of NHS Foundation Trusts should not exceed its proportion whilst the body was an NHS Trust in 2002/3. The note above shows that the Trust was compliant for 2010/11. Monitor revised the rules and guidance on how the Private Patient Income Cap operates for the 2010/11 annual accounts. The base year and the 2009/10 comparators have been amended to reflect these changes.

## 4. Other Operating Income

	2010/11 £000	2009/10 £000
Education and training	<b>5,266</b>	5,218
Charitable and other contributions to expenditure	-	41
Transfers from donated asset reserve in respect of depreciation on donated assets	<b>169</b>	127
Non-patient care services to other bodies	<b>10,716</b>	7,890
Other	<b>2,941</b>	2,861
Profit on disposal of other tangible assets	<b>2</b>	43
Reversal of impairments of property, plant and equipment	<b>1,619</b>	-
Gain on asset held for sale	-	2
<b>Total other operating income</b>	<b>20,713</b>	16,182



## 4.1 Operating Lease Income

### Operating Lease Income

Rents recognised in the period

Total

2010/11	2009/10
£000	£000
45	36
<b>45</b>	<b>36</b>

### Future minimum lease payments due

Not later than one year

Later than one year but not later than five years

Later than five years

Total

31	36
45	64
177	191
<b>253</b>	<b>291</b>

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:

	2010/11 £000	2009/10 £000
Employee expenses - staff	114,703	112,042
Employee expenses - Directors' costs	848	845
Employee expenses - Non-Executives' costs	135	131
Supplies and services - clinical	12,006	11,771
Depreciation on property, plant and equipment	5,022	5,015
Amortisation on intangible assets	113	116
Impairments of property, plant and equipment	495	8
Premises	6,045	6,078
Drug Costs	8,166	8,037
Clinical negligence	3,030	2,741
Other	1,134	1,844
Consultancy services	320	94
Supplies and services - general	2,194	2,195
Printing, stationery, travel and recruitment advertising	1,829	1,912
Services from other NHS bodies	6,128	3,710
Transport	303	567
Auditors' remuneration	50	82
Other Auditors' remuneration	20	20
Purchase of healthcare from non NHS bodies	-	39
Provision for impairment of receivables (including provision against Road Traffic income)	107	159
Legal Fees	45	105
Hospitality	14	47
Redundancies	141	381
Training Courses and Conferences	276	582
Patient Travel	23	21
Insurances	122	112
Other services	34	91
Losses, ex gratia and special payments	9	9
Loss on disposal of other property, plant and equipment	5	5
Loss on disposal of assets held for sale	3	-
Total	<b>163,320</b>	<b>158,739</b>

Included above is £313,916 (2009/10 £181,000) which relates to the Trust's share of the Central Cheshire Urgent Primary Care Consortium joint venture expenditure.

## 5.2 Auditors' Remuneration

The analysis of auditors' remuneration is as follows:

	2010/11 £000	2009/10 £000
Fees payable to the company's auditors for the audit of the company's annual accounts	50	62
<b>Total audit fees</b>	<b>50</b>	<b>62</b>
Other services	20	20
<b>Total non-audit fees</b>	<b>20</b>	<b>20</b>

## 5.3 Operating Leases

### 5.3.1 Arrangements containing an operating lease

	2010/11 £000	2009/10 £000
Minimum lease payments	387	295
<b>Total</b>	<b>387</b>	<b>295</b>

There are no significant leasing arrangements included in the above.

### 5.3.2 Arrangements containing an operating lease

	2010/11 £000	2009/10 £000
Future minimum lease payments due:		
Not later than one year	308	161
Later than one year and not later than five years	572	113
Later than five years	-	-
<b>Total</b>	<b>880</b>	<b>274</b>
Total of future minimum sublease lease payments to be received at the Statement of financial position date	-	-

**5.4 (A) Senior Manager remuneration and benefits - Emoluments**

Name	Title	Gross Pay 2011 £000s	Other Remuneration 2011 £000s	Superannuation Contributions 2011 £000s	Total Emoluments 2011 £000s	Total Emoluments 2010 £000s	Benefits in Kind * 2011 £00s	Benefits in Kind * 2010 £00s
<b>Board</b>								
Moran J	Chairman	45	-	-	<b>45</b>	45	<b>33</b>	-
Godfrey V	Non-Executive	12	-	-	<b>12</b>	12	-	-
Hopewell D	Non-Executive	15	-	-	<b>15</b>	15	<b>10</b>	-
Wood A	Senior Independent Director and Deputy Chairman	15	-	-	<b>15</b>	15	<b>15</b>	-
Chandler M	Non-Executive	12	-	-	<b>12</b>	12	-	-
Craig WD	Non-Executive	12	-	-	<b>12</b>	12	<b>7</b>	-
Dunn D	Non-Executive	12	-	-	<b>12</b>	10	-	-
Morley P	Chief Executive (until 06/10/10)	80	-	11	<b>91</b>	168	<b>106</b>	151
Bullock T	Chief Executive (from 12/10/10)	68	-	10	<b>78</b>	-	-	-
Oldham M	Director of Finance	100	-	14	<b>114</b>	111	<b>91</b>	47
Alcock R	Director of Workforce and Organisational Development	88	-	12	<b>100</b>	100	<b>45</b>	49
Bullock T	Chief Operating Officer and Director of Nursing (until 11/10/10)	58	-	8	<b>66</b>	122	-	-
Hartley J	Acting Director of Nursing (from 12/10/10 until 06/02/11)	22	-	4	<b>26</b>	-	-	-
Smith J	Director of Nursing (from 07/02/2011)	13	-	2	<b>15</b>	-	-	-
Frodsham D	Director of Business Development	90	-	13	<b>103</b>	101	67	63
Dodds P	Medical Director	154	17	24	<b>195</b>	182	-	-
<b>Total Board Members Remuneration</b>		796	17	98	<b>911</b>	905	<b>374</b>	310
<b>Employers NI</b>					<b>88</b>	87	-	-
<b>Total Board Members Remuneration including Employers NI and Superannuation</b>					<b>999</b>	992	<b>374</b>	310
<b>Associate Directors' and Board Secretary Remuneration</b>								
Ennis A	Director of Service Development (until 30/11/10)	45	-	7	<b>52</b>	81	-	-
<b>Total Associate Directors' and Board Secretary Remuneration</b>					<b>52</b>	81	-	-
<b>Employers NI</b>					<b>5</b>	7	-	-
<b>Total Associate Directors' and Board Secretary Remuneration including Employers NI and Superannuation</b>					<b>57</b>	88	-	-
<b>Total "Senior Employees"</b>					<b>963</b>	986	<b>374</b>	310
<b>Employers NI</b>					<b>93</b>	94	-	-
<b>Total Senior Employees including Employers NI and Superannuation</b>					<b>1,056</b>	1,080	<b>374</b>	310



\*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 £000s	Total accrued pension at age 60 at 31 March 2011 £000s	Total accrued lump sum at age 60 at 31 March 2011 £000s	Cash Equivalent Transfer Value at 31 March 2011 £000s	Cash Equivalent Transfer Value at 31 March 2010 £000s	Real Increase in Cash Equivalent Transfer Value £000s
<b>Board Members</b>							
Morley P	Chief Executive	10	52	156	751	784	(12)
Bullock T	Chief Executive	31	42	127	583	554	20
Dodds P	Medical Director	12	54	162	878	893	(11)
Oldham M	Director of Finance	19	32	95	409	448	(27)
Alcock R	Director of Workforce and Organisational Development	4	26	79	312	355	(30)
Frodsham D	Director of Business Development	4	25	75	416	445	(20)
Hartley J	Acting Director of Nursing	10	31	94	500	425	17
Smith J	Director of Nursing	2	21	62	235	236	-
<b>Associate Directors</b>							
Ennis A	Director of Service Development	7	28	84	419	432	(6)

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 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.

## 6. Staff Costs and Numbers

### 6.1 Staff Costs

	2010/11 £000	2009/10 £000
Salaries and wages	92,531	91,232
Social Security Costs	6,274	5,928
Employer contributions to NHS Pensions Authority	10,327	10,146
Termination Benefits	141	381
Agency and contract staff	6,419	5,581
<b>Total</b>	<b>115,692</b>	<b>113,268</b>

### 6.2 Average number of persons employed

	Total 2010/11 Number	Other permanent employees Number	Directors Number	Other Number	Total 2009/10 Number
Medical and Dental	284	284	-	-	271
Administration and Estates	632	625	7	-	653
Healthcare Assistants and other support staff	433	433	-	-	433
Nursing, midwifery and health visiting staff	792	792	-	-	799
Scientific, therapeutic and technical staff	389	389	-	-	402
Bank and agency	233	-	-	233	214
Other	271	271	-	-	283
<b>Total</b>	<b>3,034</b>	<b>2,794</b>	<b>7</b>	<b>233</b>	<b>3,055</b>

### 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 2010/11 there were 4 (2009/10:1) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £208,028 (2009/10: £4,242). 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](http://www.nhsbsa.nhs.uk/pensions).

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

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

### **a) Full actuarial (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had

up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

### **b) Accounting valuation**

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2010, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2010 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies



can also be obtained from The Stationery Office.

### ***c) Scheme provisions***

In 2008-09 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.

#### ***Lump Sum Allowance***

A lump sum is payable on retirement which is normally three times the annual pension payment.

### ***Ill-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.

### ***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	- (3)	3 (-)	3 (3)
£25,001 - £50,000	- (1)	2 (-)	2 (1)
£50,001 - £100,000	- (4)	- (-)	- (4)
Total number of exit packages by type	- (9)	6 (-)	6 (9)
<b>Total resource cost</b>	<b>- (357)</b>	<b>141 (-)</b>	<b>141 (357)</b>

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 2009/10.

## 7. Better Payment Practice Code

### 7.1 Better Payment Practice Code - measure of compliance

	2010/11		2009/10	
	Number	£000	Number	£000
Total Trade bills paid in the year	<b>48,300</b>	<b>99,224</b>	50,347	102,172
Total Trade bills paid within target	<b>45,690</b>	<b>93,105</b>	48,404	99,025
Percentage of Trade bills paid within target	<b>95%</b>	<b>94%</b>	96%	97%

The target is to pay both non-NHS and NHS trade creditors within terms agreed with suppliers. In most cases the agreed terms are payment within 30 days of receipt of invoice.

### 7.2 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust had no interest payable for the year ended 31st March 2009 under the Late Payment of Commercial Debts (Interest) Act 1998.

## 8. Finance Income

Interest on loans and receivables
Total

2010/11	2009/10
£000	£000
33	37
<b>33</b>	<b>37</b>

## 9. Finance Costs

### 9.1 Finance Cost - Interest Expense

Interest on obligations under finance lease
Total

2010/11	2009/10
£000	£000
175	226
<b>175</b>	<b>226</b>

### 9.2 Impairment of Assets

Loss or damage from normal operations
Unforeseen Obsolescence
Changes in market price
Reversal of impairments
Total

2010/11	2009/10
£000	£000
-	8
14	-
7,895	-
(1,619)	-
<b>6,290</b>	<b>8</b>

Included in the above is the impact of the revaluation of the premises as at January 2011. The revaluation exercise included the reversal of impairments that were charged to expenditure in the previous revaluation exercise. The impairment for unforeseen obsolescence relates to several scopes that it was uneconomical to repair.

## 10. Intangible Fixed Assets

	Total 2011 £000s
Gross cost at 1 April 2010	1,102
Additions purchased	165
<b>Gross cost at 31 March 2011</b>	<b>1,267</b>
Amortisation at 1 April 2010	433
Provided during the year	113
<b>Amortisation at 31 March 2011</b>	<b>546</b>
<b>Net book value</b>	
<b>Total purchased at 1 April 2010</b>	<b>669</b>
<b>Total purchased at 31 March 2011</b>	<b>721</b>

	Total 2010 £000s
Gross cost at 1 April 2009	806
Reclassifications	20
Additions purchased	276
<b>Gross cost at 31 March 2010</b>	<b>1,102</b>
Amortisation at 1 April 2009	317
Provided during the year	116
<b>Amortisation at 31 March 2010</b>	<b>433</b>
<b>Net book value</b>	
<b>Total purchased at 1 April 2009</b>	<b>489</b>
<b>Total purchased at 31 March 2010</b>	<b>669</b>

The reclassification is the transfer from tangible 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 10 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	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
<b>Cost or valuation at 1 April 2010</b>	<b>9,280</b>	<b>88,058</b>	<b>3,922</b>	<b>171</b>	<b>20,334</b>	<b>16</b>	<b>4,031</b>	<b>228</b>	<b>126,040</b>
Additions - purchased	-	1,155	47	3,515	664	-	32	89	5,502
Additions - donated	-	12	-	-	110	-	-	-	122
Impairments charged to revaluation reserve	-	(6,822)	(592)	-	-	-	-	-	(7,414)
Revaluation surpluses	220	2,914	-	-	-	-	-	-	3,134
Transferred to disposal group as asset held for sale	-	-	-	(31)	-	-	-	-	(31)
Reclassifications	-	3,378	2	(3,380)	-	-	-	-	-
Disposals	-	(213)	-	-	(3,127)	(16)	(1,052)	(18)	(4,426)
<b>Cost or valuation at 31 March 2011</b>	<b>9,500</b>	<b>88,482</b>	<b>3,379</b>	<b>275</b>	<b>17,981</b>	<b>-</b>	<b>3,011</b>	<b>299</b>	<b>122,927</b>
<b>Accumulated depreciation at 1 April 2010</b>	<b>-</b>	<b>3,286</b>	<b>157</b>	<b>-</b>	<b>11,714</b>	<b>14</b>	<b>2,375</b>	<b>103</b>	<b>17,649</b>
Provided during the year	-	1,654	82	-	2,688	2	562	34	5,022
Impairments recognised in operating expense	-	(1,138)	-	-	14	-	-	-	(1,124)
Revaluation surpluses	-	(3,159)	(221)	-	-	-	-	-	(3,380)
Transferred to disposal group as asset held for sale	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Disposals	-	(213)	-	-	(3,113)	(16)	(1,052)	(18)	(4,412)
<b>Accumulated depreciation at 31 March 2011</b>	<b>-</b>	<b>430</b>	<b>18</b>	<b>-</b>	<b>11,303</b>	<b>-</b>	<b>1,885</b>	<b>119</b>	<b>13,755</b>
<b>Net Book Value</b>									
NBV - Purchased at 1 April 2010	9,280	83,091	3,765	171	3,008	-	1,473	35	100,823
NBV - Finance Lease at 1 April 2010	-	13	-	-	5,209	2	183	90	5,497
NBV - Donated at 1 April 2010	-	1,668	-	-	403	-	-	-	2,071
<b>NBV total at 1 April 2010</b>	<b>9,280</b>	<b>84,772</b>	<b>3,765</b>	<b>171</b>	<b>8,620</b>	<b>2</b>	<b>1,656</b>	<b>125</b>	<b>108,391</b>
<b>Net Book Value</b>									
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
<b>NBV total at 31 March 2011</b>	<b>9,500</b>	<b>88,052</b>	<b>3,361</b>	<b>275</b>	<b>6,678</b>	<b>-</b>	<b>1,126</b>	<b>180</b>	<b>109,172</b>

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & Machinery	Transport	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
<b>Cost or valuation at 1 April 2009</b>	<b>9,280</b>	<b>83,685</b>	<b>3,783</b>	<b>726</b>	<b>21,365</b>	<b>52</b>	<b>3,742</b>	<b>228</b>	<b>122,861</b>
Additions - purchased	-	3,734	139	123	1,179	-	339	-	5,514
Additions - donated	-	-	-	-	97	-	-	-	97
Impairments charged to revaluation reserve	-	-	-	-	-	-	-	-	-
Revaluation surpluses	-	-	-	-	29	-	-	-	29
Transferred to disposal group as asset held for sale	-	-	-	-	(7)	-	-	-	(7)
Reclassifications	-	655	-	(678)	3	-	-	-	(20)
Disposals	-	(16)	-	-	(2,332)	(36)	(50)	-	(2,434)
<b>Cost or valuation at 31 March 2010</b>	<b>9,280</b>	<b>88,058</b>	<b>3,922</b>	<b>171</b>	<b>20,334</b>	<b>16</b>	<b>4,031</b>	<b>228</b>	<b>126,040</b>
<b>Accumulated depreciation at 1 April 2009</b>	-	<b>1,699</b>	<b>75</b>	-	<b>11,361</b>	<b>43</b>	<b>1,805</b>	<b>68</b>	<b>15,051</b>
Provided during the year	-	1,603	82	-	2,671	6	619	35	5,016
Impairments recognised in operating expense	-	-	-	-	8	-	-	-	8
Revaluation surpluses	-	-	-	-	7	-	-	-	7
Transferred to disposal group as asset held for sale	-	-	-	-	(4)	-	-	-	(4)
Reclassifications	-	-	-	-	-	-	-	-	-
Disposals	-	(16)	-	-	(2,329)	(35)	(49)	-	(2,429)
<b>Accumulated depreciation at 31 March 2010</b>	-	<b>3,286</b>	<b>157</b>	-	<b>11,714</b>	<b>14</b>	<b>2,375</b>	<b>103</b>	<b>17,649</b>
<b>Net Book Value</b>									
NBV - Purchased at 1 April 2009	9,280	80,243	3,708	726	3,758	-	1,505	41	99,261
NBV - Finance Lease at 1 April 2009	-	49	-	-	5,839	9	432	119	6,448
NBV - Donated at 1 April 2009	-	1,694	-	-	407	-	-	-	2,101
<b>NBV total at 1 April 2009</b>	<b>9,280</b>	<b>81,986</b>	<b>3,708</b>	<b>726</b>	<b>10,004</b>	<b>9</b>	<b>1,937</b>	<b>160</b>	<b>107,810</b>
<b>Net Book Value</b>									
NBV - Purchased at 31 March 2010	9,280	83,091	3,765	171	3,008	-	1,473	35	100,823
NBV - Finance Lease at 31 March 2010	-	13	-	-	5,209	2	183	90	5,497
NBV - Donated at 31 March 2010	-	1,668	-	-	403	-	-	-	2,071
<b>NBV total at 31 March 2010</b>	<b>9,280</b>	<b>84,772</b>	<b>3,765</b>	<b>171</b>	<b>8,620</b>	<b>2</b>	<b>1,656</b>	<b>125</b>	<b>108,391</b>

## 11.2 Analysis of tangible fixed assets

	Land	Buildings Excluding Dwellings	Dwellings	Assets under Construction and payments on account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value									
Protected 31 March 2011	8,900	85,697	-	-	-	-	-	-	94,597
Unprotected 31 March 2011	600	2,355	3,361	275	6,678	-	1,126	180	14,575
<b>Total at 31 March 2011</b>	<b>9,500</b>	<b>88,052</b>	<b>3,361</b>	<b>275</b>	<b>6,678</b>	<b>-</b>	<b>1,126</b>	<b>180</b>	<b>109,172</b>

	Land	Buildings Excluding Dwellings	Dwellings	Assets under Construction and payments on account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value									
Protected 31 March 2010	8,685	81,013	0	-	-	-	-	-	89,698
Unprotected 31 March 2010	595	3,759	3,765	171	8,620	2	1,656	125	18,693
<b>Total at 31 March 2010</b>	<b>9,280</b>	<b>84,772</b>	<b>3,765</b>	<b>171</b>	<b>8,620</b>	<b>2</b>	<b>1,656</b>	<b>125</b>	<b>108,391</b>

## 11.3 Economic life of property, plant and equipment

	Min. Life	Max. Life
Buildings excluding dwellings	2	89
Dwellings	29	53
Assets under construction	5	59
Plant & machinery	3	10
Information Technology	3	10
Furniture and Fittings	5	10

Land has an infinite basis.

## 11.4 Assets held at open market value

At the statement of financial position date there was no land, buildings or dwellings valued at open market value.

## 12. Non-Current Assets for sale and assets in disposal groups

Non-current assets for sale and assets in disposal groups 2010/11

	Total £000	Property, plant and equipment £000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2010	3	3
Less assets sold in year	(3)	(3)
Plus assets classified as available for sale in the year	31	31
<b>NBV of non-current assets for sale and assets in disposal groups at 31 March 2011</b>	<b>31</b>	<b>31</b>

A number of washer dryers have been transferred to non-current assets held for sale in 2010/11. In 2009/10 a Harmonic Scalpel generator had been transferred to non-current assets for sale. This has now been sold at a loss. Also in 2009/10 a number of pieces of medical equipment were sold at auction however these were transferred to non-current assets at a nil net book value.

## 13. Inventories

### 13.1 Inventories

	2011 £000	2010 £000
Materials	3,166	3,091
<b>Total</b>	<b>3,166</b>	<b>3,091</b>

### 13.2 Inventories recognised in expense

	2010/11 £000	2009/10 £000
Inventories recognised in expense	16,531	15,878
Write-down of inventories recognised as an expense	51	38
<b>Total</b>	<b>16,582</b>	<b>15,916</b>



## 14. Trade and other Receivables

	2011 £000	2010 £000
Current:		
NHS receivables	4,746	4,401
Provision for impaired receivables	(115)	(191)
Prepayments	1,247	752
PDC Receivable	61	-
Other receivable	2,435	1,976
Total current trade and other receivables	8,374	6,938
Non-current:		
Other receivables	451	451
Provision for impaired receivables	(78)	(35)
Total non-current trade and other receivables	373	416
Total trade and other receivables	8,747	7,354

### 14.1 Provision for impairment of receivables

	2010/11 £000	2009/10 £000
At 1 April	226	207
Increase in provision	195	165
Amounts utilised	(140)	(140)
Unused amounts reversed	(88)	(6)
At 31 March	193	226

Included above is a provision of £172,466 which is based on 9.6% on the outstanding receivables from the Compensation Recovery Unit.

## 14.2 Ageing of receivables

Ageing of impaired receivables

Up to three months

In three to six months

Over six months

Total

31 March 2011	31 March 2010
£000	£000
-	36
5	37
188	153
<b>193</b>	<b>226</b>

Ageing of non impaired receivables past their due date

Up to three months

In three to six months

Over six months

Total

31 March 2011	31 March 2010
£000	£000
1,040	1,389
73	39
173	14
<b>1,286</b>	<b>1,442</b>

## 15. Other Financial Assets

The Trust had no other financial assets as at 31 March 2011 or 31 March 2010.

## 16. Other Current Assets

The Trust had no other current assets as at 31 March 2011 or 31 March 2010.

## 17. Trade and Other Payables

### 17.1 Trade and other payables at the statement of financial position date are made up of:

	2011 £000	2010 £000
<b>Current:</b>		
NHS Payables	2,027	2,696
NHS Pensions	1,283	1,270
Trade Payables Capital	985	714
PDC Payable	-	13
Other payables	238	135
Other Trade payables	2,773	3,049
Accruals	2,568	2,769
<b>Total Trade and other payables</b>	<b>9,874</b>	<b>10,646</b>
Taxes Payable	2,174	2,145
<b>Total Taxes Payable</b>	<b>2,174</b>	<b>2,145</b>
<b>Non-current:</b>		
Other payables	60	31
<b>Total non-current trade and other payables</b>	<b>60</b>	<b>31</b>
	<b>12,108</b>	<b>12,822</b>

Included above is £6,281 of other trade payables which relates to the Trust's share of the Central Cheshire Urgent Primary Care Consortium joint venture expenditure.

## 18. Other Liabilities

	2011 £000	2010 £000
<b>Current:</b>		
Deferred income	390	434
<b>Total current liabilities</b>	<b>390</b>	<b>434</b>

## 19. Borrowings

	2011 £000	2010 £000
<b>Current:</b>		
Obligations under finance lease	1,438	1,454
<b>Total current liabilities</b>	<b>1,438</b>	<b>1,454</b>
<b>Non-current</b>		
Obligations under finance lease	2,268	3,192
<b>Total non-current borrowings</b>	<b>2,268</b>	<b>3,192</b>

## 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 2011 £000	31 March 2010 £000
Total long term borrowing limit set by Monitor	38,100	31,000
Working capital facility agreed by Monitor	11,000	11,000
<b>Total Prudential Borrowing limit</b>	<b>49,100</b>	<b>42,000</b>
Long term borrowing at 1 April	4,646	5,509
Net actual borrowing (repayment) in year - long term	(940)	(863)
<b>Long term borrowing at 31 March</b>	<b>3,706</b>	<b>4,646</b>
Working capital borrowing at 1 April	-	-
Net actual borrowing (repayment) in year - working capital	-	-
<b>Working capital borrowing at 31 March</b>	<b>-</b>	<b>-</b>



The five ratio tests and the Trust's performance against them is set out below;

Financial Ratios	Actual 2010/11	Approved 2010/11	Actual 2009/10	Approved 2009/10
Minimum Dividend cover	<b>2.9x</b>	<b>3.0x</b>	3.0x	3.3x
Minimum Interest cover	<b>59.7x</b>	<b>39.3x</b>	48.2x	63.9x
Minimum Debt Service cover	<b>6.3%</b>	<b>4.9%</b>	4.9x	6.1x
Maximum Debt Service to Revenue	<b>1.0%</b>	<b>1.4%</b>	1.4%	1.2%

The approved financial ratios are those submitted to Monitor as part of the Trust's 2010/11 financial plans.

## 21. Financial Lease Obligations

### Minimum Lease Payments

Gross liabilities	
of which liabilities are due	
- not later than 1 year	
- later than 1 year but not later than 5 years	
- later than 5 years	
Finance charges allocated to future periods	
Net liabilities	
- not later than 1 year	
- later than 1 year but not later than 5 years	
- later than 5 years	

2010/11 £000	2009/10 £000
<b>3,966</b>	5,031
<b>1,562</b>	1,613
<b>2,394</b>	3,407
<b>10</b>	11
<b>(260)</b>	(385)
<b>3,706</b>	4,646
<b>1,438</b>	1,454
<b>2,258</b>	3,181
<b>10</b>	11
<b>3,706</b>	4,646

## 22. Provisions for Liabilities and Charges

	Current		Non-Current	
	2011	2010	2011	2010
Legal Claims	84	70	-	-
Pensions	103	104	1,248	1,368
Other	121	403	-	-
<b>Total</b>	<b>308</b>	<b>577</b>	<b>1,248</b>	<b>1,368</b>

	Legal Claims	Pensions	Other	Total
	£000	£000	£000	£000
At 1 April 2010	70	1,472	403	1,945
Change in the discount rate	-	(91)	-	(91)
Arising during the year	61	42	121	224
Utilised during the year	(35)	(103)	(278)	(416)
Reversed unused	(12)	(8)	(125)	(145)
Unwinding of discount	-	39	-	39
<b>At 31 March 2011</b>	<b>84</b>	<b>1,351</b>	<b>121</b>	<b>1,556</b>

### Expected timing of cash flows:

Not later than 1 year	84	103	121	308
Later than 1 year and not later than 5 years	-	396	-	396
Later than 5 years	-	852	-	852
<b>At 31 March 2011</b>	<b>84</b>	<b>1,351</b>	<b>121</b>	<b>1,556</b>

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.

The Trust has offered a mutually agreed resignation scheme. A provision of £32,000 has been made for those that have been agreed in principle.

A provision of £90,000 has been made in the accounts which relates to a number of potential claims for unpaid additional sessions work by Doctors.

## 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.

£0 is included in the provision of the NHSLA at 31 March 2011 in respect of the ELS liabilities of the Trust (for which NHSLA is administratively responsible but the Trust has legal liability (2009/10: £33,000).

Financial responsibility for all other clinical negligence claims transferred to the NHS Litigation Authority (NHSLA) on 1 April 2002.

£24,744,760 (2009/10: £22,049,268) is included in the provision of the NHSLA at 31 March 2011 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 £000	Total 2011 £000
Revaluation reserve at 1 April 2010	43,517	43,517
Impairments	(7,402)	(7,402)
Revaluations	7,281	7,281
Other recognised gains and losses	(1,137)	(1,137)
Other reserve movements	(198)	(198)
At 31 March 2011	42,061	42,061

## 24. Cash and Cash Equivalents

	31 March 2011 £000	31 March 2010 £000
At 1 April	6,053	4,825
Net change in year	(2,697)	1,228
At 31 March	3,356	6,053
Broken down into:		
Cash at commercial bank and in hand	138	4,805
Cash with Government Banking Service	3,172	1,247
Other current investments	46	1
Cash and Cash equivalents as in SoFP and SoCF	3,356	6,053

The other current investments relates to the Trusts share of the cash balance held by the Central Cheshire Urgent Primary Care Consortium joint venture.

## 25. Capital Commitments

Commitments under capital expenditure contracts at the statement of financial position date were £190,000 (2009/10 : £372,000).

The commitments are for Management Information Patient Level Costing £57,000, Maternity System £41,000, Digital Dictation £12,000, Integra system £15,000, Occupational Health and Jubilee Suite £20,000, Calorific House Waster Heat £30,000 and the A&E Waiting Area £15,000.

## 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. Provision has not been made in the 2010/11 accounts. A prudent estimate of the amount involved, inclusive of legal cost is:

	Clinical Negligence	Other Legal	Total
	2011	2011	2011
	£000	£000	£000
Total value of contingent disputed claims	9,425	406	9,831
Amount recoverable under insurance arrangements in the event of these claims being successful - payable by NHSLA	(9,425)	(380)	(9,805)
Net contingent liability	-	26	26

	Clinical Negligence	Other Legal	Total
	2010	2010	2010
	£000	£000	£000
Total value of contingent disputed claims	12,171	425	12,596
Amount recoverable under insurance arrangements in the event of these claims being successful - payable by NHSLA	(12,171)	(390)	(12,561)
Net contingent liability	-	35	35

## 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 £3,640,000, however based on actual average relevant net assets this figure should be £3,579,000 and a receivable of £61,000 has been added.

## 29. Related Party Transactions

Mid Cheshire Hospitals NHS Foundation Trust is a public interest body Authorised by Monitor – the Independent Regulator of NHS Foundation Trusts.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the Mid Cheshire Hospitals NHS Foundation Trust.

Other main NHS entities with which the Mid Cheshire Hospitals NHS Foundation Trust are

regarded as related parties. During the year the Mid Cheshire Hospitals NHS Foundation Trust had a number of material transactions with other NHS entities which are listed below:

### ***Related Party Transactions***

	Income £000	Expenditure £000
<b>Value of Transactions with board members 2010/11</b>	-	-
<b>Value of Transactions with key staff members 2010/11</b>	-	-
<b>Value of transactions with other related parties 2010/11</b>		
Department of Health		
Other NHS Bodies	163,374	28,978
Charitable Funds	265	-
Subsidiaries/Associates/Joint Ventures	353	314
Other	171	21,951
NHS Shared Business Services	-	-
 Value of Transactions with board members 2009/10	-	-
Value of Transactions with key staff members 2009/10	-	-
Value of transactions with other related parties 2009/10		
Department of Health	-	1
Other NHS Bodies	156,770	11,474
Charitable Funds	266	-
Subsidiaries/Associates/Joint Ventures	101	-
Other	118	15,054
NHS Shared Business Services	-	-

**Related Party Balances**

	Income £000	Expenditure £000
<b>Value of balances (other than salary) with board members at 31 March 2011</b>	-	-
<b>Value of balances (other than salary) with key staff members at 31 March 2011</b>	-	-
<b>Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2011</b>	-	-
<b>Value of balances (other than salary) with related parties in respect of doubtful debts written of in year at 31 March 2011</b>	-	-
<b>Value of balances with other related parties 31 March 2011</b>		
Department of Health	-	-
Other NHS Bodies	4,746	3,309
Charitable Funds	15	19
Subsidiaries/Associates/Joint Ventures	-	-
Other		2,137
<b>Value of balances (other than salary) with board members at 31 March 2010</b>	-	-
<b>Value of balances (other than salary) with key staff members at 31 March 2010</b>	-	-
<b>Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2010</b>	80	-
<b>Value of balances (other than salary) with related parties in respect of doubtful debts written of in year at 31 March 2010</b>	(39)	-
<b>Value of balances with other related parties 31 March 2010</b>		
Department of Health		
Other NHS Bodies	4,401	3,592
Charitable Funds	15	13
Subsidiaries/Associates/Joint Ventures	126	2,180
Other	-	-

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/the Summary Financial Statements of the Funds Held on Trust. The Mid Cheshire NHS Foundation Trust Board are a Trustee for the Funds held on Trust.

## **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

Trade and other receivables excluding non financial assets  
(at 31 Mar 2011)

Non current assets held for sale and assets held in disposal  
group excluding non financial assets (at 31 March 2011)

Cash and cash equivalents (at bank and in hand)

Total at 31 March 2011

Total	Loans and	Available
2011	receivables	for sale
£000	2011	2011
	£000	£000
7,500	7,500	-
31	-	31
3,356	3,356	-
10,920	10,889	31

Trade and other receivables excluding non financial assets  
(at 31 Mar 2010)

Non current assets held for sale and assets held in disposal  
group excluding non financial assets (at 31 March 2010)

Cash and cash equivalents (at bank and in hand)

Total at 31 March 2010

Total	Loans and	Available
2010	receivables	for sale
£000	2010	2010
	£000	£000
6,602	6,602	-
3	-	3
6,053	6,053	-
12,695	12,692	3

All financial assets are denominated in Sterling.

### 30.4 (ii) Financial assets by category

Obligations under finance leases (31 Mar 2011)

Trade and other payables excluding non financial assets (31 Mar 2011)

Provisions under contract

Total at 31 March 2011

Total	Other
2011	financial
£000	liabilities
	2011
	£000
3,966	3,966
9,934	9,934
1,556	1,556
15,456	15,465

	<b>Total</b>	<b>Other financial liabilities</b>
	<b>2010</b>	<b>2010</b>
	<b>£000</b>	<b>£000</b>
Obligations under finance leases (31 Mar 2010)	5,031	5,031
Trade and other payables excluding non financial assets (31 Mar 2010)	10,677	10,677
Provisions under contract	1,945	1,945
Total at 31 March 2010	17,653	17,653

All financial assets 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 2011.

## **31. Third Party Assets**

The Trust held £1,655 cash at bank and in hand at 31 March 2011 (£1,301 at 31 March 2010) 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 a limitation on its liabilities up to £1 million as at 31st March 2011.

## **33. Losses and Special Payments**

There were 107 cases of losses and special payments totalling £86,493 approved during 2010/11. These have been prepared on an accruals basis. During 2010/11 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.

# Appendices

## Appendix 1

### *Composition of Governors*

The names of the Governors and details on their constituency, as at 31 March 2011, whether they are elected or appointed and the duration of their appointments.

Name	Constituency	Elected / Appointed	Term Expired
<b>Ames</b> , Tracey	Public – Vale Royal	Elected	31 March 2011
<b>Amson</b> , Derek	Patient & Carers – Principal Carer of a Patient Aged 15 Years or less	Elected	31 March 2011
<b>Baynham</b> , Michael	Public – Vale Royal	Elected	31 March 2011
<b>Blount</b> , Betty	Staff & Volunteers – Clinical Support Staff	Elected	31 March 2011
<b>Bowles</b> , Brian	Patients & Carers – Patients	Elected	31 March 2011
<b>Cannon</b> , David (1)	Mandatory Appointee - Cheshire East Council	Appointed	31 March 2011
<b>Carr</b> , Susan	Mandatory Appointee – Central & Eastern Cheshire PCT	Appointed	31 March 2011
<b>Cooper</b> , Christine	Public – Crewe & Nantwich	Elected	31 March 2011
<b>Dibben</b> , Nigel	Patients & Carers – Patients	Elected	31 March 2011
<b>Dunning</b> , John	Non Mandatory Appointee – Congleton Chamber of Commerce, South Cheshire Chamber of Commerce, and Warrington Chamber of Commerce & Industry	Appointed	31 March 2011
<b>Fairhurst</b> , Gill	Public – Vale Royal	Elected	31 March 2011
<b>Gardner</b> , Brian	Non Mandatory Appointee – Congleton District Voluntary Action, Crewe & Nantwich Voluntary Action & Voluntary Action Vale Royal	Appointed	31 March 2011
<b>Gray</b> , Stuart	Public – Crewe & Nantwich	Elected	31 March 2011
<b>Hadfield</b> , Michael	Public – Crewe & Nantwich	Elected	31 March 2011
<b>Hopkins</b> , Colin	Staff & Volunteers – Medical & Dental Practitioners	Elected	31 March 2011
<b>Keenay</b> , Lynne	Public – Crewe & Nantwich	Elected	31 March 2011
<b>Lakey</b> , Lorna	Staff & Volunteers – Registered Volunteers	Elected	31 March 2011
<b>Lyons</b> , John	Patient & Carers – Patients	Elected	31 March 2011

Name	Constituency	Elected / Appointed	Term Expired
<b>Macaulay</b> , Brenda	Patients & Carers – Patients	Elected	31 March 2011
<b>Mawdsley</b> , Harry	Public – Congleton	Elected	31 March 2011
<b>Nimmo</b> , Peter	Staff & Volunteers – Representative of Recognised Staff Organisations and Trade Unions	Elected	31 March 2011
<b>Parkinson</b> , Charlie	Mandatory Appointee: Cheshire West & Chester Council	Appointed	31 March 2011
<b>Paul</b> , Neil	Non Mandatory Appointee – GP Leads in Central & Eastern Cheshire PCT area	Appointed	31 March 2011
<b>Pordes</b> , Philippa	Staff & Volunteers – Qualified Nursing & Midwifery Staff	Elected	31 March 2011
<b>Ritchings</b> , Andrew	Staff & Volunteers – Other Professionally Qualified Staff	Elected	31 March 2011
<b>Stalker</b> , Pat (2)	Patients & Carers - Principal Carer of a Patient aged 16 years or more	Elected	1 July 2013
<b>Walton</b> , Brian (3)	Staff & Volunteers - Non Clinical Support Staff	Elected	1 July 2010
<b>West</b> , Hazel	Public – Vale Royal	Elected	31 March 2011
<b>West-Burnham</b> , Joss	Non Mandatory Appointee: Manchester Metropolitan University	Appointed	31 March 2011
<b>Yates</b> , Diane	Public – Congleton	Elected	31 March 2011

## Notes :

(1) Cllr David Cannon was appointed to the Council of Governors as the Governor Representative for Cheshire East Council following the resignation of Cllr Betty Howell. This appointment was effective April 2010.

(2) Mrs Pat Stalker was elected to the Patient & Carers Constituency – Carer of a Patient aged 16 years or more. This appointment was effective July 2010.

(3) Mr Brian Walton was elected to the Staff & Volunteers Constituency – Non Clinical Support Staff. This appointment was effective July 2010.

(2) As a result of the closure of Cheshire Community Voice, Mrs Jane Smart resigned from the Council of Governors effective September 2010. Cheshire Community Voice was subsequently removed from the Trust's Constitution as a partnership organisation from which a Governor was to be appointed.



## Appendix 2

### *Directors' Expertise and Experience*

#### ***Mr John Moran, Chairman***

John Moran took up the role as Chair on July 1 2008. He joins the Trust Board for a four year period. His considerable business experience, gained mainly in the private sector, will prove invaluable as the new NHS Foundation Trust continues to develop and improve its services and facilities to the public.

An investment and commercial banker by profession, John developed his career at NatWest and Royal Bank of Scotland Group where he was a Director of NatWest Ventures, Corporate Director for NatWest in Manchester and latterly Corporate and Commercial Director for RBS in Merseyside.

He is currently Non-executive Chair at regeneration consultancy, Fsquared. He also provides consultancy services to a range of North West businesses.

John lives in Cheshire and is married with four grown up children and two grandchildren. He likes to relax in his garden and on the golf course when time permits.



#### ***Dr Alan Wood - Senior Independent Non-Executive Director and Deputy Chairman***

Alan grew up on the Isle of Bute, off the west coast of Scotland. He studied chemistry at university and spent some time in pharmaceutical research, which included some enjoyable years gaining a Ph.D.

Alan then converted to a commercial career with ICI, spending nearly thirty years at various management levels in marketing and export sales. He also gained experience in business process design, career planning and general business and company management. He has been through at least three business restructurings, and ultimately managed to fall victim to one - at a time more or less of his choosing.

Since Alan's (stimulated, early) retirement at the end of 1999 he has done some business consultancy in the education and skills area for the North West Development Agency, but has now discontinued this. He does mentor young people for the Prince's Trust.

Alan is married and lives in Hartford. He has two adult children, one in Liverpool and one in London. When he is not in the hospital he either plays golf or goes to the gym.



***Mr Mike Chandler, Non Executive Director***

Mike has lived in Nantwich since 1994. He runs a business and professional development consultancy, Chandler Associates, established in 1995, working with engineering and technology companies for whom he undertakes strategic business development, often as an integral part of their management team.

Trained as a Civil Engineer at Manchester University, he initially worked in power station construction and design. Then followed a period in Swaziland in southern Africa prior to gaining an M.Sc. in construction management from Loughborough University before concentrating on business development. In the early '90s Mike worked in the oil, gas and chemicals sector, marketing specialist loss prevention and risk analysis software.



In 2001/02 he was a part of the team that brought about the Crewe Jigsaw, a Community Art project, erected on Crewe Station.

As Chair of Environment Africa Trust, he is involved in sustainable economic development in sub-Saharan Africa, their major project being the Mpingo Conservation Project in Tanzania. Mpingo is the black hardwood used to make high quality woodwind instruments such as the oboe, clarinet, flute and bagpipes. A supply chain has now been established, from forest village to manufacturer, launching the world's first FSC certified clarinet in January 2011, funded by Comic Relief.

Mike is a Chartered Engineer, Member of the Institution of Civil Engineers and a Member of the Institute of Directors. His interests include going to the theatre, his classic car, target rifle shooting, various charity activities locally, and the grandchildren.

***Mr Bill Craig, Non Executive Director***

After graduating with an honours degree in psychology from the University of St Andrews, Bill held a number of personnel, training and industrial relations roles in food and paper industries 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 SME's and business performance improvement consultancy using a systemic approach to organisational design and development.



A Member of the Chartered Institute of Personnel and Development, Bill is married and lives in Goostrey, Cheshire where he has been heavily involved in the greenfield development of community facilities. His hobbies include golf, reading and watching Crewe Alexandra.



***Mr Dennis Dunn, Non Executive Director***

Dennis Dunn is Pro Vice Chancellor International of the Manchester Metropolitan University (MMU) and Dean of MMU in Cheshire. Formally a Governor of the MCFHT, Dennis brings to the Board his expertise in education, skills, training and organisational development. As an academic he is a published author and former Chairman of BIT World.

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.



His own education included undergraduate studies at MMU and post-graduate studies at Lancaster University. He is visiting professor at universities in China and the Czech Republic. Dennis was awarded the MBE in the Queens Birthday Honours list 2010 for his services to Higher Education.

A serving magistrate since 1988 he is committed to social justice and equality in society, including access to quality healthcare for all within our region. Currently overseeing a £70 million development in South Cheshire for the MMU, Dennis is a passionate advocate for the development of the Trust and our commitment to excellence in the healthcare services we provide.

***Mr David Hopewell, Non Executive Director***

David is a chartered accountant by profession. He spent several years working with Shell, both overseas and in the UK. Subsequently, he took up a post at the Government Office North West, moving on to become Resources Director at Cheshire Peaks and Plains Housing Trust. David is currently the Finance Director for the UK charity, Retrak, which supports street children in Africa.



***Mrs Val Godfrey, Non Executive Director***

Re organisation of local government in Cheshire brought to an end Val's 20 years service as a Councillor with Vale Royal Borough Council where she was the lead for Strategic Partnerships, equality and diversity and young people. She is a member of Cuddington Parish Council and is active in several voluntary and community organisations in the Winsford and Northwich areas; she's a magistrate, chairs the Vale Royal Playscheme Association and is a member of the Rotary Club of Northwich.

After running a charity working with young people for fourteen years, she managed Winsford's Regeneration Partnership, and now works part time with the Winsford Education Partnership. Val and her husband Frank have lived in Cuddington for over forty years.



***Mrs Rachel Alcock, Director Workforce & Organisational Development***

Rachel entered the NHS in 1996 joining the HR Team at the University Hospital of North Staffordshire, where she enjoyed a number of promotions which provided her with the opportunity to work with different clinical and non-clinical specialties. In 2003, Rachel joined the Cheshire and Merseyside Workforce Development Confederation as Workforce Development Manager where her role included working closely with the Cardiac Network, in addition to Workforce Lead for the Independent Sector Treatment Centre Projects. In 2004, Rachel became Head of Human Resources for the Cheshire and Merseyside Strategic Health Authority which involved leading the HR Service for the SHA, including the Mersey Deanery.



Rachel is a member of the Chartered Institute of Personnel and Development and completed the NHS Leadership Centre Programme, Leadership Through Effective HRM, which included electives in both Rotterdam and Boston.

Rachel is married and enjoys skiing, travelling and generally being active.

***Mrs Tracy Bullock, Chief Executive***

Tracy joined Mid Cheshire Hospitals in October 2006 as the Director of Nursing and Quality. Tracy took on the additional roles of Operations and Deputy Chief Executive, until she was appointed to the Chief Executive role in October 2010.

Tracy joined the health service in 1983 as a student nurse and gained 18 years of clinical experience before taking on her first managerial role at the Royal Bolton Hospital. Subsequently Tracy worked in a variety of managerial roles such as Clinical Risk, Governance, Business Management etc, until she left the acute care setting.

In 2002 Tracy started working as an Associate Director, with a newly formed national team of health professionals who were instrumental in providing support to some of the most challenged NHS Trusts in the country and supporting them to become Foundation Trusts. During this time Tracy gained experience working in Acute, Primary Care, Ambulance and Mental Health Trusts.



Tracy is married to Johnathon and enjoys travelling, reading and more recently, gardening.



***Dr Paul Dodds, Medical Director, Deputy Chief Executive***

Paul was born and bred in Nantwich, before studying medicine at Manchester University. He was appointed Consultant Physician with an interest in Cardiology at the Trust 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.

Paul is married to Ali and, away from work, his main interests include gardening and religiously following Everton Football Club.



***Mrs Denise Frodsham, Chief Operating Officer (previously Director of Performance and Service Planning)***

Denise has worked in the NHS for over 26 years, including six 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. Recently, she has had experience of cross-boundary working and management of collaborative services.



She holds both a postgraduate diploma and a master's degree in Business Administration; certification in Occupational Health and Safety (NEBOSH); accreditation as a clinical pathology assessor; a fellowship in medical microbiology; and a higher national certificate in Medical Laboratory Sciences.

Denise is married with one child, and leads a very hectic social life with family and friends, as well as trying to keep active through gardening, walking and (more recently) learning to dance ballroom.

***Mr Phil Morley, Chief Executive (1 April 2010 to 6 October 2010)***

Phil has worked in the Health Service for 25 years, across a variety of organisations and in a number of roles. He recognises the privilege of working with some great leaders and being a part of changes that have been of true benefit to both staff and patients. Previous jobs have been in Bradford, Grimsby, London, York, Dumfries and Nottingham.

He spent a number of years working for the Department of Health



helping the most challenged hospitals and other healthcare organisations to turnaround and put quality back at the centre.

His clinical background is Haematology and his passion is the constant search for high quality services that meet patients needs, expectations and rights. Services that are delivered by staff working in an environment that allows them to enjoy their work, contribute to the organisation and to feel involved and committed as the NHS continues to evolve. His skills are in service improvement methodology and in organisational behaviour, organisational development and relational practice.

Phil's hobbies include squash, cricket, cooking and walking.

***Mr 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 and has recently undertaken study with the NHS Leadership Academy in respect of Executive Director Development.

Mark is married with three boys and enjoys skiing, football and walking.

***Mrs Julie Smith, Director of Nursing (Appointed 7 February 2011)***

Julie has worked in the NHS for over 20 years training as a nurse in Belfast. Julie has worked 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 working in areas of quality improvement and redesign of the delivery of clinical services.

Most recently Julie 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. Julie's passion is the delivery of high quality care resulting in good patient experience and she has a particular interest in vulnerable groups.



# Appendix 3

## Board of Directors

Name	Position	Board of Directors	Remuneration Committee	Audit Committee	Charitable Funds Committee	Performance & Finance Committee	Strategic Integrated Governance Committee	QuEST Committee
Mr Philip Morley	Chief Executive (to 6 October 2010)	Attended 7 of 8 meetings. Stepped down in October 2010	Attended 2 of 2 meetings					Attended 3 of 3 meetings. Stepped down from Committee in October 2010
Mrs Tracy Bullock	Chief Executive	Attended 13 of 14 meetings	Attended 2 of 2 meetings			Attended 6 of 7 meetings. Stepped down from Committee in October 2010		Attended 4 of 4 meetings
Mrs Rachel Alcock	Director of Workforce and Organisational Development	Attended 12 of 14 meetings					Attended 10 of 12 meetings	
Dr Paul Dodds	Medical Director	Attended 13 of 14 meetings					C. Attended 11 of 12 meetings	Attended 3 of 4 meetings
Mrs Denise Frodsham	Chief Operating Officer	Attended 12 of 14 meetings			L. Attended 4 of 6 meetings	Attended 5 of 6 meetings. Joined Committee in October 2010		
Mr Mark Oldham	Director of Finance and Strategic Planning	Attended 14 of 14 meetings		L. Attended 6 of 6 meetings		Attended 12 of 13 meetings		
Mrs Julie Smith	Director of Nursing and Quality (appt. 7 February 2011)	Attended 1 of 2 meetings. Joined in February 2011					Attended 1 of 2 meetings. Joined Committee in February 2011.	
Mr John Moran	Chairman	C. Attended 13 of 14 meetings	C. Attended 4 of 4 meetings					Attended 4 of 4 meetings
Mr Michael Chandler	Non Executive Director	Attended 14 of 14 meetings	Attended 4 of 4 meetings	Attended 6 of 6 meetings				
Mr William Craig	Non Executive Director	Attended 13 of 14 meetings	Attended 4 of 4 meetings	Attended 6 of 6 meetings			Attended 11 of 12 meetings	
Mr Dennis Dunn	Non Executive Director	Attended 8 of 14 meetings	Attended 3 of 4 meetings	Attended 4 of 6 meetings	Attended 3 of 6 meetings			
Mrs Valerie Godfrey	Non Executive Director	Attended 10 of 14 meetings	Attended 4 of 4 meetings	Attended 6 of 5 meetings	C. Attended 5 of 6 meetings			Attended 3 of 4 meetings
Mr David Hopewell	Non Executive Director	Attended 12 of 14 meetings	Attended 4 of 4 meetings	C. Attended 5 of 6 meetings		Attended 11 of 13 meetings		
Dr Alan Wood	Non Executive Director, Senior Independent Director	Attended 14 of 14 meetings	Attended 4 of 4 meetings	Attended 5 of 6 meetings		Attended 12 of 13 meetings	Attended 11 of 12 meetings	













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