Mid Cheshire Hospitals NHS
NHS Foundation Trust

Annual Report and Accounts 2009/10

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

Mid Cheshire Hospitals NHS Foundation Trust
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Chapter 1

Chairman's Foreword

I am pleased to present our results for the period to 31 March 2010 evidencing a further year of progress in what are very challenging times for the health economy.

The year has seen a further increase in demand for our services and I must pay tribute to all of our staff at all levels for their continued dedication and hard work throughout the year as we cared for an increasing number of patients.

We have just had one of the coldest winters for 30 years and as a consequence our staff have seen unprecedented surges in attendances in A&E resulting in rises in emergency admissions which placed great pressures on our facilities. At many times over this period we were literally full and whilst we worked hard to make sure that we could respond to further emergencies, at times and in common with other hospital trusts, we had to divert emergency admissions to other local hospitals.

This unprecedented activity with emergency attendances put our target to treat patients within four hours in Accident & Emergency under great pressure. A massive coordinated effort by the management and staff when dealing with these patient surges allowed us to stay on top of this important government target and my thanks on behalf of the board go to the many staff members involved for the hard work and effort involved.

Despite these challenges we have ended last year in good shape and we have pushed ahead with many of the initiatives I commented on in my last report to help develop our services and provide better and more responsive services to our many patients.

In this foreword I would like to highlight a number of our successes and highlight some challenges that we face. You will find much more detailed comments on these issues as you read this report but I would like to draw your attention to the following significant areas

- We had 68,500 admissions in the year and experienced a total of 246,800 outpatient attendances – this was a further increase over the 2008/09 figures. Work continues across the health economy to develop primary care services that will lead to less pressure on acute hospital services. We are a key partner in these discussions and over the medium term will be working with our partners in the health economy to develop services that can prevent admissions.

- We have again performed well against our many clinical targets; this year achieving the MRSA target of 12 by a margin of 4. We were delighted to have achieved the Clostridium difficile target against a high prevalence of norovirus

within the community which ultimately led to a number of outbreaks within the Trust. A high prevalence of norovirus will inevitably lead to a higher incidence of Clostridium difficile. I was heartened in the year to see the robust action by our clinicians and managers to isolate areas of concern and put rigorous infection control regimes in place to swiftly eradicate the problems. As you will appreciate in all hospital settings this work is continuous and our vigilance remains high.

- Disappointingly we were rated as 'fair' for services by the Care Quality Commission against the 'good' for services achieved with the predecessor body the Healthcare Commission. We will continue to strive for a better rating this year and expect the work accomplished in our 10 out of Ten programme referred to in the Chief Executives Afterword to assist us greatly in this area.

- Monitor, our regulator, gave us ratings of 'amber' for Governance in line with last year's performance. We expect a financial risk rating this year of three. The 18 week referral to treatment target was achieved and this time across all our specialties in accordance with the new targets set in year. We achieved 97.27% against a target of 98% in respect of patients seen within 4 hours in A&E. Technically this places us in the underachieved category rather than fail. For the reasons stated earlier in this report this represents something of an in year turn round as we overcame some of the severe Christmas pressures which resulted in a challenging third quarter.

- We have opened a fully refurbished 30 Intermediate tier bedded unit at Elmhurst in Winsford. However we are disappointed that our plans to develop a similar facility in Northwich, combined with a new primary care centre for the town on our site at Victoria Infirmary have been delayed due to the financial position of the healthcare economy. Discussions continue with the PCT, but in the meantime we have had to temporarily relocate our inpatient beds from Northwich to our main hospital site at Crewe. However, we have retained all our staff and maintained our focus on rehabilitation.

- From April 2010 all Trusts are legally obliged to register with the Care Quality Commission. I was pleased to note that our registration was unconditional.

- I am very proud of our Macmillan Cancer Centre which opened in May 2008. I have always viewed this centre as a quality environment and am pleased that this was endorsed by achieving the Macmillan Environmental Quality Mark in December 2009.

- Our Privacy and Dignity Matron was invited to the launch of the Alzheimers' Society Report 'Counting the Cost, Caring for People with Dementia on Hospital Wards' to share the many examples of good practice that we have introduced. It is always pleasing to see the Trust being recognised externally for its achievements especially in an area I personally consider important.

- 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.

These next few years will be a testing time for all who work across our health economy. 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 on services.

Government set out its plans some time ago to reposition healthcare spending so that in the longer term a healthier population will place less demands on acute services and the management of long term conditions. As a consequence of this, policy spending and investment in primary care facilities has increased, and a transition over time should occur in the level of activity undertaken within the acute sector.

The pace of this change will now start to accelerate. Key to this in our local health economy will be the strength of the partnership working by all of the healthcare participants.

As this foreword is written, our Trust is having to take action to reduce costs and achieve even greater savings, as this transition in budgets occur. Meanwhile we jointly address the needs of our population to ensure we promote healthy living, but at the same time have the right hospital facilities in place to meet the needs of our community.

We have a duty to use our resources carefully and wisely for the benefit 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 in this last year we achieved a financial surplus of £2.0m on a turnover of £164.5m. We achieved this surplus after taking action to assist the overall health economy budgets by rebating £4m to our local commissioners Central and Eastern Cheshire PCT. The surplus is lower than the amount that we realistically need to continue to invest in our estate, from building new facilities to refurbishing existing wards and theatres. I repeat my comments of last year when I said that this represents one of our major challenges and also risks as we move forward.

We continue to strive to maintain the very best standards of care, and routinely our staff 'go the extra mile' to make sure that our patients are looked after and well cared for. Our programme of continuous improvement is now well embedded across the Trust and our Chief Executive, Phil Morley, has personally lead our 10 out of Ten quality initiatives which are rolled out across all areas of the Trust.

There have been no substantive changes to our board structure in this last year save for the re-appointment of Dr Alan Wood and Mr Bill Craig as Non Executive Directors for a further term of office. My thanks go to all the board members who have worked extremely hard through a difficult period to assist with the achievement of these results.

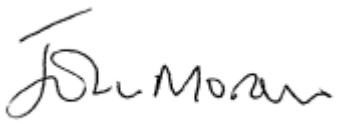
Our membership continues to grow and it has now reached 7,200 at our year end. We have been able to engage with members and the public via our newsletters and public events over the year. It is heartening to see more and more members taking a real interest in what we do and joining us at a number of interesting and informative events that we have been able to arrange over the course of this last year. Engagement with our members and the public is a vital part of our accountability and our Governors have continued to develop these areas over this last year.

I would also like to thank our Governors for all their work over this last twelve months as we developed our committee structures and continued to push ahead with membership recruitment and engagement. Our Governing Council of 30 active and committed Governors represent a range of different constituencies from Staff bodies, Patients and Carers, Public representation and appointed Governors. During the year our Governors have been able to develop better and more effective communication with members, and continuing to develop

our engagement with members and the public will be a key requirement as we go forward.

I hope you enjoy reading the detail about your Hospitals that is contained in this report. You will see that apart from the financial information, we have published a wealth of information about our clinical activities and of course we have a whole section dedicated to Quality Accounts.

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



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 Executive Assistant acting in the Trust Secretary role. The Board comprises

- The Chairman, John Moran.
- The Chief Executive, Phil Morley
- 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, 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 3,300 staff, we provide clinical services through four Clinical Divisions:

- Diagnostic and Clinical Support, including Medical Imaging, Pathology, Victoria Infirmary Northwich, Elmhurst Intermediate Care Centre, Winsford and the Urgent Care Centre in conjunction with the Shropdoc Consortium, GP's and Cheshire East Community Health
- Emergency Care, including Accident & Emergency and Minor Injuries, Dermatology, General Medicine, and Rheumatology
- Surgery and Cancer, including Anaesthetics and Intensive Care, ENT, General Surgery, Gynaecology, Ophthalmology, Oral Surgery, Orthopaedics and Trauma, the Treatment Centre for day case work, and Urology
- Women, Children and Sexual Health, including GUM, Neonatology, Obstetrics, and Paediatrics

During 2009/10 over 68,500 admissions were recorded by the Trust as well as 246,800 attendances at Outpatients. 75,500 also attended at A&E. Of those who were admitted or attended Outpatients, 70,300 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.

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 2010 was £164.5m.

Chapter 3

Director's Report

Board of Directors

The Board of Directors serving in the financial year 2009/10 are listed below:

Name	Position
Mr P Morley	Chief Executive
Ms R Alcock	Director of Workforce & Organisational Development
Mrs T Bullock	Deputy Chief Executive & Director of Nursing
Dr P Dodds	Medical Director
Mrs D Frodsham	Director of Performance & Service Planning
Mr M Oldham	Director of Finance & Strategic Planning
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 become a world class provider of secondary and related healthcare services by 2014"

The Trust has agreed seven strategic objectives to support the delivery of the Trusts aims and vision:

- Quality & Safety
- Organisational Delivery
- Strong Independent FT
- Workforce Development & Effectiveness
- Emergency Preparedness
- Fit for Purpose Infrastructure
- World Class Provider of Choice in Acute, Related and Appropriate Services.

These seven strategic objectives set the framework for all decision making within the Trust.

They are the basis of:

1. Board Assurance Framework
2. Board Annual Objectives
3. Committee's Annual Plans
4. Executive and Non-Executive Director's Objectives
5. Council of Governors Objectives
6. Divisional Board's Assurance Frameworks
7. Quarterly Performance Reviews

Laid out below is the progress made in each of the strategic objectives.

The Board manages key operational risks through the Board Assurance Framework which is monitored monthly at Board of Directors. The Board has considered its key risks to achievement of objectives and these can be found in the Statement on Internal Control on page 127 together with mitigating actions.

Strategic Objectives

Quality & Safety

Quality and Safety is a key strategic objective for Mid Cheshire Hospitals NHS Foundation Trust and is also considered a national priority. As a national priority there is a requirement that all Trusts will publish Quality Accounts for the year ending 31 March 2010. Chapter 7 contains the Quality Accounts in full and describes the Trust's commitment to quality and safety, key strategic priorities and performance against a number of quality and safety indicators. This section of the report is intended to complement the information in the Quality Accounts by providing narrative on a number of projects and initiatives that are more qualitative in nature.

Care Indicators

Care indicators were introduced in April 2008 as a pilot for the North-West of England. The aim of the project was to monitor and improve the standard of nursing documentation around core nursing assessments:

- Falls
- Food & Nutrition
- Observations
- Medicine Management
- Pressure Area Care
- Pain Management
- Infection Prevention & Control

The care indicators are audited on a monthly basis and the results are monitored at a monthly meeting with ward managers, matrons and the Deputy Director of Nursing & Quality.

The Trust wishes to be transparent in respect of quality and safety and therefore displays this information on the Trust's quality & safety boards at the entrance to each ward. The boards also display the number of hospital acquired pressure ulcers, patient falls, MRSA bacteraemias (blood stream infection), complaints, compliments and admissions to each ward within the month.

In addition to the seven standard care indicators, the Trust has extended the audits to include bowel care and cannula care.

The bowel indicator was first implemented in March 2009 with an overall average score being 75% compliant. The main issue identified for non compliance related to the patient's admission documentation which is being addressed through the Nursing and Midwifery Documentation Review Group. Compliance in November 2009, when compliance was measured, was on average 93% within the Trust, which is fantastic considering the updated documentation had not been implemented at that time.

Suggestions for care indicators for the

future include discharge arrangements and bladder care.

Releasing Time to Care (The Productive Ward)

Work has continued over the past year with the Releasing Time to Care; Productive Ward project which aims to allow nursing staff increase the time they spend directly caring for their patients.

Last year, the Trust focused its efforts on two showcase wards (wards 2 and 12). This year the programme rolled out its learning from the project to other wards. All wards have reviewed their stock levels and standardised where stock and equipment should be stored. All wards were able to revise their stock levels and minimise waste.

Further work has also taken place to reduce the time taken to serve meals and to reduce meal wastage. In January, the Trust recorded its lowest ever meal wastage figures of 5.19%, which was a reduction of 32% since January the previous year.

The Trust has also revisited its nursing handover processes and agreed to implement the following standards across all ward areas:

- Every member of staff on the receiving shift receives handover for all patients
- The person giving handover is the person looking after the patient
- All wards use the same template for handover which will be generated electronically wherever possible
- All wards adhere to the target times for handover between each shift
- Standardisation of shift patterns across most wards in the Trust

Senior nursing and midwifery staff working clinical shifts

Over the past year, senior nursing and midwifery staff have committed to working in clinical areas with nurses and midwives and to care for patients and explore with them their experience. The senior staff include the Director of Nursing / Deputy Chief Executive, Deputy Director of Nursing & Quality, Associate Director of Integrated Governance, Governance Lead, Patient Safety Lead, Divisional Lead Nurses and matrons.

Every month each person works a clinical shift in an area of their choice and produces a summary report detailing what happened, what went well and what could be done better or differently.

All areas of the hospitals have been covered in this way including wards, out patient departments, accident and emergency, theatres, pre admission clinics, the mortuary and specific staff groups such as the phlebotomists.

This programme supplements the observational audits which have been running for a number of years, whereby two senior nursing and midwifery staff undertake a period of observation which focuses on patient safety, staff uniform and appearance, privacy and dignity, infection control, hand hygiene, communication with patients, visitors and staff, nutrition, medicines management and the overall environment.

Monitoring patient acuity and dependency levels

Over the past year, the Trust has continued to embed the AUKUH (Association of UK University Hospitals) adult acuity/ dependency tool to help determine optimum staffing levels on the wards. The AUKUH tool has been developed to help NHS hospitals measure patient acuity and/ or dependency to provide evidence based

decision making about nurse staffing levels and workforce requirements. Acuity and dependency measurement currently takes place twice yearly in January and June.

In 2009, the results suggested that the funded (budgeted) establishment for some emergency care wards was too low and did not provide adequate cover for mandatory training, unsocial hours and sickness. This gap in funding led to a significant amount of expenditure being used on bank and agency staff. Consequently, it was agreed to provide an additional budget for 26 healthcare assistants and three qualified nurses. These posts have been recruited to over the year.

Meal Assistance Support Programme

In January 2010, the Meal Assistance Support Programme commenced as a pilot on one of the emergency care wards. A number of senior staff (nursing and non nursing) working in non clinical roles agreed to provide support at lunch time and assist patients with their meals. This programme is an extension of the volunteer support programme that already provides this service on a number of wards at mealtimes.

Every day, two to three staff visit the ward and spend time on a one on one basis with patients, helping them with eating and drinking. The feedback to date has been extremely positive from both patients and ward staff. However, the people who feel most benefit from these arrangements are the non clinical staff as they take time out from their usual activities and spend quality time with patients. The project has been so successful that the rota is to be extended to include more staff and more wards.

Promoting privacy and dignity

As part of the funding secured by the Strategic Health Authority to assist the Trust in delivering same sex accommodation, a Privacy and Dignity Matron has been appointed. The role incorporates promoting privacy and dignity throughout the Trust, improving the quality of care for patients with dementia and learning disabilities and providing education and training for staff.

The Trust is encouraging staff to become dignity champions, a message that has been highlighted through events such as the Dignity Action Day, and patient experience is being monitored through audits such as Essence of Care and Privacy and Dignity care indicators which have recently been implemented.

All staff have received education highlighting the importance of treating patients, relatives, other staff and the public with dignity and respect. Training is also being taken out to the wards via our Privacy and Dignity road shows.

Dignity and respect now forms part of mandatory training illustrating the importance placed on dignity by the Trust as a whole.

"Whatever good things we build end up building us."
Jim Rohn

Left to right, Phil Morley, Chief Executive MCHFT, Anna Gaughan, Regional Dignity Lead, Philippa Pordes, Privacy & Dignity Matron MCHFT and Tracy Bullock, Deputy Chief Executive, Director of Nursing MCHFT at the MCHFT Dignity Action Day held on 25th February 2010.

For further information please refer to the Quality Accounts.

Celebrating Nurses Day – 12 May 2009

To mark the occasion, nurses invited children from St Anne's Catholic Primary School and Mablins Lane Primary School to help them celebrate this special day. Nurses spent the day showing the school children some of the roles and tasks undertaken by nurses which was great fun for all involved. One of the main priorities in hospital is infection control and prevention and the children were taught the importance of proper hand washing – using a 'Glo-box' to highlight where germs hide.

They were also shown how to monitor a pulse and listened to each other's heartbeat with stethoscopes. Dressed in nursing uniforms, they had bandages and plaster casts applied, hopefully ensuring that if a real A&E visit were required, it would be a less intimidating experience. There were competitions to names the bones on a skeleton and the children were asked to design the nurses' uniform of the future, which produced some weird and wonderful ideas involving jet packs and bug-busting capes!

In addition, Northwich-based beauty students from Mid Cheshire College came into Leighton Hospital for the afternoon to pamper the hard-working nurses. Eight NVQ Level 3 nail services group technicians spent their afternoon providing manicures and pedicures for around 40 nurses.

Patient satisfaction surveys

Through surveys patients can actively impact on the services the Trust provides. Patient surveys can be a valuable learning tool through which the Trust can identify aspects of service in which it performs well and also aspects of service that require development. All surveys are conducted in line with the Trust Patient and Public Involvement Strategy.

National patient survey highlights

The Trust is committed to, and values the feedback provided from, participating in the National Patient Survey Programme, co-ordinated by the Care Quality Commission. The 2009 National Outpatient Survey Benchmark report demonstrates survey results and comparisons with all other Trusts.

Achievements made following the last national out patient survey include:

- Achieving 7 scores in top 20% of Trusts nationally
- 32 out of 55 questions scored over 70%
- 10 questions scored 60-70%

A plasma information screen has been installed in the Outpatient Department to keep patients informed of clinic appointment times and at the same time provide information on local information and health campaigns.

A steering group with patient representation has coordinated the development and monitoring of action plans. Each division has developed a programme of local patient surveys and results, along with actions taken, are displayed on the Trust website: www.mcht.nhs.uk/areas/patients/surveys.aspx.

Capturing Real Time Feedback

The Trust has introduced a new method of seeking views from visitors, patients and carers and introduced a portable touch screen system.

The screen has been trialed on the maternity ward to ask new mums about the experiences of treatment. The screen is in the day room and available 24 hours a day so responses can be added at the patient's convenience. Over 50 mums have entered their views and results will be analysed and actions taken as appropriate.

Patient information

The provision of information is an essential part of the patient journey, and a fundamental element in the overall quality of the patient experience. Patients have a right and a need to know about their condition, treatment options, and the availability of services. To support the development of appropriate information the Trust continues to use and increase the membership of the Readers Panel. Over 20 patient information leaflets were reviewed by the panel including skin biopsy procedures, wound care information following head and neck skin lesion surgery, information for people at risk of a fall, cataracts and bereavement services.

The Trust also has a Patient Experience and Quality Committee, which includes six governors as members and monitors activity to ensure satisfaction levels in all areas. The Trust also has patient representatives on each divisional board and receives support and feedback from volunteers on many committees and groups including the National Service Framework for Older People Group and the Patient Information Committee. Job descriptions for the divisional roles have been developed by the volunteers and an additional duty has been included to quality assurance action plans from patient surveys.

Finally, the Trust distributed quarterly newsletters for staff and patients - Keeping in Touch and Opera (Older Peoples Education Relationships Action Group) - to all Foundation Trust members, GP surgeries, pharmacies and libraries. Keeping in Touch has now been combined with the Foundation Trust newsletter "Your Future" to save paper and costs.

Complaints

When investigating complaints, the Trust takes into account the Principles for Remedy that have been established by the Parliamentary and Health Service Ombudsman. As such, the Trust is committed to providing an explanation, offering an apology where required and taking action to avoid similar incidents occurring in the future.

New Local Authority Social Services and National Health Service Complaints Regulations came into effect on 1 April 2009. These have helped the Trust to provide greater flexibility in the handling of complaints and achieve earlier local resolution through face to face discussion and through focussing on the specific needs of the complainant.

In 2009/10 the Trust received 245 complaints, a decrease of 9% (23 complaints) over the previous year. Of the complaints received, 113 were fully upheld, 69 were partially upheld and 63 were not upheld.

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 2009/10 ten complainants asked the Ombudsman to review their complaint. To date no complaints have been upheld by the Ombudsman but have, in general, been returned to the Trust for further local work to be carried out, including arranging a meeting with the complainant and providing further information.

Complainants may also make their complaint to Central and Eastern Cheshire Primary Care Trust (the PCT), our local Commissioner. In 2009/10 the PCT received eight complaints about the Trust.

The Trust is keen to ensure that, where appropriate, actions are identified in order to strengthen our systems and to reduce the likelihood of similar issues recurring.

Additional information in relation to complaints can be found in the Quality Accounts, page 114.

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. Every NHS trust provides a PALS service. PALS staff can 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 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 2009/10 PALS have carried out seven talks or presentations to different groups in the community. These include Crewe and Nantwich Carers Support Group and Probus.

PALS have introduced 'Your Hospital, Your Views' boards, of which there are currently five in the Trust. These boards aim to provide people with information on how to raise concerns, inform them of some changes that have been put into place as a result of their issue being raised through PALS and show feedback from PALS service users.

In 2009/10 1,402 concerns were raised with PALS, regarding the care of a patient, or that of a relative, at Leighton Hospital, Crewe or the Victoria Infirmary, Northwich. This is a increase of 9% on the previous year. PALS resolved 98.5% of those concerns, with only 1.5% (20 people) intending to make a formal complaint. The numbers of complaints and comments received is, of course, small in comparison to the overall number of outpatient attendances and inpatient stays that we provide each year.

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 2009/10 included:

- 'PALS provide an excellent and efficient service. Keep up the good work'.
- 'It was good to talk to someone who listened and got my problem sorted out. Well done PALS. Thank you'.
- 'The PALS staff were very good and sorted out my problem with courteous, friendly and prompt service. Brilliant'.
- 'The lady I spoke to in PALS was sympathetic and helpful. I cannot praise her enough'.

A new mum using the portable touch screen system.

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 2010. 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 compliment the quality information reported within the Quality Accounts.

The high level activity data detailed below demonstrates the continued increase in levels of patient attendances and care delivered during 2009/10 for both non elective admissions and elective treatments.

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

In terms of achievement against key national performance targets, the Trust achieved its year end targets for both 18 weeks (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 2009/10 was in relation to achieving the four hourly performance target in the emergency care target (98% of patients treated within four hours). The Trust did achieve 98.04% for Quarter 4 (January to March 2010), but overall completed the year within the 'underachieve' category of (97.27%). As a result of the continued challenges to achieve this target, the Trust in October 2010, invited the Department of Health Intensive Support Team to visit and assist with a review of all areas of the non elective patient pathways. A detailed action plan has been developed which is now being implemented across the whole Trust. This is beginning to evidence sustained improvement moving into 2010/11.

The following table lists all of the key targets the Trust has been working towards this year. These 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 Patients whose operation once cancelled is rebooked within 28 days	ACHIEVE <=0.8% cancelled on day & <=5% are not rebooked within 28 days = achieve UNDERACHIEVE <=1.5% cancelled on the day & <=15% are not rebooked within 28 days	1.436% operations cancelled on day 14.43% not rebooked within 28 days	**UNDERACHIEVED**
For non-admitted patients, maximum of 18 weeks from referral to treatment	95%	97.58%	**ACHIEVED**
For admitted patients, maximum of 18 weeks from referral to treatment	90%	92.84%	**ACHIEVED**
Percentage of recorded patient data which is complete as part of the 18 week standard	Data completeness of all patients treated must be between 80% & 120%	Admitted Pathways 91.8% Non Admitted Pathways 95.4%	**ACHIEVED** **ACHIEVED**

Performance Standard	National Target	Trust Performance Year End	Trust Position
Percentage of patient records with recorded ethnic group information	ACHIEVE >=85% UNDERACHIEVE >=70%	Outpatients = 87.53% Full Consultant Episodes = 83.36%	**ACHIEVED** **ACHIEVED**
Maximum time of waiting of four hours in A&E from arrival to admission, transfer or discharge	ACHIEVE > 98% UNDERACHIEVE <98% BUT >97% FAIL <97%	97.31%	**UNDERACHIEVED**
Maximum 2 week wait from urgent GP referral to be seen for all suspected cancers including referred those from the breast screening programme	93%	93.29% (breast screening referrals 56.35% - only implemented from January 10)	**ACHIEVED**
Maximum 31 day wait from diagnosis to treatment for all cancers	96%	98.4%	**ACHIEVED**
Maximum 31 day wait for treatment for all subsequent cancers	94%	100%	**ACHIEVED**
Maximum 31 day wait for subsequent treatment all cancers	94%	100%	**ACHIEVED**
Maximum 62 day wait from referral to treatment for all cancers	85%	85.55%	**ACHIEVED**
Maximum 62 day wait to first treatment from all consultant cancer screening service referrals	90%	93.22%	**ACHIEVED**
People suffering a heart attack to receive Thrombolysis within 60 minutes of the call	68%	66.7%	**NOT ACHIEVED**
Percentage of women who initiated breast feeding on delivery	62%	59.65%	**NOT ACHIEVED**
Percentage of women who are smoking at delivery	<15%	19.54%	**NOT ACHIEVED**

Service Developments

The main developments that the Trust undertook during 2009/10 were chosen as offering the optimum opportunities to improve the provision of local health care in areas of most need and to deliver against the Trust's strategic objectives.

Specific service development initiatives undertaken included the following:

- Development of the Urgent Care Centre. This facility opened on time in September 2009 as an additional facility aligned to the A&E department. Its role is to deliver care to patients who are not considered to require A&E care but can be treated by a GP or primary care nurse. The facility which includes a fully refurbished 'front of house' emergency reception, also offers registration to patients categorised as 'hard to reach groups'. These are patients which local public health data has identified as having specific needs and do not usually access community based GP practices. The Urgent Care Centre also provides a care coordination unit, offering a signposting facility for primary care professionals and identifying opportunities to organise rapid access Outpatients and community services to support patient care in other ways than admission to hospital.

- Intermediate tier bed based services. The Trust in conjunction with Cheshire East Community Health opened, in April 2009 and on schedule, a 30 bedded intermediate tier bed based unit in Winsford. This unit is funded to support 'step up' and 'step down' referrals and offers real opportunities for the Trust to deliver enhanced rehabilitation care in more suitable facilities. Feedback from staff and patients has been hugely positive and this is further supported with a 98% highly satisfied patient satisfaction survey undertaken in November 2009.

- Quality investments for 2009/10 largely focused on increasing consultant numbers in areas of greatest growth (3 acute physicians, additional staff grades in cardiology and gastroenterology, and additional sessions in dermatology and ophthalmology). This will increase Consultant presence on wards and support pathway developments for earlier discharge and one stop outpatient's clinics.

- Investments to support maternity matters were approved by the Board for implementation during 2009. This includes a fully integrated community and acute site computer system, a refurbishment of an emergency theatre as well as additional midwives and Consultant staff to provide increased labour ward cover.

- Further service developments to develop the delivery of services within community settings and to work closer with GP's has focused on enhancing access to diagnostics and electronic

linkages. The Trust has been highly successful in its provision of direct access diagnostics, using electronic requesting and reporting systems. This was expanded during 2009/10 to provide access to the hospital computer system in community settings so that hospital consultants could provide outpatient services in GP premises and also so that GP's can view electronic patient records to improve the shared care of patients.

Partnerships

The provision of high quality services delivered by the Trust continued to be a high priority and during 2009/10 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 2009/10 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 during 2009/10 to improve the quality and range of services we deliver to patients

Promoting the care of patients with dementia in the acute setting

In November 2009 the Alzheimer's Society published their report 'Counting the Cost, Caring for People with Dementia on Hospital Wards'. The report made several recommendations as to how care for dementia patients could be improved in an acute setting including ensuring patients get enough to eat and drink, appropriate signage for the cognitively impaired and access to training and education for staff.

Work currently being undertaken at the Trust was recognised by the Alzheimer's Society as an example of good practice and our Privacy and Dignity Matron was invited to London to present this work at the launch of their report.

Particular interest was shown in the electronic dementia guidelines and the Activity Lounge run by Debbie Slack, Lead Nurse for Older People. The lounge encourages social activities for patients with dementia, where they can enjoy playing dominoes, memory boxes and music.

Training and education for staff in dementia has been secured and recognition in the Trust's work has led to a three month secondment for the Privacy and Dignity Matron to the Strategic Health Authority. The project is to review progress in North West acute trusts against the recommendations made in the Alzheimer's Report.

Partnering Volunteers

The Trust has a very long and happy tradition of welcoming volunteers from the 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 our volunteers and to reward long service. In addition regular coffee mornings were

organised and a quarterly newsletter published to keep volunteers up to date with hospital news and other issues which may be of interest to them.

Partnering patients and the public

The Local Government and Public Involvement in Health Act (2007) relates to 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.

The patient experience team have met with members of OCEAN, a new charitable organisation aiming to provide for the black and minority ethnic groups, and the wider community. Leaflets relating to conditions particularly affecting their community, such as sickle cell anaemia, have been obtained and are now displayed in ward areas.

The National Service Framework (NSF) steering group for long term conditions jointly co-ordinated a public information event in Northwich with Central and Eastern Cheshire Primary Care Trust which was supported by a wide range of external statutory, voluntary and community organisations. In addition, there were two “Pregnancy to Parenthood” public events co-ordinated by the ante natal midwives.

Local Involvement Networks (LINks)

LINks cover all publicly funded health and social care services (with the exception of some services for children) no matter who provides them. The establishment of LINks does not change the statutory duty of Foundation Trusts to engage with and consult the communities served nor does it change the vital role of governors.

Cheshire East LINks conducted an enter and view visit to the Treatment Centre and overall, the visit was very positive. Feedback included the Centre being impressive, light, clean and airy with excellent facilities. The LINk viewed the theatre and endoscopy corridors and had access to the cleaning machines and sterilising endoscopes.

There were a few concerns raised from the visit around the lack of hand washing and toilet facilities. The Treatment Centre management team have now submitted a business case to the divisional management team in relation to the additional provision of these facilities. Overall, staff within the Treatment Centre who were involved with the visit found it to be a very positive experience.

Partnering Local Safeguarding Arrangements

In response to the Commission for Social Care Inspection (CSCI) inspection carried out in 2008, Cheshire East Council developed a new Local Safeguarding Adult Board (LSAB) to further strengthen inter-agency working across this important agenda. Membership of the Board includes senior representatives from the Local Authority, Housing, Health, Police, Fire Service, Probation/CPS, and the Third Sector. An inaugural meeting took place in May 2009 and in recognition of the priority given to this agenda the Trust committed Board level representation at this and future meetings.

The LSAB is responsible for determining policy, coordinating activity between agencies and promoting joint learning. The implementation of best practice and monitoring and reviewing the effectiveness of the policies, procedures and guidance in place to safeguard vulnerable adults in Cheshire East is also a key function.

The Trust has had long standing Board representation on the Local Safeguarding Children's Board (LSCB). Membership of the LSCB has supported the Trust in the development and implementation of key agendas such as the introduction of the Common Assessment Framework and ContactPoint. The Trust has also adopted locally agreed policy and best practice and provides assurance to the LSCB in respect of progress against national reports and recommendations.

Mid Cheshire Hospitals NHS Foundation Trust contributes £6,000 to both the LSCB and LSAB in funding, per annum.

Local compact

Other examples of joint working include membership of the local compact which has recently combined with Congleton and Macclesfield community and voluntary services. A steering group of voluntary sector members and representatives from the community and statutory sectors developed this agreement, in order to provide a framework for mutual trust and acceptance of the respective roles and responsibilities of voluntary, community and statutory groups.

Equality, Diversity and Inclusion

Following widespread consultation with stakeholders, the Trust introduced its Single Equality Scheme (SES) in 2007. The supporting action plan which was informed by equality impact assessments (EIA) on the Trust's functions is monitored by the Trust's Equality and Diversity Committee, chaired by an Executive Director of the Trust. Plans for the coming year include a review of the scheme and of the equality impact assessments.

Successes during 2009/10 have included the development of a Multi-Faith Room, the development of business planning and investment processes to include equality and diversity considerations, the establishment of a staff Black Minority Ethnic (BME) network, and the strengthening of the Trust's EIA processes.

An Equality, Diversity and Human Rights Strategy is being consulted on with key partners both internal and external to the Trust and a complete review of the Single Equality Scheme is planned, beginning with an event in April. The implementation of the Strategy and policy with the revised Single Equality Scheme will be the priority for 2010/11. This will include improvements in data collection and analysis, service equality impacts and resulting improved stakeholder involvement. Targets and measures will be confirmed in the review of the Single Equality Scheme.

Strong Independent Foundation Trust

Delivering on Financial Surplus

During 2009/10 the Trust has continued its strong financial stewardship delivering an income and expenditure surplus of £2.0m. Whilst, this is a deterioration on the financial surplus delivered in 2008/09 (£4.1m after adjusting for exceptional revaluation impairment), this has resulted from the Trust's agreement to cap the financial liability of the Trust's main commissioner to assist with their challenged economic position.

This agreement resulted in £4m of activity valued at national tariff for which the Trust

received no income, taking this into account the underlying financial performance shows an improvement on the previous year of £1.9m.

This surplus has allowed the Trust to invest in capital expenditure whilst maintaining an appropriate level of liquidity, and met its obligations under paying suppliers within terms, ensuring support for the local economy.

This sound financial performance is reflected in an anticipated score of 3 against the Monitor Financial Risk Assessment, and whilst this represents a reduction from the previous year's level 4, this was anticipated due to the non recurrent financial support to the Primary Care Trust's position, described above.

The Trust's full accounts can be found from page 129.

Analysis of Income

The total income of the Trust in the financial year was £164,502k. This represents an increase on the previous year of £12,683k, equating to 8.4%. The majority of income has been received from Primary Care Trusts for health care provided to patients.

An analysis of income is provided in the table below:

Analysis of Income 2009/10

Income Source	2009/10 £000s	2008/09 £000s	Change £000s
Patient Care Activities	148,320	137,122	11,198
Education and Training	5,218	5,176	42
Non Patient Care Services to Other Bodies	7,890	6,630	1,260
Other Non-Clinical Income	3,074	2,891	183
Total	**164,502**	**151,819**	**12,683**

Trust Revenue Expenditure

The Total expenditure incurred in 2009/10 is £162,544k, of which £3,805k covered the capital financing costs such as Public Dividend Capital (PDC) and interest receivable and payable, leaving a balance of £158,739k covering operating expenses such as pay and consumables.

Analysis of Operating Expenses 2009/10

	2009/10 £000s	2008/09 £000s	Change £000s
Employee Expenses - Staff	112,042	102,446	9,596
Supplies and Services - Clinical	11,771	11,512	259
Premises Costs	6,078	6,022	56
Drug Costs	8,037	7,161	876
Clinical Negligence Insurance	2,741	1,833	908
Services from other NHS Bodies	2,156	156	2,000
Impairments	8	7,084	(7,076)
Other Expenditure	15,906	14,891	1,015
Total	**158,739**	**151,105**	**7,634**

During the year the Trust employed an average of 3,055 full time equivalent staff, an increase of 169 on the previous year. The average employee cost rose from £35.5k to £36.7k, an increase of 3.4% resulting from annual cost of living increases and the impact of employees moving up on incremental scales.

Whilst clinical supplies costs have been contained within the levels of inflationary increases and premises costs have stabilised after previous years significant increases associated with energy increases, there continues to be significant cost pressures associated with drugs and contributions to the clinical negligence insurance scheme which are being seen nationally. Investments in the Pharmacy Service in 2010/11 will give a greater focus on the financial efficiency of the current prescribing practices.

The increases in services from other NHS bodies is associated with the Therapy Services contract which is now provided by Central & Eastern Cheshire Heath.

Capital Investments

During the year the Trust undertook £5.8m of capital investment, to improve services for both patients and staff. Key developments include completion of second midwifery theatre, development of an Urgent Care Centre adjacent to Accident & Emergency department plus improvements to wards to enhance privacy and dignity.

This was funded partly from charitable donations (£97k), partly from finance leases (£1,134k) and the balance from depreciation, surplus and movement in capital creditors.

A summary of the capital investments, including tangible and intangible, undertaken is shown in the table below :

	£000s
Delivery Theatre	512
Ward Refurbishment	544
Urgent Care Centre	737
Delivering Same Sex Accommodation	286
Disability and Discrimination Refurbishment	109
Car Parks, Roads and Pavements	262
Storage and Back Up Facilities	250
Video Endoscopy System	997
Other	2,093
Total	**5,790**

Prudential Borrowing Limit and Compliance with the Prudential Borrowing Code

As an NHS Foundation Trust, Mid Cheshire Hospitals NHS Foundation Trust is required to comply and remain within a prudential borrowing limit, which consists of two elements:

i) 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 Monitor's website: www.monitor-nhsft.gov.uk

ii) The amount of any working capital facility approved by Monitor.

The Trust prudential borrowing limit is:

- Long Term borrowing facility £31.0m
- Working capital facility £11.0m

In the financial year 2010/11 the Trust reported accumulated borrowings against the long term facility of £4.6m 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 2009/10 is at level 3, as compared with a plan of 4, as shown below:

Metric 2009/10	Achieved Rating	Plan Rating
Earnings before interest, tax, depreciation and amortisation (EBITDA)	3	3
EBITDA % of plan achieved	4	5
Return on Assets	4	5
Income and Expenditure surplus margin	3	4
Liquidity ratio	3	3
Overall Rating	**3**	**4**

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 table below details the governance ratings for 2008/09 and 2009/10.

Table of Analysis – 2008/09 Governance Ratings

	Annual Plan 2008/09	Q1 2008/09	Q2 2008/09	Q3 2008/09	Q4 2008/09
Governance Risk Rating		G	A	G	A
Mandatory Services	G	G	G	G	G

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

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 and >2 is a red rating.

The tables above outline the Trust's quarterly ratings for 2009/10 along with a comparison against the 2008/09 rating. In 2009/10 the Trust declared a risk against the following

targets:

- Achievement against the cancer targets as the thresholds were under review nationally and the Trust was introducing a new Information Technology system to enable more robust monitoring.
- Achievement of the MRSA bacteraemia target. The target of 12 was consistent with the 2008/09 target which was not achieved and this was considered to be an ongoing risk.

However, the Trust was delighted that the risks perceived against the MRSA target were not realized and indeed met the target for all four quarters and the year. For quarter one all targets were achieved and a green rating obtained.

The two week cancer target was narrowly failed in Quarter 2 but all other cancer targets achieved. However, as the four hourly emergency care standard was also underachieved in this quarter, this led to an overall amber rating. In relation to the four hourly standard the Trust had a previous track record of consistent achievement and therefore did not declare any potential risks to meeting this. However, the Trust unfortunately underachieved in quarter three. Although the Trust achieved the quarter 4 standard the year end position was an underachievement.

The Trust recognised that the issues in relation to achieving the four hourly standard would not be overcome in isolation and required a whole health economy approach. As such, the Trust invited the Department of Health's Intensive Support Team to review the emergency care pathway across the economy and make suggestions for changes. The review was supported by the NHS Northwest and took place in October 2009. From this a robust health economy action plan was developed and has largely been delivered. Although no formal intervention was made by Monitor, it was a requirement for the Trust to report the four hourly performance monthly.

The Trust ended the year with a quarter four amber rating due to failing the Thrombolysis and 62 day Cancer Referral to Treatment Time targets. The Thrombolysis target was subsequently failed for the year end also. The element of the target that was specifically failed was in relation to the 'Call to Needle' time. As a result of this the Trust will be working with North West Ambulance Service (NWAS) to improve performance.

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 2010, the Trust paid 97% by value (2008/09: 98%) of non NHS trade bills within this standard and 95% (2008/09; 88%) of NHS trade bills.

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 0.3%, with actual income within this level at 0.2%.

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 the audit was £82k as set out in 5.1 to the Accounts. This consists of:

- Annual Audit Fee (£48K)
- Audit of International Financial Report Standards restatement of balances (£14k)
- 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 2010/11 plan which gives a surplus of £2.0m 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 2009/10, 5.2% of total income was incurred on management costs.

Whilst this represents a small increase on last year (2008/09: 4.9%), this has been impacted by an increased drive in clinical engagement in the management of the Trust. In line with the operating framework plans are in place to reduce this in 2010/11.

Workforce Development and Effectiveness

As advised previously, recognising the need to actively promote equality, diversity and human rights, the Trust has dedicated resources for a lead post on this important agenda.

A focus during the year has been the increase in the numbers of our workforce who are trained in equality and diversity matters. Progress against this is highlighted in our staff survey results from 2009, which has shown a significant increase in the number of staff reporting that they have been trained in this area.

During the year, the few equal pay claims registered against the Trust were dismissed by the Employment Tribunal prior to any full hearings.

The Trust website has published information relating to Equality Impact Assessments, the Single Equality Scheme and action plan, and workforce information. A summary of some of the published workforce information is as follows:

End of March 2009			
Ethnicity Group	Number	% of Total Trust	% of Known Ethnicity
White	3068	94.14%	95.79%
Mixed	13	0.40%	0.41%
Asian or Asian British	79	2.42%	2.47%
Black or Black British	19	0.58%	0.59%
Other ethnic groups	24	0.74%	0.75%
Undisclosed / Unknown	56	1.72%	-
Grand Total	3259		

End of March 2010			
Ethnicity Group	Number	% of Total Trust	% of Known Ethnicity*
White	3170	93.79%	95.02%
Mixed	11	0.33%	0.33%
Asian or Asian British	103	3.05%	3.09%
Black or Black British	27	0.80%	0.81%
Other ethnic groups	25	0.74%	0.75%
Undisclosed / Unknown	44	1.30%	-
Grand Total	3380		

*Known ethnicity excludes ethnicity recorded as not known, unstated.

End of March 2009		
Age Range	Number	%
16-19	28	0.86%
20-29	513	15.74%
30-39	795	24.39%
40-49	961	29.49%
50-59	818	25.10%
60-69	134	4.11%
>70	10	0.31%
Grand Total	3259	

End of March 2010		
Age Range	Number	%
16-19	25	0.74%
20-29	521	15.41%
30-39	821	24.29%
40-49	972	28.76%
50-59	876	25.92%
60-69	154	4.56%
>70	11	0.33%
Grand Total	3380	

End of March 2009		
Gender	Number	%
Female	2651	81.34%
Male	608	18.66%
Grand Total	3259	

End of March 2010		
Gender	Number	%
Female	2732	80.83%
Male	648	19.17%
Grand Total	3380	

End of March 2009		
Disability	Number	%
Recorded Disability	62	1.90%
Trust Total Staff	3259	

End of Feb 2010		
Disability	Number	%
Recorded Disability	71	2.10%
Trust Total Staff	3380	

Sickness Absence

HM Treasury FReM requires that NHS Foundation Trusts declare sickness absence performance.

In the year ended 31 March 2010 the Trust set itself a target percentage attendance of 95. 5 % reflecting sickness absence at 4. 5 %. The Trust is able to report that cumulative performance for the year being attendance of 95. 25 % reflecting sickness absence of 4.75 %.

Policies in relation to disabled employees

The Trust has an Equality and Diversity Policy which ensures that all staff regardless of age, sex and disability, for example, are valued equally and treated fairly. This is further endorsed and supported by the Flexible Working Policy and Procedure. Both Policies can be found on the Trust's intranet site under Human Resource Policies.

Consultation with Employees

The Trust has very positive relationships with both staff side committees, Joint Consultation and Negotiation Committee (JCNC) and Joint Local Negotiation Committee. Both committees are extensively involved and consulted with

in all matters affecting staff and the Trust. An update is provided at each meeting of the JCNC on all Consultations or change proposals that are taking place, which may affect how colleagues are employed in the Trust or a change in working practices

In addition to the consultative committees we also have more innovative methods of communicating with colleagues, these include:

- Team Brief
- Annual Forward Thinking Event
- Specific Chief Executive or Executive Director briefing sessions
- Divisional Management Team roadshows
- 12 month of employment Anniversary Lunches with the Chief Executive and Director of Workforce & OD
- Over 20 years service Anniversary Lunches with the Chief Executive and Director of Workforce & OD

Recognising the role that all staff will play in the future success of the Trust, a series of briefing sessions were launched in March 2010, which involved communicating the challenges ahead, and giving colleagues the opportunity to put their ideas forward for improving quality and reducing costs. Ideas can be put forward in a variety of ways, and a weekly meeting is held, chaired by the Director of Finance & Strategic Planning, to consider the ideas and decide which are able to be taken forward.

Staff Engagement

The Trust participates in the NHS annual staff survey which takes place usually between September and December each year. For the 2009/10 survey, the Trust had a response rate of 61%, against a response rate of 63% in 2008/09. The Trust is delighted to report the response rate for 2009 is higher than the national average for acute hospitals in England.

Although awaiting confirmation from the Care Quality Commission national reports, the first draft for the Trust highlights the following areas:

- Staff training - from 2007 the quality and quantity of training that was delivered has improved, particularly in equality and diversity, infection control and handling confidential information.
- Team working - a significant increase in the fact that staff feel that their team meets regularly.
- Planned working - increases in staff feeling more involved in decisions that affect their work, that there are enough staff to do their job properly and more people feel they are able to do the job to the standard they are personally pleased with.
- More staff believe that the care of patients is the Trust's top priority.
- Violence and harassment - overall the Trust have fewer incidents and report them when they do happen as staff believe that the Trust will take action.
- Infection control - scoring higher that other Trusts for availability of materials for staff and patients.

Some of the areas where the Trust could do better include:

- Letting staff know how they are doing in their job
- Letting staff know how valued they are and that their work is important
- Improving communication throughout the Trust

The Trust's top 4 ranking scores were as follows:

- Impact of Health & Wellbeing on ability to perform
- Staff saying hand washing materials are available to them
- Fairness and effectiveness of incident reporting
- Percentage of staff appraised in the last 12 months

Whilst the bottom 4 ranking scores related to:

- Percentages of staff witnessing potentially harmful errors, near misses or incidents in the last month
- Percentage of staff working in a well structured team
- Percentage of staff agreeing their role makes a difference to patients
- Percentage of staff able to contribute to improvements at work

Following the 2008 staff survey, the Trust prioritised the following areas for improvement in the staff survey:

1. % of staff satisfied with quality of work and patient care they are able to deliver
2. % of staff who feel valued by work colleagues
3. % of staff with a well structured appraisal
4. % of staff job satisfaction
5. % of staff who feel able to contribute towards improvements at work
6. % of staff working in a well structured team environment
7. % of staff receiving support from their immediate line manager
8. % of staff experiencing physical violence from patients/relatives
9. % of staff who believe the Trust provides equal opportunities for career progression or promotion
10. % of staff who report good communications between senior management and staff

All of the above areas have seen improvement in the scores from 2008/09 to 2009/10, with the exception of improving good communication between senior management and staff and improving working in a well structured team environment.

Each Division has received individual feedback on the survey results and action plans to address the areas of concern are being monitored by the Divisional Workforce Committees and form part of the Divisional Quarterly Performance Review.

The Trust will continue to focus efforts on areas of improvement during 2010.

In addition to undertaking the staff survey, the Trust was again assessed against the Investors in People standard, which involved a team of internal assessors who were overseen by an external assessor on behalf of the Centre for External Assessment and Recognition (NW) Ltd.

The review involved interviewing approximately 5% of the workforce to gain further valuable information on what the priority areas should be for the Trust. In an overall context, there were several strengths, notably:

- leadership and management development
- agreement of learning objectives
- a focus on continuous improvement
- a strong commitment to equality of opportunity
- a culture of empowerment
- effective team work

The review found it was evident that action had been taken to address the areas for development highlighted at the last assessment, in particular relating to communication and leadership & management. The Internal Review team also reported many examples of sharing of good practice and a culture of cross-team working towards continuous improvement.

The information from both the staff survey and the Investors in People assessment will continue to inform action plans at both Trust and Divisional levels.

Tracy Bullock, Deputy Chief Executive, signs the Skills for Health Pladge, on behalf of MCHFT

Learning & Development

Vocational learning - Skills for Life:

The Trust committed to the Skills Pledge, which is a voluntary, public commitment made by an organisation to invest in the skills of its workforce. The Trust has committed to actively encourage and support employees to gain the skills and qualifications that will meet the needs of the business and will support their future employability, and provide further support to staff to acquire basic literacy and numeracy skills and work towards a first full Level 2 qualification.

The Trust's NVQ Centre alongside the new NVQ Training Provider undertake initial skills screening which is the initial process to determine learners who may have a literacy or numeracy need and to identify learners who would benefit from further assessments.

Currently 70 NVQ candidates have been assessed.

NVQ

The Trust has a City and Guilds NVQ accredited Centre. Within the Centre there are 3 Internal Verifiers, 35 Assessors and 57 candidates who are currently progressing with the following programmes:

- Health and Social Care
- Health

In December 09 the Trust selected Business Focus Associates to work alongside the NVQ Centre to deliver a further range of NVQ programmes for staff, these programmes include:

- Business Administration
- Customer Service
- Leadership
- Team leading

Apprenticeships

Apprenticeships are integrated workbased 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 is currently working with Knowsley Community College, in association with, Business Focus Associates, to deliver the development programmes for 22 apprenticeship posts in the Trust. These are in the following areas:

- Learning and Development
- Medical Records
- Emergency Assessment Area
- Physiotherapy
- Occupational Therapy
- Medical Wards
- Gastroenterology
- Ante Natal Clinic
- Child and Adolescent Unit
- VIN Outpatients

This would see Apprentices developing via the following programmes:

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

New Role Development - Assistant / Advanced Practitioners

The Trust currently has Assistant Practitioners in training in the following areas:

- Neonatal Intensive Care Unit
- Theatres
- Treatment Centre
- Maternity Services
- Pathology
- Paediatrics
- Emergency Assessment Unit
- Accident and Emergency
- VIN Outpatients
- Head and Neck Unit
- Pre-Discharge Ward

Advanced Practitioners are currently in training in the following areas:

- Gynaecology Inpatients
- Paediatrics
- Labour Ward
- Surgery

All trainees' are due to complete training within 2010/11 and a review is currently underway to identify any further developments required to support these new workforce roles. It is envisaged that Advanced Practitioners will support junior doctor rotas and Assistant Practitioners (unqualified) will support qualified Nurses.

The Trust successfully secured funding from NHS North West for the development of Advanced Practitioner roles, to commence training in 2010/11 (2 years' training programme), operating in the areas of:

- Accident and Emergency
- Emergency Assessment Unit
- Paediatrics
- Neonatal
- Gynaecology
- Sexual Health

Management Trainees

The Trust was successful in hosting two first year National Graduate Management Trainees, one in Human Resource Management and one in General Management. The Trust also hosted a

second year National Graduate Finance Trainee.

Leadership Development

The professional review of the end of the first year of both the Becoming a Mid Cheshire Hospitals NHS Foundation Trust Manager and the Managers Moving On Programme took place in September 2009. The feedback from both programmes was extremely positive, both in terms of the personal growth described by participants and the improvements that they had made in their areas of work. The second year of cohorts commenced in September 2009. Both programmes became accredited with the Institute of Leadership and Management and are recognised by Manchester Metropolitan University as credits towards the Masters programme in leadership.

Work has been undertaken during the last year to develop a senior leadership programme in the Trust, which will launch in April 2010. This programme is aimed at improving the leadership capability of both clinical and managerial leaders in the Trust, developing the confidence and accountability to help develop the future of the Trust.

In addition to the above, a coaching framework was developed to help the Trust move to a culture of leadership and management in a coaching style, to help deliver the quality strategy for the Trust. The framework involves both the training of formal coaches, plus developing managers in how to have coaching conversations with their colleagues.

Team diagnostic sessions have taken place with three of the divisional boards to help in their development to become more effective.

The Quality Matters Programme has also provided operational managers and senior leaders with new skills in service improvement tools and techniques.

Health and Wellbeing

The Trust collaboration with East Cheshire Hospital NHS Trust (ECT) in Occupational Health Services was formally launched in April 2009. The service provides health related advice and counselling support services for staff and managers at the Trust, ECT and two Primary Care Trusts. In addition, due to the growing reputation of the service for clinical excellence, the Trust won its first significant contract for providing to another NHS organisation in the North West.

The team led the immunisation programmes for both H1N1 and Seasonal Flu vaccinations in both Trusts, which resulted in both Trusts achieving some of the highest immunisation rates amongst staff in the North West. In recognition, the team has been shortlisted in the top three nominations for Team of the Year in this year's Celebration of Achievement.

The Occupational Health Team - winner of the MCHFT Team of the Year award.

Values & Behaviours

During the year the Trust took the opportunity to review the values and behaviours that would be required to deliver the 10 out of Ten Quality Strategy. A small working group was pulled together which included staff side colleagues, and the following values and behaviours were developed:

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
- take personal responsibility
- have the courage to speak up and make my voice heard
- value and appreciate the worth of others
- play my part to the best of my ability

Health & Safety

There were 21 reportable incidents to the Health & Safety Executive (HSE) as required by the Reporting of injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). None of these required further investigation by HSE.

HSE communication with NHS Trusts relating to dermatitis and Lifting Operations Lifting Equipment Regulations (LOLER) are being addressed and monitored by the Trust's Health & Safety Committee.

Emergency Preparedness

The Trust has a Head of Emergency Planning who supports the Executive Director responsible for Emergency Preparedness. The Emergency Planning Group work 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) has been formed to ensure compliance with the requirements of the Civil Contingencies Act 2004. Senior representatives from all Category 1 responder organizations attend this forum. 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 Head of Emergency Preparedness for the Trust regularly attends the Health and Risk Assessment Groups. In addition to this, task groups are attended regularly to manage particular risks including decontamination, heat wave and hospital evacuation.

Major Incident Planning

Following the Trust's involvement in Exercise Maximus in January 2009, the Trust's Major Incident Plan was amended to include the lessons learned. Exercise Maximus was a health led multi-agency regional strategic level exercise, using both the desktop and command post formats. It provided an opportunity for health professionals to identify the potential impact on regional NHS services from a sustained response to a mass casualty incident in Greater Manchester. It was also

an occasion for partner organisations to improve their understanding of the wider implications of a mass casualty event.

In August 2009, the Trust was involved in a MAJAX Influenza Exercise organized on behalf of the Lead Primary Care Trust. This exercise involved all local NHS organisations and was designed to identify gaps in Trust Pandemic Influenza Plans. Lessons learned from this exercise have been used to inform further planning and have been incorporated within the Trust's Pandemic Influenza Plan.

The Trust's Command and Control arrangements, particularly those that link with other agencies, have also been tested extensively over the course of the influenza pandemic, and have been adapted accordingly.

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. This will define the commitment of the Trust, and the process to be followed, in order that local operational business continuity plans can be developed.

The Divisional Risk and Governance Managers have been identified as the business continuity co-ordinators for each Division. They are being assisted by the Head of Emergency Preparedness in the development of Divisional plans, and in the implementation of local operational business continuity arrangements.

This work has been given fresh impetus by the ongoing work carried out by all Divisions in preparation for the swine flu outbreak (see below). Each Division has now prioritised its services, and is in the process of developing plans for each area that is crucial to the delivery of high priority services. All Divisions will be required to have Divisional Business Continuity Plans that link to the Corporate Plan by April 2010.

Pandemic Influenza

On 29 April 2009 the World Health Organisation raised the international pandemic influenza alert from Phase 4 to Phase 5, as a result of a new influenza strain H1N1 (commonly referred to as 'swine flu') being identified in Mexico and the United States. On the 11 June 2009 the World Health Organisation raised the international pandemic influenza alert to Phase 6. This indicated that a global pandemic was under way.

For the swine flu pandemic the Department of Health put in place command and control arrangements for the NHS. Helen Bellairs (CEO Western Cheshire Primary Care Trust), assumed the role of Swine Flu NHS Gold Commander for Cheshire, Halton and Warrington. As a result of this, and to satisfy Department of Health and Strategic Health Authority requirements, the Head of Emergency Preparedness has been involved in daily reporting, and Command and Control communications, for the duration of the pandemic. This has been continued with the emergence of winter pressures and the reporting / coordination requirements involved with these pressures.

In response to the pandemic, the Trust's Pandemic Influenza Plan has been subject to many reviews and changes during

2009. The Plan was assessed by the Lead Primary Care Trust in early 2009 and given a green status. The Board of Directors approved the Trust's Pandemic Influenza Plan in July 2009. Subsequently the Plan has been continually updated due to the nature of swine flu, and the demand (or predicted demand) on services.

In November 2009 the Medical Director led an Emergency Preparedness Workshop which assessed each Division's "state of readiness" for the anticipated increase in swine flu activity. Following this an action plan was developed by the Integrated Governance Department, which has been monitored by the Emergency Planning Group, and presented to the Board of Directors. Although swine flu activity continues to decline this action plan will be carried forward to ensure optimum preparedness for any future pandemic.

The Trust's Occupational Health Department, Cheshire Occupational Health a joint collaborative with East Cheshire NHS Trust, immunised staff against seasonal and swine flu. The H1N1 campaign started on 2 November 2009 and ran until the end of January 2010 with vaccinations continuing to be offered to staff arriving for their occupational health appointments until end of March 2010. In relation to the Swine Flu vaccinations, the Trust achieved 45% uptake across all front line clinical healthcare workers and achieved a top 10 position in the North West.

Fit for Purpose Infrastructure

Trust Premises

The Trust's premises on the main Leighton site were originally constructed in 1972. In line with many buildings constructed at that time, fire control measures included the use of asbestos. Whilst the existing asbestos poses no health risk, construction and refurbishment work is unable to take place with it in situ. Over recent years there has been a programme to remove this asbestos in order to be able to develop the site further and keep the facilities modern and safe.

This has brought with it its own problems as this removes the existing fire controls and recent reviews from Cheshire Fire and Rescue have resulted in four enforcement notices and action plans have been agreed. These action plans include temporary mitigating controls whilst the programme of work is undertaken.

The section on Strong Independent Foundation Trust describes the capital additions which have been undertaken in year, which includes the refurbishment of Ward 14, where the measures agreed have been incorporated. A further 2 wards will be refurbished in 2010/11 and funds have been approved to undertake this work.

Whilst there have been a number of notable infrastructure developments over recent years, including the addition of the

Treatment Centre for Day Case Surgery, Ophthalmology and ENT outpatient premises and the Macmillan Cancer Centre, there remain areas which have not been developed, including:

- Main Theatres accommodation
- Outpatient accommodation
- Intensive Care and Neonatal Critical Care

Whilst the Capital programme includes some development in Outpatients in 2010/11, all these schemes would require significant investment to replace existing facilities and a strategy is being developed considering the options.

Given the Trust's statutory commitment under the Cheshire Fire and Rescue programme coupled with backlog maintenance of £2.6m worth of "significant risks" which will need to be dealt with over the next 5 years, the financial challenge will be significant.

Information Management and Technology

The Trust recognises the need to invest in modern information technology, which is particularly key in such an information rich environment as health care, during the year the Trust has been implementing the following key systems:

- Management Information and Patient Level Costing (MIPLC) – this system will allow faster and more easily accessible information on performance and detailed analysis of the cost of activities undertaken, by linking key activities back to the patient episode. This will allow improved performance monitoring and a better understanding of where variations in cost occur. The next steps are then to understand where these improve outcomes.

- Digital Dictation – allowing faster turnaround of clinical correspondence to patients and General Practitioners.

- Disaster Recovery – to improve the resilience and back up of essential systems to allow continued operation during potential major incidents.

Further plans for 2010/11 include:

- The completion and further development of the MIPLC system

- Upgrade to the Trust's electronic medical imaging system

- Implementation of electronic requesting and access to results of pathology tests eliminating unnecessary testing and improving response times

Fire Safety

In October 2009 the Trust was issued with four enforcement notices from Cheshire Fire & Rescue (CF&R). The Trust is pleased to note that it has already fully complied with two of the notices and has plans in place to address the further two notices within the agreed timeframes.

An audit was also carried out by CFRs on both Elmhurst and Victoria Infirmary, Northwich in October 2009. There were no recommendations or reports received from CFRs for either site.

No fires were reported at any of the MCHFT properties during this period. There were 49 Unwanted Fire Signals (UwFS) at Leighton Hospital, 3 at Victoria Infirmary, Northwich and none at Elmhurst.

Sustainability Strategy

Introduction and Definition

The Trust's Sustainability Strategy establishes the commitment to sustainability and sets out 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. With climate change considered the most serious global environmental threat, sustainability and carbon reduction are becoming corporate responsibilities for all organisations. 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.

"Saving Carbon, Improving Health", the NHS Carbon Reduction Strategy for England (NHS Sustainable Development Unit, January 2009) sets out the vision, responsibilities and key actions for all NHS organisations. The key areas for action are energy and carbon management, procurement and food, travel and transport, water, waste, building design, organisational and workforce development, partnerships and networks, governance and finance. 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 Trust. The expansive and long-term nature of the sustainability agenda means that implementing sustainability issues will be an incremental process.

In September 2007 the NHS Management Board made the following commitment to sustainable development: "To continue to develop the NHS role as a good corporate citizen, taking sustainable approaches to reducing health inequalities, building stronger local communities, safeguarding the environment for the benefit of whole communities, including alleviating climate change through reductions in carbon attributable to NHS activities, and thus ensuring its own long term viability".

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/ procurement options

- Include climate change in the risk register including financial risk
- Reduce/minimise environmental impact whilst maintaining continuous improvement
- Integrate the principles of sustainability into all areas of Trust business

Supporting Actions

The Trust will enable these changes by:

- Ensuring the commitment made by the Board of Directors is translated into clear direction and responsibilities and that sustainability is mainstreamed in the Trust's objectives, corporate strategies and annual report
- Setting up a Trust Sustainability Group led by an Executive Director and reporting to the Board of Directors
- Providing regular reports to the Board of Directors and conducting regular reviews of policy
- Developing and implementing reduction plans to address the major components of NHS carbon emissions including direct energy consumption, procurement, transport (including business, commuting and patient travel) and waste
- Using a structured environmental auditing system to review the progress towards objectives
- Implement life cycle costing
- Pursuing an active communications initiative to engage all staff, patients, visitors and others who visit or use our facilities

Recycling has been championed in the Treatment Centre

- Provide training for employees, partners and contractors especially in terms of sustainability, climate change and carbon literacy
- Working with partners especially NHS organisations and local authorities in developing whole community solutions to carbon emissions. Also work closely with regional and national agencies to develop leading sustainability practice
- Following the Good Corporate Citizenship assessment model to measure and access the Trust's performance
- Measuring performance against pre-determined targets and from these performance measures identify how improvements can be made.

Summary Position 2008/09 – 2009/10

For the periods 2008/09 and 2009/10 the Trust has

- Increased waste recycling by 367%
- Reduced water usage by more than 19%
- Reduced gas consumption by more than 6%
- Increased electricity consumption, as a result of increased activity and additional buildings, by 28.25%
- Increased oil usage due to additional testing of emergency preparedness capacity by 70.2%

Waste Management

Definition	Tonnes 2008/09	Tonnes 2009/10	Disposal Cost 2008/09	Disposal Cost 2009/10
Total amount of waste produced by the Trust	1,024	1,635	£224,157	£278,036
Method of disposal (Landfill)	470	452	£46,670	£47,572
Method of disposal (Heat treated then deep landfill)	367	427	£127,531	£160,323
Method of disposal (Incinerated then deep landfill)	36	58	£19,877	£34,935
Method of disposal (Recycled)	149	696	£30,078	£35,204

Finite Resource

Definition	Consumption 2008/09	Consumption 2009/10	Cost 2008/09	Cost 2009/10
Water	146,788 M^3	118,063 M^3	£337,040	£388,598
Electricity	19, 687 GJ	25,249 GJ	£624,851	£593,957
Gas	95,690 GJ	89,406 GJ	£752,831	£553,737
Oil	456 GJ	776 GJ	£5,782	£10,193

GJ - a unit of energy equaling 1 x 10^9 (one thousand million)

World Class Provider of Choice

Clinical improvements and developments

The Trust continues to invest in services to improve the quality of care to patients.

Investments to increase the levels of consultant led services have meant the Trust can develop or enhance services for:

- Breast reconstruction
- Orthopaedic shoulder surgery
- Gynaecology
- Macular degeneration (Ophthalmology)
- Acute physicians to support care in the Emergency Assessment Unit
- Histopathology
- Dermatology

Building on the success as a Bowel Screening Unit locally, the Trust has become the centre for screening for the whole of Cheshire.

The Trust's colorectal surgeons have gained recognition for leading edge laparoscopic surgery by being recognised as one of only two training centres in the region. The surgeons have also pioneered, on site, the enhanced recovery programme and working with a multidisciplinary team have developed the programme which has halved the length of stay for patients with cancer through improved pain management and rehabilitation techniques.

Despite significant increases in admissions the Trust have achieved national targets for wait times for elective surgery (18 weeks).

To support front of house services and improve the environment for patients the Trust have, with support from Central & Eastern Cheshire Primary Care Trust, developed a new waiting area in the Accident and Emergency Department. In addition, with Partners the Trust have developed an Urgent Care Centre adjacent to the Accident & Emergency Department to give patients faster access to treatment.

Infection Control is an important part of the Trust's work and the Infection Control Department have ensured the Trust achieved Clostridium difficile targets and in the case of MRSA, reduced the number of bacteraemia to eight, 30% better than target. Next year the Trust plans to reduce the numbers of MRSA bacteraemia again, to a maximum of five. To support the Trust to be MRSA free, screening for all elective patients has been introduced, a year ahead of target and will be extended to emergency patients in 2010/11.

Diagnostic tests are an increasingly important part of the decision making tools for clinicians to manage patients care. Despite a significant increase in the demand for tests the diagnostic department have reduced wait times across the board. This was helped by investment in a new CT scanner which has increased the range and speed of services provided.

In addition, the Trust now provide Cardiac Magnetic Resonance Imaging reducing the need for invasive procedures for people with heart disease.

The Trust has also introduced DEXA scanning for the first time locally. This test measures bone density and supports the care and management of patients with osteoporosis and rheumatism.

The Trust has agreed over £0.25m investment in pharmacy services. The review has identified how through this

investment medicines management can be improved, reducing medication errors and waste.

A key part of the National Health Strategy is keeping patients at home or out of hospital where possible. To support this strategy, the Trust invested in a home phlebotomy service that offers patients who have difficulty getting to hospital the opportunity to have essential blood tests carried out in their own home.

Clinical Services Strategy

In April 2010 the Board of Directors set out the direction for Clinical Services from 2010-2015. In developing this strategy the Board of Directors have taken into account:

- The operating environment in which the Trust must deliver services over the next 5 years
- The local market – the context in which the Trust will play a full and committed role
- The Trust's vision, values and objectives
- The key changes for the Trust to deliver the vision
- The key clinical service developments across Divisions and support services

The strategy was set against the Trust's seven key strategic objectives:

- Quality and Safety
- Organisational Delivery
- Strong Independent FT
- Workforce Development and Effectiveness
- Emergency Preparedness
- Fit for Purpose Infrastructure
- World Class Provider of Choice in Acute and Related Appropriate Services

In order to ensure clinical effectiveness the Board agreed that services must be based upon:

- Quality – deliver services whose performances are on a par or better than peer
- Efficiency – deliver services that meet or exceed national targets for performance
- Financial balance – deliver services that achieve a minimum of 2% surplus to allow capital investment
- Find new ways of collaborating with others to deliver services

The Board of Directors also recognises there are significant challenges, and in developing strategy the Trust must understand these. The key challenges are:

1. Rapid and large scale reduction in health funding
2. Increased expectation of the public and monitoring of standards
3. An increasingly ageing population
4. An increasing capability and cost of medicine to treat disease
5. An infrastructure developed over 30 years ago which is progressively no longer fit for purpose

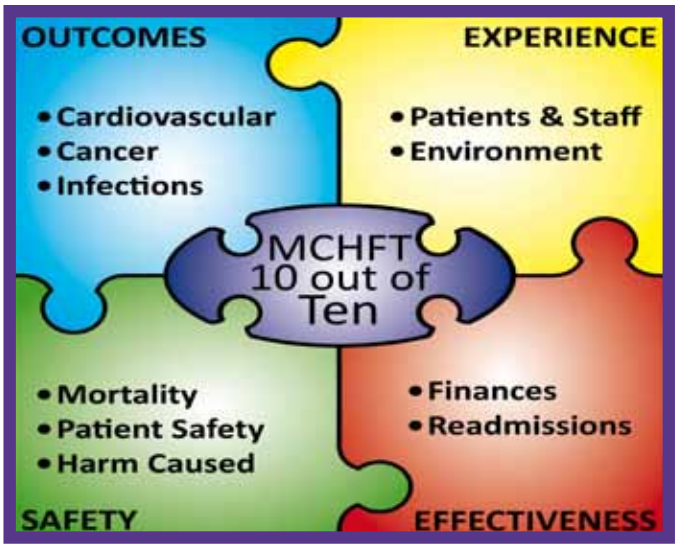
The objectives agreed were as follows:

Effectiveness:

Quality

10 out of Ten is the main vehicle for Divisions to deliver:

- Hospital Standard Mortality rates on a par or better than peer
- Cancer wait times are better



than peer
- Hospital acquired infections are on a par or below peer

Productivity
- To achieve the 4 hour, 18 week and Cancer Targets
- To be in the upper Quartile for day case rates
- Reduction in length of stay to peer to deliver the quality and financial benefits

Finance
- All specialties to breakeven and Divisions to make a 2% income and expenditure surplus
- Reduced reliance on temporary staff and agency costs
- Robust divisional performance management
- Patient level costing combined with quality outcomes will be a key determinate of service provision

Partnerships:
- Long term conditions - require collaboration and partnership with Social Services, Primary Care and other providers to move care closer to home avoiding hospital admission by 2012
- Emergency Surgical Care - to develop partnerships with other acute providers for General Surgery, Urology, ENT, Ophthalmology and Gynaecology to ensure continued quality and financial viability by 2011
- Elective Surgery - to develop partnerships to ensure the maximum local provision for surgical services with an emphasis on day case and high volume surgery. The Trust will work with other Acute Providers to provide complex and specialist surgery by 2012
- Obstetrics and NICU - to explore how Obstetric and Neonatal services can maintain local services by 2014
- Pathway redesign - to work with partners to develop services nearer to patients homes by increasing secondary care provision in the community by 2012
- Integrated Care Organisation – to work with East Cheshire NHS Trust and Cheshire East Community Health to develop a single provider organisation by 2013
- University Hospital North Staffordshire – the Trust will require close partnership with a teaching Hospital. The preferred partner will be University Hospital of North Staffordshire
- Staff engagement, including with staff side colleagues, will be a key focus

Configuration:

- The Trust, in order to reduce costs whilst improving the quality of care local to patients, will reduce its bed base by 25% over the next three years through a reduction in length of stay, increased day case rates and pathways of care that maintain care in the community.
- The Trust will develop plans to improve theatres, ICU and OPD facilities
- The Trust will work with relevant partners within the Cheshire wide economy to explore a number of options to enable a sustainable NHS service for the populations they serve
- The Trust will reduce the number of patients seen in Outpatients within hospitals by 20% over the next 3 years through a combination of pathway redesign and moving services into the community

Service Redesign and the Quality Matters programme

In January 2008 the Board of Directors agreed the development of a full business case to implement LEAN transformation methodology as a strategic approach to transforming services.

The aim was:

1. to continue to build upon the turn around success of the Trust
2. to have the ability to continue to improve the quality of patient care and to invest in services as appropriate
3. to provide direction to, and a consistent approach in which to conduct service development and pathway redesign
4. to enable the Trust to continue to be financially viable by achieving efficiency savings each year as set out in the integrated business plan
5. to provide a framework from which to agree future business development and investment.

A pilot was run in 2008/09 with a full implementation in 2009/10.

The programme for 2009/10 focused over two years on three care pathways

- Emergency Care
- Elective pathway
- Gynaecology out-patients

The overall aims were to support the delivery of the Quality Strategy, contribute to the Cost Improvement Programme for the Division, further develop the expertise of LEAN service transformation methodology and embed a service transformation culture within the Trust.

The plan identified some key outcomes:

Service

1. Reduce the length of stay across Emergency and Elective care pathways
2. Maximise the utilisation of theatres
3. Improve the process flow-through Accident & Emergency and the Emergency Assessment Unit
4. Improve standard mortality rates in some specialties
5. Improve the productivity within

specific care pathways
6. Improve the patient experience
7. Reduce readmission rates
8. Improve on Healthcare commission ratings on quality and finance
9. Improve staff experience through improving morale in the Trust

Work is now advanced on the key projects with implementation of the changes to commence from July 2010.

Staff

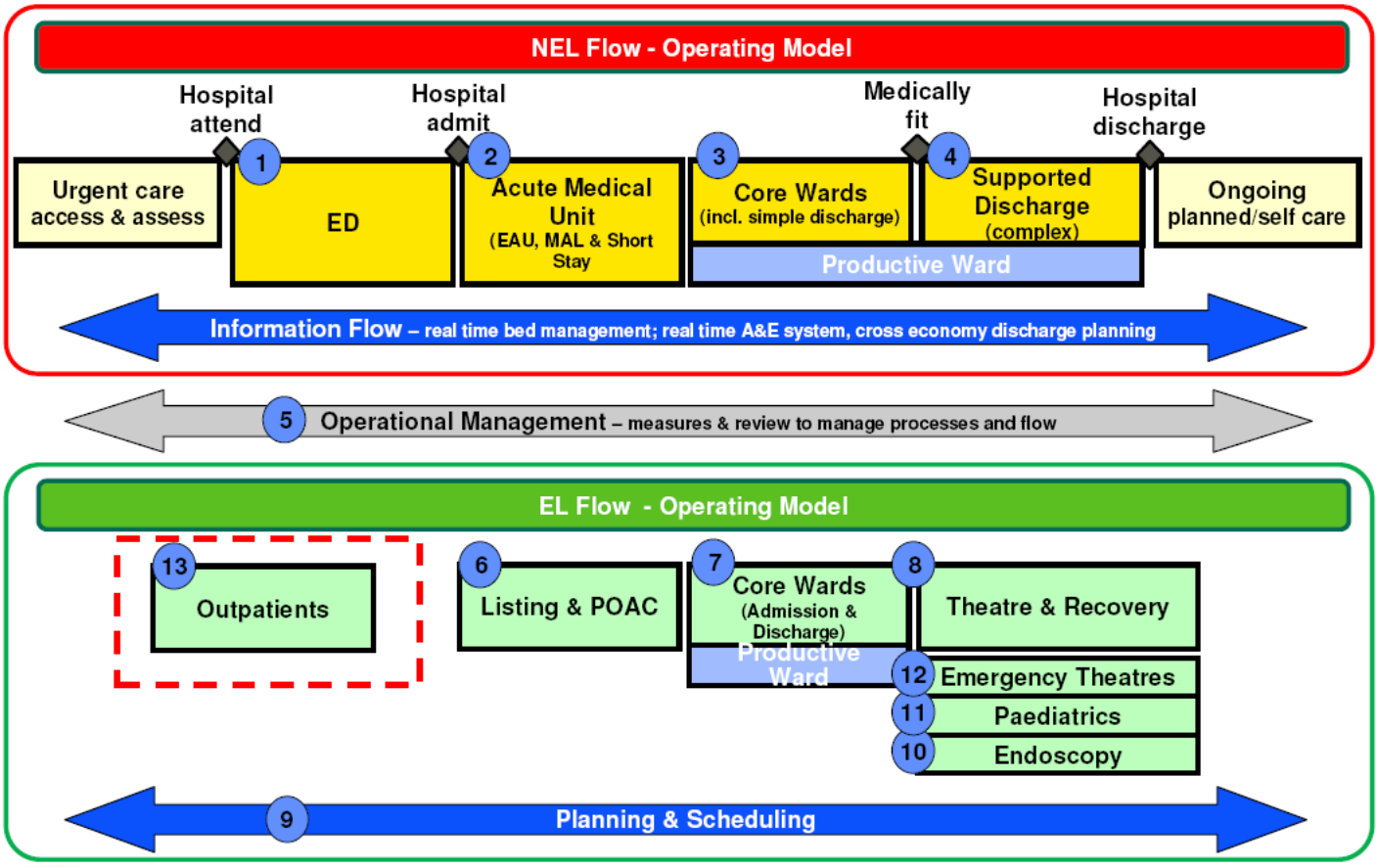
1. Empowered staff committed to continuous improvement and with capability to deliver "LEAN" service improvements without external support
2. Clinical Leadership focused on, and committed to continuous service improvement/ quality

Organisation

1. Foundations of a transformational culture
2. Effective programme management/ over arching programme design for transformation
3. Clear and integrated transformation programme linked to the key business objectives
4. Performance and reporting framework including benchmarking
5. Significant contribution to the Trust Cost Improvement Programmes

The programme has primarily focused on redesigning the two core patient flows as represented in the figure below;

Quality Matters Programme - work streams



Frontline staff (doctors and nurses) have defined how the processes should work, identifying gaps, inconsistencies and inefficiencies with current ways of working.

A wide range of fundamental process changes have been implemented or are in progress to improve the quality of care e.g. review reduce patient delays and the management control of the processes.

The approach taken has been purposefully focused on the core patient flows, this is where value is added to our patients and should provide the focus around which all other aspects of the Trust should be organised.

Research

Research is a core part of the NHS, enabling the NHS to improve the current and future health of the people it serves. The Trust works in partnership with research networks across the North West including the Greater Manchester and Cheshire Cancer Research Network and Cheshire and Merseyside Local Research Network.

The number of patients receiving NHS services provided or subcontracted by the Trust in 2009/10, that were recruited during that period to participate in research approved by a research ethics committee, was 321.

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 their members. Our Council of Governors was formed with effect from 1 April 2008. Our Council of 31 Governors consists of 23 elected Governors representing membership constituencies (10 Public Governors, 7 Staff and Volunteer Governors, 6 Patient and Carer Governors) and 8 appointed Governors. As at 31 March 2010, the Trust had 2 elected Governor vacancies.

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 for 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, i.e. to 31 March 2011.

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

The Council has the following key decision making roles:

- Appointment of the Chair, including appraisal and performance management
- Appointment of Non Executive Directors
- Appointment of External Auditors
- Advising the Board of Directors the wishes of Members and the wider community
- Ensuring the Board of Directors complies with its terms of authorisation and operates within that licence. A right to approach Monitor directly exists where the Council has concerns that the Foundation Trust has breached its terms of authorisation and has been unable to resolve them locally
- Recruitment and engagement of Members
- Advising on strategic long term direction to help the Board of Directors effectively determine its policies

A table summarising the Governor appointments and the constituencies they represent can be found at Appendix 1 on page 200.

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. Governor attendance has been very strong. This is a reflection of the efforts made by the Board of Directors to consult with Governors. There have also been a number of 'closed' workshops with Governors where the Board of Directors has engaged with the Council in relation to;-

- Recruitment of and Engagement with Members
- Roles & Responsibilities of Governors
- Governor Objectives for 2009/10
- A review of the first year of activity as Foundation Trust Governors
- Clinical Service Strategy 2010/11

Each of the workshop groups were facilitated by either an Executive or Non-Executive Director to help generate discussion and gain views from Governors.

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

Name	23 April 2009	23 July 2009	12 November 2009	21 January 2010
Ames, Tracey	Yes	Yes	Yes	Yes
Amson, Derek	Yes			Yes
Baynham, Michael	Yes	Yes		Yes
Blount, Betty	Yes	Yes	Yes	Yes
Bowles, Brian	Yes	Yes	Yes	Yes
Carr, Susan	Yes		Yes	
Cooper, Christine	Yes		Yes	Yes
Dibben, Nigel (1)	n/a	n/a	Yes	Yes
Duncan, James (2)				n/a
Dunn, Dennis (3)		n/a	n/a	n/a
Dunning, John	Yes	Yes	Yes	Yes
Fairhurst, Gill	Yes		Yes	Yes
Forsyth, Bill (4)			n/a	n/a
Gardner, Brian	Yes		Yes	Yes
Hadfield, Michael	Yes	Yes	Yes	Yes
Hopkins, Colin	Yes	Yes	Yes	Yes
Howell, Betty (5)	n/a	n/a		
Keenay, Lynne				Yes
Lakey, Lorna	Yes	Yes	Yes	Yes
Lyons, John	Yes	Yes	Yes	Yes
Macaulay, Brenda	Yes			
Machin, Peter (6)	Yes	n/a	n/a	n/a
Mawdsley, Harry	Yes	Yes		Yes
McClure, Adam (7)			n/a	n/a
Nimmo, Peter		Yes	Yes	Yes
Parkinson, Charlie (5)	n/a	n/a	Yes	
Paul, Neil (4)	n/a	n/a	n/a	Yes
Pordes, Philippa			Yes	Yes
Ritchings, Andrew	Yes	Yes	Yes	Yes
Smart, Jane	Yes	Yes	Yes	Yes
West, Hazel	Yes	Yes	Yes	Yes
West-Burnham, Joss (3)	n/a	n/a	Yes	Yes
Wood, Newland (1)	n/a	n/a	n/a	n/a
Yates, Diane	Yes	Yes	Yes	Yes

Notes :

(1) Mr Nigel Dibben was appointed to the Patient & Carers Constituency – Patient in September 2009 replacing Mr Newland Wood. Sadly Mr Newland Wood passed away in May 2009. Mr Wood will be greatly missed by all on the Council of Governors and at the Trust for the enthusiastic support he provided.

(2) Mr James Duncan resigned from the Public Constituency of Crewe & Nantwich in December 2009. Mr Duncan has been replaced by Mr Stuart Gray who commenced in post in March 2010.

(3) Mr Dennis Dunn was appointed as a Non Executive Director of the Trust on 1 May 2009 and resigned from his role as Governor (Appointed Governor: Manchester Metropolitan University). Mr Dunn was replaced by Dr Joss West-Burnham who was appointed in September 2009.

(4) Dr Bill Forsyth resigned from the Council of Governors in November 2009. Dr Forsyth was an appointed Governor: GP Leads in Central & Eastern Cheshire Primary Care Trust Area. Dr Forsyth was replaced by Dr Neil Paul who was appointed in January 2010.

(5) Cllr Betty Howell was appointed as the Governor representative for Cheshire East Council and Cllr Charlie Parkinson as the Governor representative for Cheshire West & Chester Council following the disbandment of Cheshire County Council on 31 March 2009. The appointments were made with effect from September 2009. Unfortunately, Cllr Howell had to resign from Council and following ratification by Cheshire East Council in March 2010, Cllr Howell was replaced by Cllr David Cannon.

(6) Mr Peter Machin resigned from the Council of Governors in July 2009. Mr Machin was a representative of the Patient & Carers Constituency – Principal Carer of a Patient aged 16 Year or More. This post is currently vacant.

(7) Mr Adam McClure resigned from the Council of Governors in August 2009. Mr McClure was a representative of the Staff & Volunteers Constituency – Non-Clinical Support Staff. This post is currently vacant.

The Executive Assistant, acting in the role of 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 have also been involved in other work at the Trust and a table below outlines their involvement.

Membership of Council Committees as at 31 March 2010

Committee	Current Members	Meeting Dates
Membership & Communications Committee	Mrs Betty Blount Mr Brian Bowles Mr John Lyons Mr Peter Nimmo Mrs Jane Smart Mrs Diane Yates	8 June 2009 13 July 2009 10 August 2009 14 September 2009 12 October 2009 9 November 2009 14 December 2009 11 January 2010 8 February 2010 8 March 2010
Nominations & Remuneration Committee	Ms Tracey Ames Mr John Dunning Mr John Lyons Mr Michael Hadfield	10 November 2009 6 January 2010

During the course of 2009/10 the membership of Council Committees was reviewed to ensure committee members held the appropriate skill base whilst continuing to be representative of the various member constituencies.

Governor Involvement

Please find below details of the Governor Membership of Council of Governor (CoG) and Board of Director (BoD) Committees, as a 31 March 2010

Ms Tracey Ames	Nominations and Remuneration Committee (CoG)
Dr Michael Baynham	Infrastructure Development Committee (BoD)
Mrs Betty Blount	Membership and Communications Committee (CoG)
Mr Brian Bowles	Patients Experience Committee (CoG) Membership and Communications Committee (CoG)
Mr John Dunning	Nominations and Remuneration 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 (BoD) Membership & Communications Committee (CoG) Nominations & Remuneration Committee (CoG)
Mr Harry Mawdsley	QuESt Committee (BoD)
Ms Brenda Macaulay	Patients Experience Committee (CoG)
Mr Adam McClure	Membership and Communications Committee (CoG)
Mr Peter Nimmo	Membership and Communications Committee (CoG)
Dr Neil Paul	QuESt Committee (BoD)
Mrs Phil Pordes	Patients Experience Committee (CoG)
Mrs Jane Smart	Membership and Communications Committee (CoG)
Ms Hazel West	Strategic Integrated Governance Committee (BoD)
Mrs Diane Yates	Charitable Funds Committee (BoD) Membership and Communications Committee (CoG)

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

Clinical Services Strategy . The Trust has developed, with the support of Governors, a Clinical Service strategy. The strategy which was over 6 months in development, was approved by the Board of Directors in April 2010.

Governors were involved with Divisions from the early stages in developing a vision for the future of our clinical services.

Theatre Re-Design. Mrs Hazel West is the Governor representative on the Theatre Re-Design Steering Group. The aim of the project is to make the operating theatres and the before and after processes at Leighton Hospital more efficient, therefore improving the experience the patient has. The overall principles are to maximise the use of theatres, minimise cancellations, remove obstacles, such as delays in other departments or lack of equipment, make best use of available beds, listing patients appropriately both in time and speciality and increase punctuality.

Victoria Infirmary Northwich. Ms Tracey Ames has supported work the Trust has been undertaking in relation to the provision of outpatient and diagnostic

services at Victoria Infirmary. This work includes a review of current utilisation in terms of range of services provided and efficiency of the site both in terms of space utilisation and clinic efficiency. A report has now been drafted and the implementation of extended services has been transferred to Divisions to assess within the clinical service strategy. The Trust have already expanded services to include a one stop cardiology service and additional diagnostics to provide services more closer to home for the population of Northwich.

Lead Governor

In November 2009, Mrs Jane Smart was appointed as acting Lead Governor. This role involves being a point of contact for Monitor should the need arise, chairing such part of Council of Governor meetings which cannot be chaired by the Chair or Deputy Chair due to a conflict of interest. The Lead Governor also has a standing invitation to attend Board of Director meetings as an observer. As at 31 March 2010 a number of nominations had been received for the substantive role to which Ms Tracey Ames was subsequently appointed.

General engagement with Governors and Members

In addition to the workshops at the Council of Governors meetings and the membership on various groups and strategic items of work, there has been a targetted focus in gaining the views of Governors and Members as follows:

- Quality Accounts Consultation
- Equality & Diversity Strategy and Policy Consultation
- Youth Council

Members of the Board of Directors always attend the 'closed' workshop sessions of the Council of Governors and stay for the initial business of the Council – attendance is as set out below:

Attendance of Board Members at Council of Governor Meetings

Name	23 April 2009	23 July 2009	12 November 2009	21 January 2010
Executive Directors				
Mr P Morley	Yes	Yes	Yes	Yes
Mrs R Alcock		Yes		
Mrs T Bullock		Yes		Yes
Dr P Dodds			Yes	Yes
Mr A Ennis	Yes		Yes	
Mrs D Frodsham	Yes		Yes	
Mr M Oldham		Yes		Yes
Non Executive Directors				
Mr J Moran	Yes	Yes	Yes	Yes
Mr M Chandler	Yes	Yes	Yes	Yes
Mr W Craig	Yes	Yes	Yes	
Mr D Dunn			Yes	Yes
Mrs V Godfrey	Yes	Yes	Yes	Yes
Mr D Hopewell	Yes	Yes		Yes
Dr A Wood			Yes	Yes

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.

Nomination 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 2 times in the year.

On 10 November 2009 the Committee met to consider membership of the Committee, to discuss the Chairman's Appraisal and Objectives and to consider Governor Objectives and Appraisal. Approval was also requested to extend the tenure of Dr Alan Wood's appointment as a Non Executive Director.

On 6 January 2010 to approve Governor Objectives prior to presentation at Council on 21 January 2010 and consider Mr W Craig's extension of tenure as a Non Executive Director

In relation to the reappointment of Dr Wood and Mr Craig, consideration was given to the skill mix of the Non Executive Directors in post. Stability within the Board of Directors was also considered following the appointment of two new Non Executive Directors only a number of months previously.

Attendance at the Committee meetings:

	10 November 2009	6 January 2010
Mr J Moran (Chairman)	Yes	Yes
Ms T Ames	Yes	
Mr J Lyons	Yes	Yes
Mr J Dunning*	Yes	Yes
Mr M Hadfield*	Yes	Yes

* Note: Council of Governors approved membership of the Committee as Ms T Ames, Mr J Lyons, Mr J Dunning and Mr M Hadfield following their self nomination and following Mr Dunn's appointment as a Non Executive Director.

Chapter 5

Board of Directors

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

The Board is collectively responsible for the exercise of the powers and performance of the Foundation 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 2010 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 Board of Directors.

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 elements of their values 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 Executive Assistant acting in the Trust Secretary role. Should you wish to view the register please contact the Trust on 01270 61218. 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 as outlined previously the two Non Executive Director vacant posts were filled, effective 1 May

2009 whilst the Senior Independent Director and a Non Executive Director were reappointed following an appointment process which involved the Council of Governors.

The Board 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 performance reviews 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 the divisional boards within the Trust.

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 2010 are set out below:

Name	Position	Term of Contract	Unexpired Term	Notice Period	Liability for Early Termination
Moran J	Chairman	4 year Term	2 years 9 months	None	None
Craig WD	Non Executive Director	3 year Term	2 years 10 months	None	None
Chandler M	Non Executive Director	4 year Term	1 year 4 months	None	None
Dunn D	Non Executive Director	3 year Term	2 years 1 month	None	None
Godfrey V	Non Executive Director	3 year Term	2 years 1 month	None	None
Hopewell D	Non Executive Director	4 year Term	1 year 8 months	None	None
Wood A	Non Executive Director	3 year Term	2 years 7 months	None	None

Name	Position	Term of Contract	Unexpired Term	Notice Period	Liability for Early Termination
Morley P	Chief Executive	Permanent	N/A	6 months	6 months salary
Alcock R	Director of Workforce & Organisational Development	Permanent	N/A	6 months	6 months salary
Bullock T	Deputy Chief Executive, Director of Nursing	Permanent	N/A	6 months	6 months salary
Dodds P	Medical Director	Permanent	N/A	6 months	6 months salary
Ennis A	Director of Service Development	Permanent	N/A	6 months	6 months salary
Frodsham D	Director of Performance & Service Planning	Permanent	N/A	6 months	6 months salary
Oldham M	Director of Finance & Strategic Planning	Permanent	N/A	6 months	6 months salary

Non Executive Director appointments can be terminated by a ¾ 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 210.

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 once during the year, the members and attendance are shown below:

Member	Attendance
Non Executive Directors	
Mr. J Moran (Chair)	1
Mr. M Chandler	1
Mr. D Dunn	1
Mr. W Craig	1
Mrs V Godfrey	1
Mr. D Hopewell	1
Dr. A Wood	1
Executive Director	
Mr. Phil Morley (Chief Executive)	1

Mr Morley left the meeting when the item of the Chief Executive's remuneration was raised.

Remuneration of Senior Managers Policy

Executive and Associate Directors receive a fixed salary established at the beginning of each year, and 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 6 July 2009.

In 2009/10, 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 and Associate Director 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 2010, 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 were 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 5.4A to C in the accounts on page 170.

Phil Morley
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 2009/10:

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	Elected member of Vale Royal Borough Council	*	
Mr. D Hopewell	Finance Director of Charitable Trust, Retrak	*	
Mr. J Moran	Director of Liverpool & Sefton Health Partnership Limited 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 County Council's Overview and Scrutiny Committee at least once a year, concerning matters such as the Trust's Annual Report 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 General Practitioners, with the Primary Care Trusts and with North West Strategic Health Authority. 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 are the Trust's appointed external auditors. 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 five independent Non Executive Directors chaired by a Qualified Accountant. The Trust's External and Internal Auditors, the Trust's Finance Director are normally in attendance whilst Executive Directors and Senior Managers attend as required.

During 2009/10 the Committee met on these occasions with the following attendance:

Attendance at Audit Committee Meetings

Name	06 April 2009	1 June 2009	10 August 2009	12 October 2009	14 December 2009	8 February 2010
Mr. M Chandler	Yes	Yes	Yes	Yes	Yes	Yes
Mr. W Craig	Yes	Yes	Yes	Yes	No	Yes
Mr. D Dunn	-	No	Yes	Yes	No	No
Mrs V Godfrey	Yes	Yes	Yes	Yes	Yes	No
Mr. D Hopewell (Chair)	Yes	Yes	Yes	Yes	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.

Chapter 6

Membership

Membership commentary

The membership in total has grown by 38% over the year in all constituencies and whilst the Trust has growth plans for 20010/11 the key focus for 2010/11 is engagement with members.

The table below shows the membership size and movement with estimates for 2010/11.

In 2009/10 the Trust increased representation in the younger age categories through the establishment of a Youth Council. Ensuring proportional representation in all areas, areas, age ranges and constituencies and active engagement with members will be the key focus of the Council of Governors for the coming year.

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

i) Staff Governor surgeries
ii) Member workshops
iii) Regular newsletters
iv) Website
v) Public meetings on specific issues
vi) Annual General meetings
vii) Big Tent Events
viii) Governor and member meetings
ix) Trust consultation events
x) 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.

There have been no elections this year so no figures on member turn-out are available.

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)	3,150	3,629
New members	592	471
Members leaving	113	100
At year end (31 March)	3,629	4,000

Staff constituency	Last year	Next year (estimated)
At year start (1 April)	1,241	2,596
New members	1,424	120
Members leaving	69	50
At year end (31 March)	2,596	2,666

Patient constituency	Last year	Next year (estimated)
At year start (1 April)	807	976
New members	195	407
Members leaving	26	50
At year end (31 March)	976	1333

Analysis of current membership

Public constituency	Number of members	Eligible membership
Age (years):		
0 - 16	26	4,188
17 - 21	177	17,344
22 +	3,260	236,756
Undisclosed	166	
Ethnicity:		
White	3,228	254,944
Mixed	9	1,643
Asian or Asian British	22	489
Black or Black British	18	756
Other	3	276
Undisclosed	349	
Socio-economic groupings:		
ABC1	2,537	136,570
C2	863	39,224
D	128	42,105
E	101	36,635

Public constituency	Number of members	Eligible membership
Gender:		
Male	1,678	125,102
Female	1,864	133,005
Undisclosed	87	
Patient constituency	Number of members	Eligible membership
Age:		
0 - 16	2	40,789
17 - 21	20	15,653
22 +	917	209,037
Undisclosed	37	

Analysis of election turnout

There were no elections in the year.

Chapter 7

Quality Account 2009/10

Part 1

Summary Statement on Quality from the Chief Executive

Mid Cheshire Hospitals NHS Foundation Trust (the Trust) is proud to present its first published annual Quality Account for the period of April 2009 to March 2010. Last year the Trust published a Quality Report which outlined the quality areas that would be measured in 2009/10 and how it would take forward its aspiration to be a World Class Provider through the implementation of the five year '10 out of Ten' quality strategy. The aim of this strategy is to identify the Trust's top 10 quality indicators and to establish the measurements that will be used to monitor effectiveness against these.

Following consultation the Trust has agreed the following definition of Quality:

Effective and efficient delivery, a positive experience by both service users and staff; the best possible clinical and patient outcomes.

In addition to the above, the Trust recognises the reduction of avoidable harm as a key imperative.

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

The Quality Account for 2009/10 will illustrate progress over the year and will reaffirm the commitment of the Board of Directors to quality and set priorities for the forthcoming year. The section relating to the consultation on quality demonstrates the extent of consultation and collaboration which has been undertaken to incorporate the views of stakeholders, public and staff in producing this final account.

Mid Cheshire Hospitals NHS Foundation Trust strives to deliver the best possible quality of care to users and carers whilst continually recognising potential areas to further improve both the quality and safety of services it provides. In December 2008, the Board formally acknowledged its accountability for the delivery of high quality care through the agreement of a five year quality strategy.

To date, delivery against the commitments for year one has been achieved which includes the collaborative development of the top 10 indicators and the metrics that will be used to measure success against these.

In restating its accountability in 2009, the Board sees quality and safety as being

fundamentally aligned and views the quality and safety improvement strategy as complementary to the integrated governance strategy and infrastructure.

This alignment was further endorsed when the Trust joined the Patient Safety First Campaign and the Leading in Patient Safety Programme (LIPS) in 2009.

In recognition of the priority given to quality and safety, the Board of Directors have 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 terms of reference and membership were ratified at the January 2010 Board and the inaugural meeting took place in March 2010.

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.

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.

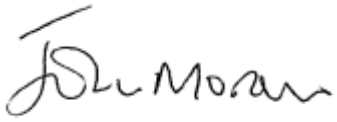
In preparing these accounts, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data, quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with relevant requirements and guidance issued by Monitor

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

Data submitted within the Quality Account is based on mandatory submissions and is taken directly from those submissions, therefore is considered to be accurate. This is further endorsed by a number of internal audit reports on data accuracy, particularly of the schedule 6 requirements, where it is stated that 'the Board can take substantial assurance that the controls upon which the organisation relies to manage this risk, as currently laid down and operated, are effective'.

By order of the Board



John Moran
Chairman

Phil Morley
Chief Executive

Part 2

Priorities for improvement in 2010/11

The Trust has a significant number of quality and safety improvement initiatives underway, which have been distilled into a number of key priorities for 2010/11. These are largely focused on the implementation of year two of the quality and safety improvement strategy.

In year one, the top ten indicators were agreed. Year two will determine baseline assessments against each indicator to establish the Trust's current performance. Where baseline or benchmarking data is currently available, stretch targets will be agreed for the next four years. Below is an outline of the top ten indicators and a summary of how progress will be monitored, measured and reported.

Outcomes

Cardiovascular

Aim:
To reduce mortality rates in patients who suffer an Acute Myocardial Infarction (AMI) within a 30 day period;

2009/10 – 9.70%
2010/11 – 9.02%
2011/12 – 8.35%
2012/13 – 7.67%
2013/14 - <7.00%

Monitored:
Data relating to mortality in AMI within 30 days is not routinely collected by the Trust. Processes are currently being implemented to allow for this monitoring and benchmarking against peer organisations.

Measured:
The Trust is currently working with C.A.S.P.E Healthcare Knowledge Systems (CHKS), a performance benchmarking tool, to measure Acute Myocardial Infarction mortality.

Reported:
Acute Myocardial Infarction mortality data within 30 days will be reported to the Quality, Effectiveness & Safety Committee (QuESt).

Cancer

Aim:
To improve survival rates for patients diagnosed with cancer.

Monitored:
The survival rates for patients diagnosed with cancer will be monitored annually.

Measured:
The survival rates for patients diagnosed with cancer will be measured by the Public Health team at the Primary Care Trust and the North West Cancer Intelligence Service.

Reported:
Survival rates for patients diagnosed with cancer will be reported to the Quality, Effectiveness & Safety Committee (QuESt).

Infections

Aim:
To reduce the rates of healthcare acquired infections:

MRSA – zero blood steam bacteraemias
Clostridium difficile – to perform better than the nationally agreed target

2009/10 MRSA - <5
2009/10 Clostridium difficile - <106
(National targets are agreed annually)

Urinary tract infection – to develop a monitoring mechanism and establish a benchmark during 2010/11

Monitored:
MRSA & Clostridium difficile are monitored

on a monthly basis. The Trust is currently developing a methodology of collecting appropriate information in relation to urinary tract infection.

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; therefore the Trust will devise a mechanism internally.

Reported:
The monitoring and reduction of all hospital acquired infections will be reported to the Quality, Effectiveness & Safety Committee (QuESt).

Safety

Mortality

Aim:
To reduce mortality rates by 10% 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 in order to identify areas for improvement in the quality of care provided by the Trust. Action plans are then developed in order to address the lessons learnt to ensure changes in practice are made. This group meets on a bi-monthly basis.

Measured:
The hospital uses CHKS Risk Adjusted Mortality Index 10 which is a national healthcare benchmarking system. This system provides monthly information in order that the trust can closely monitor mortality rates with the aim of seeing a 10% reduction in 2010/2011.

Reported:
The Hospital Mortality Reduction Group meets on a bi-monthly basis and reports to the Quality, Effectiveness & Safety Committee (QuESt).

Patient Safety

Aim:
To monitor and reduce the number of consultant episodes (unnecessary patient moves) during each patient admission. The current average of patient moves for an elected stay is 1.31 moves, for non elective stay the average is 1.79 moves. The Trust aim to reduce the average number of moves following further analysis of the data.

Monitored:
The episodes will be monitored through ISOFT which is a patient management system used at the Trust.

Measured:
The number of consultant episodes during each non-elective admission will be measured using the Management Information System at the Trust.

Reported:
The monitoring and reduction in the number of consultant episodes during each patient admission will be reported to the Quality, Effectiveness & Safety Committee (QuESt).

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 changes in practice. This is reported in the Integrated Governance Quarterly 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 in Patient Safety programme, the Trust has commenced a process of reviewing health records using the Global Trigger Tool to determine if any avoidable harm was caused.

Reported:
All serious patient safety incidents and actions taken / planned are reported to the Trust Board 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. This is discussed at the Operational Integrated Governance Committee which has representation from all of the divisions. Patient safety incidents will also be reported to the Quality, Effectiveness & Safety Committee (QuESt).

Experience

Environment

Aim:
To monitor and virtually 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 Chief Executive/ Director of Nursing. 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 PALS). 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.

Reported:
The outcomes from DSSA group will be reported to the Quality, Effectiveness and Safety Committee (QuEST). Outcomes will also be reported to the Central & Eastern Cheshire Primary Care Trust (CECPCT) Contract Monitoring Committee.

Patients & Staff

Aim:
To monitor and revise the ratio of doctors and nurses to each inpatient bed within the Trust.

Nursing

2010/11 – 60% of wards will be within 10% of the required establishment.
2011/12 – 75% of wards be within 10% of the required establishment.
2012/13 – 90% of wards to be within 10% of the required establishment.
2013/14 – 100% of wards to be within 10% of the 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:
An acuity* group has been established which is chaired by the Deputy Chief Executive/Director of Nursing. This group meets bi-monthly and submits reports every 6 months to the Trust Board. The European Working Time Directive (EWTD) will be used in the monitoring of medical staff hours worked. This will be used as the safety assessment when calculating the ratio of medical staff to inpatient beds.

Measured:
The 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, evaluated and implemented.

Reported:
The outcomes from the acuity group will be reported to the Quality, Effectiveness and Safety Committee (QuEST).

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

Effectiveness

Finance

Aim:
To calculate and compare the percentage of the Trust's budget that is spent on direct management costs. Once benchmarking data is available target reductions will be set.

Monitored:
The percentage of non clinical spend will be monitored and compared with other available benchmarking data with a view to identifying areas for improvement. Action plans will then be developed.

Measured:
Measurement will be made by taking the amount of actual expenditure outside of the clinical divisions and comparing this as a percentage of total actual expenditure.

Reported:
This will be reported quarterly through the Performance and Finance Committee. This will be also reported to the Quality, Effectiveness and Safety Committee (QuESt).

Readmissions

Aim:
To monitor and reduce the number of patients who are readmitted to hospital within 7 days of discharge. Overall Trust reduction of 0.9% by 2014:

2010: 4%
2011: 3.7%
2012: 3.4%
2013: 3.2%
2014: 3.1%

Monitored:
Readmission to hospital within a 7 day period as an emergency will be monitored on a monthly basis.

Measured:
Readmission rates have previously been monitored on a monthly basis for patients who were readmitted as an emergency. Processes are currently being put in place to monitor readmissions within a 7 day period.

Reported:
The results of the monitoring and investigating patients who are readmitted to hospital within 7 days will be reported to the Quality, Effectiveness & Safety Committee (QuEST). In addition to this, readmission rates are also reported to CECPCT for patients readmissions within 14 days.

The priorities for 2010/11 were arrived at through a number of mechanisms:-

- Those outlined in the 10 out of Ten strategy
- Those mandated or suggested by Monitor and the Department of Health
- Those identified in the Quality Report published for 2008/09

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.

Review of Services

During 2009/10, the Trust provided and / or sub-contracted 39 NHS services.

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

The income generated by the NHS services reviewed in 2009/10 represents 100% of the total income generated from the provision of NHS services by the Trust for 2009/10.

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

1. Service dimensions such as population demographics, trading account position and whether or not the service is core.

2. Service delivery which looks at aspects relating to meeting performance standards and targets / quality standards.

3. Service design which reviews where the service is located e.g. central or community.

4. Service development which explores planned changes to services over the next five years.

5. 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

During 2009/10, 32 national clinical audits and 6 national confidential enquiries covered NHS services which the Trust provides.

During the same period, the Trust participated in 78% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2009/10 is dependent on the audit project methodology, and these are listed in figure 1. The number of cases submitted to each audit or enquiry is also presented as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Figure 1: Submission rates for national clinical audits and national confidential enquiries

Audit	Submission Rates* %
Continuous Data Collection	
NNAP: Neonatal Care	100
NDA: National Diabetes Audit: Paediatric	100
ICNARC CMPD: Adult Critical Care Units	100
National Elective Surgery PROMs: Four Operations	96
CMACE: Perinatal Mortality	100
NJR: Hip and Knee Replacements	77
NBOCAP: Bowel Cancer	44
MINAP (inc Ambulance Care): AMI and other ACS	99
Heart Failure Audit	12
NHFD: Hip Fracture	Not Known
TARN: Severe Trauma	64
Intermittent / One-Off Samples	
National Sentinel Stroke Audit	100
National Audit of Dementia: Dementia Care	In progress
National Falls and Bone Health Audit	100
National Comparative Audit of Blood Transfusion: Changing Topics	Not Known
College of Emergency Medicine: Pain in Children	100
College of Emergency Medicine: Asthma	100
College of Emergency Medicine: Fractured Neck of Femur	100
National Mastectomy and Breast Reconstruction Audit	99
National Carotid Endarterectomy Audit	In progress
ASIG You're Welcome and NICE PH3 Guidelines Implementation Survey	100
BHIVA Survey of Paediatric Aspects of Adult HIV Care	100
BASHH Audit on the Management of PID in GUM Clinics 2009	100
Cervical Cytology Screening Practice in GUM Clinics	100
BHIVA Clinical Audit of HIV and Hepatitis B/C Co-infection	100

National Confidential Enquiries	
NCEPOD: Elective and Emergency Surgery in the Elderly	In progress
NCEPOD: Perioperative Care Study	In progress
NCEPOD: Parenteral Nutrition	46
NCEPOD: Surgery in Children	In progress
NCEPOD: Deaths in Acute Hospitals (Caring to the End)	61
NCEPOD: Acute Kidney Injury: Adding Insult to Injury	50

* Submission rates are as accurate as current information allows, as eligible submission figures are not always available.

Reports for the audits listed have been reviewed by the Trust in the appropriate audit period. Continued improvement initiatives are monitored by the relevant clinical divisions.

The reports of 61 local clinical audits were reviewed by the Trust in 2009/10. Clinical audit action plans are held within the Clinical Audit & Effectiveness office.

Research and Innovation

Participation in Clinical Research

Research is a core part of the NHS, enabling the NHS to improve the current and future health of the people it serves. The Trust works in partnership with research networks across the North West including the Greater Manchester and Cheshire Cancer Research Network and Cheshire and Merseyside Local Research Network.

The number of patients receiving NHS services provided or subcontracted by the Trust in 2009/10, that were recruited during that period to participate in research approved by a research ethics committee, was 321.

CQUIN: Commissioning for Quality & Innovation framework

A proportion of the Trust's contracted income in 2009/10 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and its commissioners through the CQUIN payment framework. Further details of the 2009/10 agreed goals and new goals agreed for 2010/11 is available on request from the Deputy Director of Performance & Quality.

Two of the agreed CQUINs related to the development of an alcohol pathway within the Trust and improving the discharge arrangements for patients leaving hospital.

The development of the **alcohol pathway** aims to ensure that patients treated within the Trust with alcohol related conditions are appropriately assessed and referred to alcohol support services. In this way the local health services can support individuals who want to address their alcohol issues as well as treating them for the consequence of these issues. The alcohol CQUIN monitors the Trust in agreeing the pathway between professionals, training staff in the use of the pathway and then delivering the screening, advice and initial interventions detailed within the pathway. The Trust is on track to have successfully implemented the alcohol pathway by the end of 2009/10.

The improvement of **discharge arrangements** is aimed at patients with particularly complex needs who require a number of different organisations to help meet these needs after they leave hospital. These improvements should reduce the unnecessary time patients stay in hospital and better plan for their care after they leave hospital. The discharge CQUIN monitors the Trust on the time it takes to complete the necessary assessment information, making better use of technology to communicate assessments between care organisations and ensuring that patients who apply for continuing health care funding have all the appropriate information and support whilst doing this. The Trust is on track to have successfully improved the discharge arrangements by the end of 2009/10.

The monetary total for the amount of income in 2009/10 conditional upon

achieving quality improvement and innovation goals was £686,000. The associated payment in 2009/10 remained at £686,000 as the payment for achieving quality was fixed by CECPCT.

What others say about the Trust

External visits for the current year have included:

Delivering Same Sex Accommodation Peer Review

A report was submitted to the Operational Integrated Governance Committee following this visit by the Strategic Health Authority, Primary Care Trust and Department of Health in October 2009. There was very positive feedback about the innovative way the Trust had utilised the funding to meet this requirement, including the secondment post of Privacy and Dignity Matron and the signage which has been developed for ward areas. An action plan has been completed following this visit and this is being monitored by the Delivering Same Sex Accommodation Group.

Environmental Quality Mark

The Macmillan Cancer Centre which opened in May 2008 was assessed against the requirements for the Macmillan Environmental Quality Mark in December 2009. The Trust is very pleased to advise that the centre was presented with the award in January 2010.

Patient Safety First Campaign

The Trust has signed up to the Patient Safety First Campaign and has at its heart a vision of an NHS with no avoidable death and no avoidable harm. This certificate demonstrates the Trust's progress and commitment to the campaign.

Care Quality Commission Registration

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. Each year they give a rating to every NHS Trust in England to show how it performed over the last year.

Figure 2 - CQC Ratings for the Trust

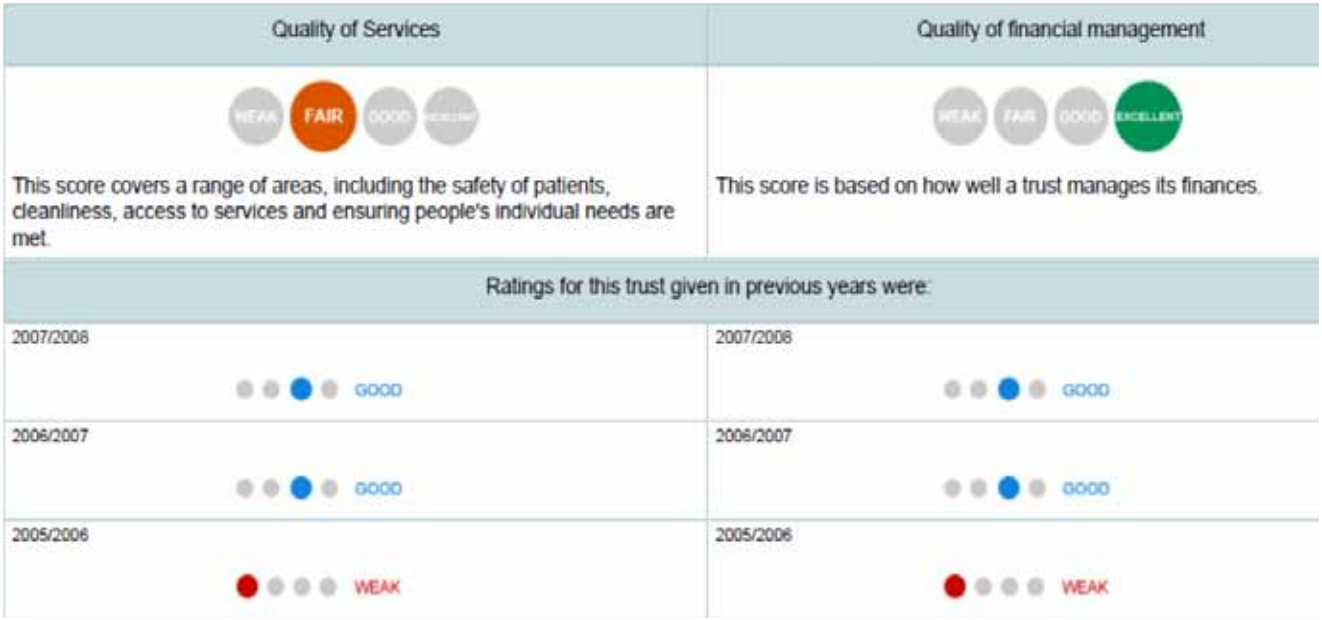


Figure 3 - CQC Assessments results for 2008/09

	Score
Safety and cleanliness	**13**/14
Waiting to be seen	**9**/12
Standard of care	**7**/8
Dignity and respect	**9**/9
Keeping the public healthy	**4**/5
Good management	**16**/18

CQC Rating

The annual healthcheck is made up of a wide number of indicators that provide an overall assessment of the 'quality of services' and 'quality of financial management'. This year's results awarded the Trust a rating of 'excellent' for 'quality of financial management' and 'fair' for 'quality of services'.

Overall the 'quality of care' rating is themed into 4 broad areas:

1. Meeting Core Standards.
2. Existing Commitments
3. National Priorities
4. The rating also looks at how well healthcare organisations perform in a number of different areas of interest to patients and the public

1. Meeting Core Standards
   The Trust successfully achieved all the 44 standards contained within the Standards for Better Health.

2. Existing Commitments
   There are 9 indicators that make up the existing commitments. MCHFT achieved an overall rating of 'Almost Met' in this category. 6 indicators were fully met and 3 not. The Trust under-achieved in relation to cancelled operations on the day, outpatients waiting time and data quality on ethnic group.

3. National Priorities
   There are 13 indicators overall that make up the national priorities. MCHFT achieved an overall rating of 'fair' in this category. 8 indicators were met and 5 not met. The 5 indicators not met included Infant health & inequalities, MRSA bacteraemia incidence, stroke care, 18 week referral to treatment times and staff satisfaction.

4. As well as providing an overall rating, the assessments look at how well healthcare organisations perform in a number of different areas of interest to patients and the public, for example, safety and cleanliness where MCHFT met 13 out of 14 of the assessments and standards of care, where 7 out of 8 of the assessments were met.

All the areas of underperformance have been actioned and the improvements monitored at the Performance and Finance Committee meetings and Board of Directors.

The Trust is registered with the CQC. This came into effect on April 1st 2010. There are no conditions attached to the registration

The most recent review carried out by the CQC was an unannounced inspection in relation to the Hygiene Code. The review took place on 10th February 2010 and the following conclusions were reported:-

"Of the 17 measures reviewed there were no areas of concern with regard to 15 measures. With the remaining two measures, areas requiring improvement were identified."

In view of this, the Trust has developed an action plan to address the areas requiring improvement. The action plan is monitored by the Strategic Infection Control Committee to ensure that timescales are met.

The Trust was asked to submit progress against the action plan by 7 April 2010. The provisional response from the CQC indicates that no further information relating to this is required. The Trust now awaits formal confirmation of this response. The Trust has not been invited to take part in any special reviews by the CQC during the reporting period.

Data Quality

NHS & General Medical Practice Code Validity

The Trust submitted records during 2009/10 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

98.9% for admitted patient care;

99.7% for outpatient care;

95.6% for accident and emergency care.

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

99.6% for admitted patient care;

99.9% for outpatient care;

99.1% for accident and emergency care.

Information Governance Toolkit Attainment Levels

The Trust's score for 2009/2010 for Information Quality and Records Management assessed using the Information Governance Toolkit (version 7) was 74.6%.

Clinical Coding Error Rate

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

- Primary Diagnoses incorrect: 9.3%
- Secondary Diagnosis incorrect: 9.8%
- Primary Procedures incorrect: 5.4%
- Secondary Procedures incorrect: 2.3%

The Trust would like to state that the clinical coding results should not be extrapolated further than the actual sample audited. The services reviewed within this sample were: general medicine, urology, paediatric medicine, head, chest and lower limb diagnoses of multiple significant trauma.

Part 3

Review of Quality Performance

The 2009/10 Quality Account specifically details progress against 2008/09 key priorities. It then progresses to review 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 headings of:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

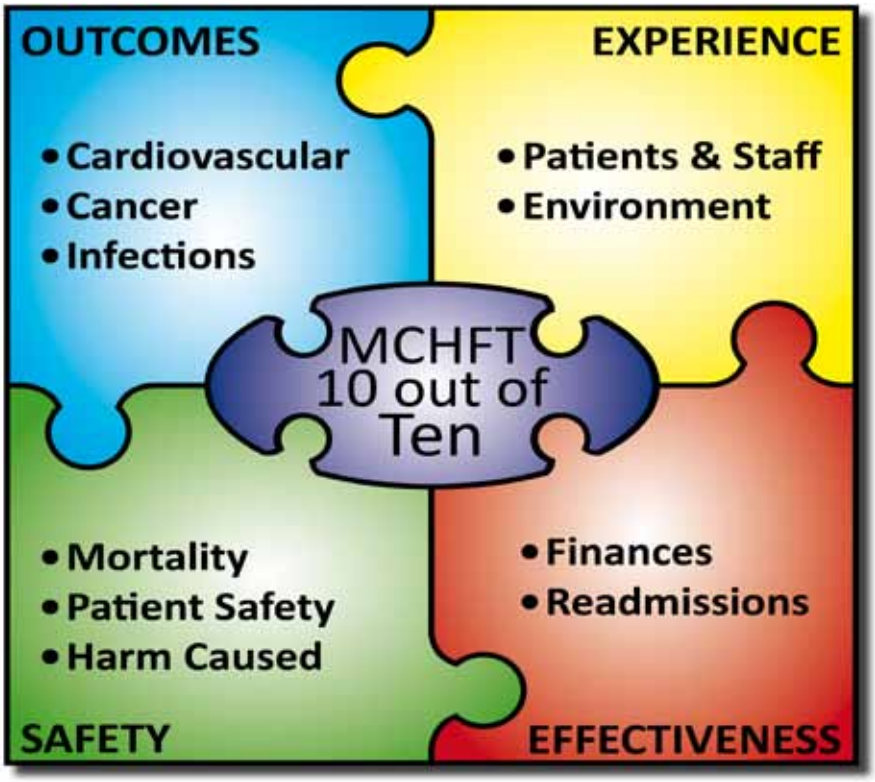
Progress against 2008/09 Key Priorities

10 out of Ten

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 one of the 10 out of Ten strategy successfully achieved the following objectives:

- Identify the Trust's top 10 quality indicators
- Divisional boards to agree their top 10 priorities
- Each department to develop their top 10 priorities
- Individual objective setting and appraisals to be commenced

Following an extensive consultation programme, the 10 out of Ten key indicators were agreed.



For each of the above indicators, a series of metrics have been agreed or are under development where baseline data is not available. Reporting against these indicators will formally take place in next year's Quality Account.

Quality Matters

The Quality Matters project is a three year programme using "Lean" methodology to review Trust wide services aimed at:

- Improving patient care
- Improving staff morale
- Improving efficiency

A pilot phase commenced in 2008/09 to test the processes and patient pathways in Ophthalmology and Obstetrics. The changes made created "one stop" templates for patients with glaucoma and improved efficiency of services for ante-natal patients. Alongside this, the Trust rolled out the 'Productive Ward' series and introduced a number of modules which have demonstrated the release of nursing time to provide direct care for our patients.

2009/10 saw the commencement of year 2 of the project where the emergency care pathway, theatre efficiency and gynaecology outpatients were selected for review with the intention to:

- Maximise the utilisation of theatres
- Improve the process flow through Accident & Emergency and the Emergency Admissions Unit
- Improve the productivity within specific care pathways
- Improve the patient experience
- Reduce readmission rates
- Improve the Care Quality Commission ratings on quality
- Improve staff experience through increasing morale in the Trust
- Reduce serious untoward incidents
- Reduce complaints
- Release £1.8 million for reinvestment in patient services

This year has seen the assessment and redesign of processes leading towards the implementation of outcomes which are expected to see results from April 2010 onwards.

Coaching for Quality and Organisational Development

In 2009/10 a coaching for quality framework was agreed, setting out how the Trust would introduce a coaching culture. The two main elements of the framework were:

- Developing, leading and managing in a coaching style
- Developing in-house trained coaches

Through a tendering exercise I-Coach were successfully selected to work with the Trust, and training began during the first part of 2010.

The coaching for quality framework was developed as part of the overall approach to leadership and management development. September 2009 saw the completion of the first cohort of a newly developed two-stage management and leadership development programme. The programme consisted of a professional review process which demonstrated positive improvement outcomes. The second cohort commenced in September 2009.

Senior management development has taken place using a number of psychometric tools to support the development of team working, managing change, difficult situations and effective communication. In addition, Divisional

Board members have had time with the executive team as part of a strategic team development process. The purpose of this is to work with divisions on current issues and support the development of sustainable solutions.

Clinical Pathway Action Groups

Three Consultant led groups were identified to review and establish improvements to pathways or practice within specified areas. These were:

a. Elective care

This clinical pathway action group succeeded in establishing pathways for elective total knee replacement and hip replacement. Due to the success of these pathways, work is underway to review the pathway for rectal bleeding. To date this has resulted in reviewing and extending the practice of nurse endoscopists, revision of the referral pathway and additional clinical capacity for endoscopy sessions. Patient satisfaction is being monitored and has to date been very positive.

b. Primary and Community care – Chronic Obstructive Pulmonary Disease (COPD)

Through this clinical pathway action group, a new service will be launched on 1 April 2010, which integrates health care professionals into a single, 7 day service for COPD management, covering Primary and Secondary Care. The business case has been agreed between the East Cheshire NHS Hospitals, MCHFT and CECPCT and a pathway completed. The COPD Guidance Document is already in use.

c. Planned and end of life care

This clinical pathway action group was established to develop and improve the Trust's performance in relation to the management of patients nearing their end of life. A baseline assessment was undertaken to establish compliance against recently published guidelines (End of Life Strategy, DH 086277). Following this an action plan was developed to address:

- Development and delivery of End of Life awareness / training sessions to medical and nursing staff
- Performance monitoring the use of the 'End of Life Care of the Dying' Pathway and benchmarking against external data
- Development of proposals for specific palliative care beds as part of the Primary Care Trust's intermediate bed based services commissioning plans

The outcomes of the project have shown significant improvement in the performance of the Trust against these objectives. This was re-audited in February 2010 to ensure continuous improvement is maintained.

Review of Performance In Relation To Patient Safety

Priority 1: Reduce avoidable harm

Why?:

> 'Almost 4,000 NHS patients in England died as a result of "safety incidents," while a further 7,500 suffered severe harm' according to figures released in 2009 by the National Patient Safety Agency (NPSA).

All patient safety incidents at the Trust are reported to the National Patient Safety Agency (NPSA). The NPSA provide the Trust with feedback on this information and provide comparisons with similar sized organisations.

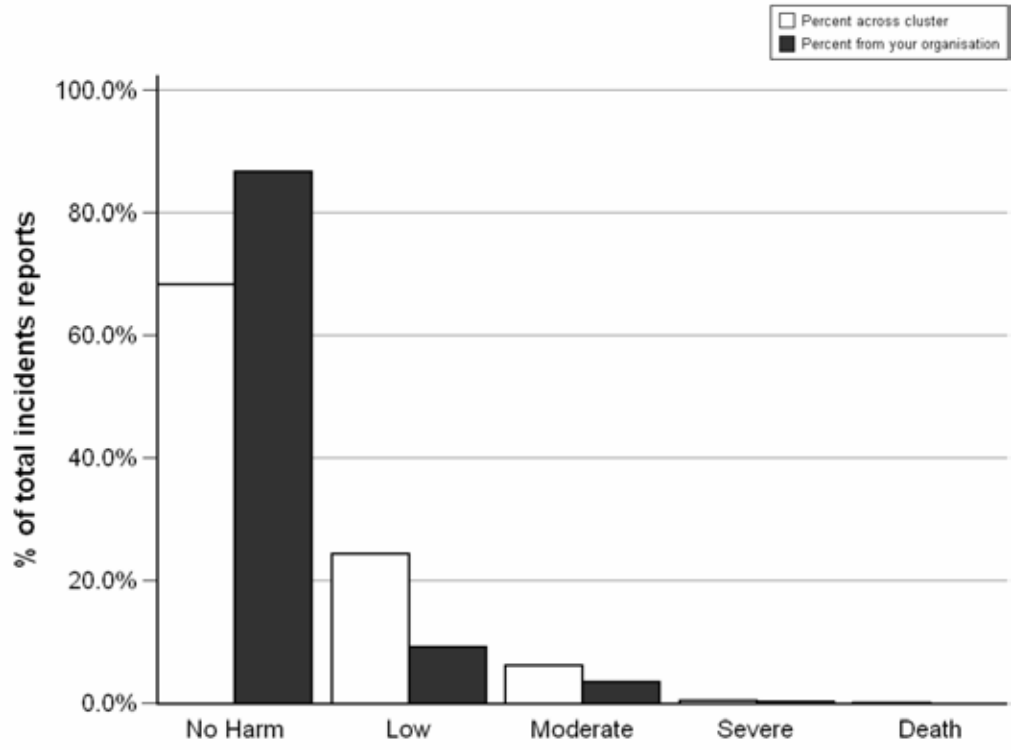
Graph 1 shows how the Trust compares with other organisations in the cluster* with regard to degree of harm incurred by patients in the incidents reported during the period 1 April to 31 September 2009.

This is the most current data available from the NPSA.

In comparison to previous data the Trust is maintaining a reduction in harm caused to patients. The majority of patient safety incidents resulted in no or minor avoidable harm to patients. Going forward, the Trust aims to set targets and timescales to further reduce avoidable harm caused to patients.

* cluster – District general hospitals of similar size and activity to MCHFT

Graph 1: Comparison data of patient harm

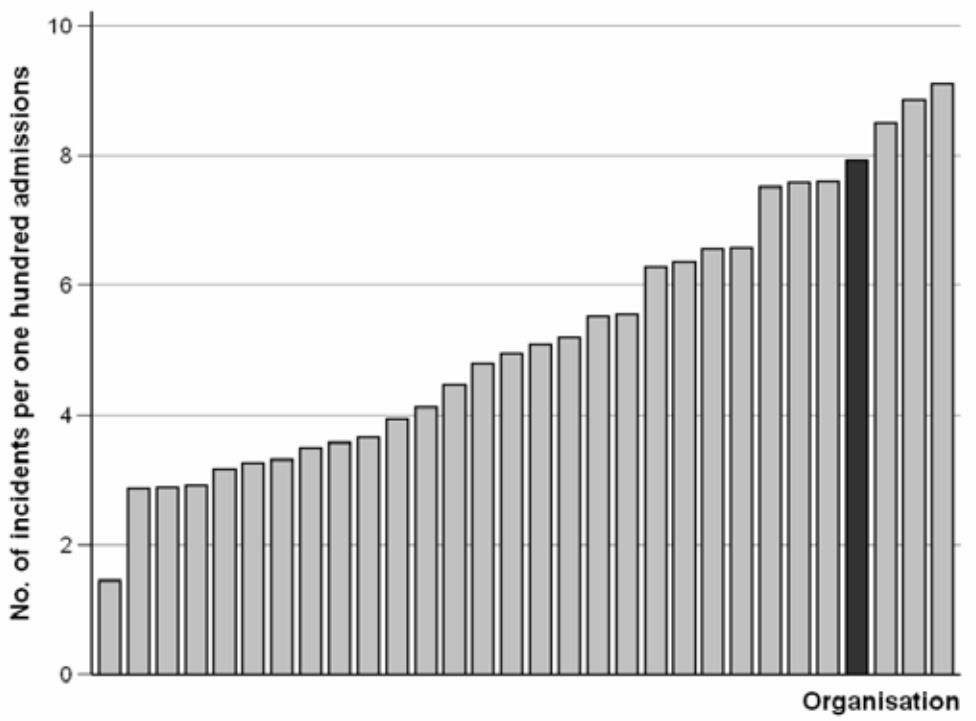


Priority 2: Maintain the Trust's Safety Culture

Why?:

The National Patient Safety Agency (2009) 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.

Graph 2: Rate of Reported Patient Safety Incidents per 100 Admissions within Trust Cluster Group during April 2009 - September 2009



Graph 2 shows the rates of reported patient safety incidents per 100 admissions in the organisations in the Trust's cluster group (small district general hospitals) during the period 1 April to 31 September 2009. The highlighted bar represents Mid Cheshire Hospitals NHS Foundation Trust. This is the most current data available from the NPSA.

For the past three years the Trust has remained in the top centile of reporters compared with other organisations within the cluster. The Trust has a high reporting culture which has been demonstrated in the NPSA reports for three years consecutively. The Trust aims to increase the reporting of incidents and near misses by 1% year on year.

Medication incidents

The Trust has been recognised by the NPSA as under reporting medication incidents; therefore additional resources have been put into an additional reporting system within pharmacy. Early indications are that this is proving successful as there is an increase in reporting. The Trust aims to see a 10% increase in medication near

miss and minor incident reporting next year and a Safer Medicines Practice Group has been established to analyse the information and identify lessons to learn and changes in practice. Additionally, the Trust will take forward the Medicines Management Module from the Productive Ward project.

Priority 3: Implement National Patient Safety Initiatives

Why?:

To develop the capacity and capability in the Trust to eliminate avoidable harm to patients (NHS Institute for Innovation and Improvement 2009).

Patient Safety First Campaign

The Trust has signed up to the Patient Safety First Campaign which is led by a Senior Consultant and the Patient Safety Lead. The Patient Safety First Campaign has at its heart a vision of an NHS with No Avoidable Death and No Avoidable Harm (Patient Safety First Campaign 2009). The Trust has committed to making progress in relation to the following interventions:

Deterioration

Aim:

To reduce in-hospital cardiac arrests and mortality rates through earlier recognition and treatment of a patient who is deteriorating.

Progress:

- A gap analysis has been undertaken against the six key areas relating to patient deterioration
- The Trust has effectively developed and implemented an Early Warning System specifically for maternity patients
- A task and finish group has been established to introduce SBAR to the Trust which is a tool to standardise handover of care between clinicians
- A Mortality Reduction Group has been established, which is led by the Medical Director
- A systematic audit of inpatient deaths has been established
- Links have been strengthened between clinical coders and consultants

Leadership

Aim:

To ensure a leadership culture at Trust Board level which promotes quality and patient safety and provides an environment where continuous improvement in harm reduction becomes routine throughout the organisation.

Progress:

- Nurses are involved in the programme with representation from all clinical divisions
- The Trust has developed courses for Becoming a Manager and Managers Moving On which focus on leadership and professional development
- Senior Nurse Managers (which includes the Deputy Chief Executive/ Director of Nursing) with a current clinical qualification, spend 1 day per month working in clinical areas and write a reflective piece identifying good practice and areas for improvement
- When in the organisation, the

Chief Executive visits one patient each morning to discuss their experiences whilst under our care. The information gained from the patients is discussed and disseminated to the Executive Team, Governors and a range of staff groups on a regular basis, whilst ensuring anonymity and patient confidentiality at all times

- After Action Reviews are routinely undertaken to learn from key pieces of work that have either gone particularly well, or gone off track. These are reported to the Trust Board
- The Trust, in collaboration with British Association of Medical Managers, has been involved in a two year Clinical Leaders Programme

Pre Op Care

Aim:

To improve care for patients undergoing elective surgical procedures in the hospital setting.

Progress:

- The World Health Organisation (WHO) Safe Surgical Safety Checklist was rolled out to all theatres by March 2010
- Pre surgery briefs are being held as part of the WHO safe surgery checklist in order to ensure that everyone involved in the surgery is aware of what they should be doing and that all the equipment required is readily at hand

NHS Institute of Innovation & Improvement

Leading in Patient Safety Programme (LIPS)

The Trust has signed up to the Leading in Patient Safety programme which aims to develop the capacity and capability to eliminate avoidable harm to patients. This programme involves Trust board members, senior clinicians and senior managers from across the organisation.

Actions from this include:

- The patient safety team undertake patient safety 'walkarounds' discussing patients with clinicians, identifying changes in practice and promoting incident & near miss reporting
- Use of the Global Trigger Tool which helps to randomly select health records and review them for harmful events and make appropriate changes
- Changes in the way the Trust presents its information to provide a clearer picture of improvement or identifying areas for action

Review of Performance In Relation To Clinical Effectiveness

Priority 1: Saving Lives - Reducing Mortality Rates

Why?:

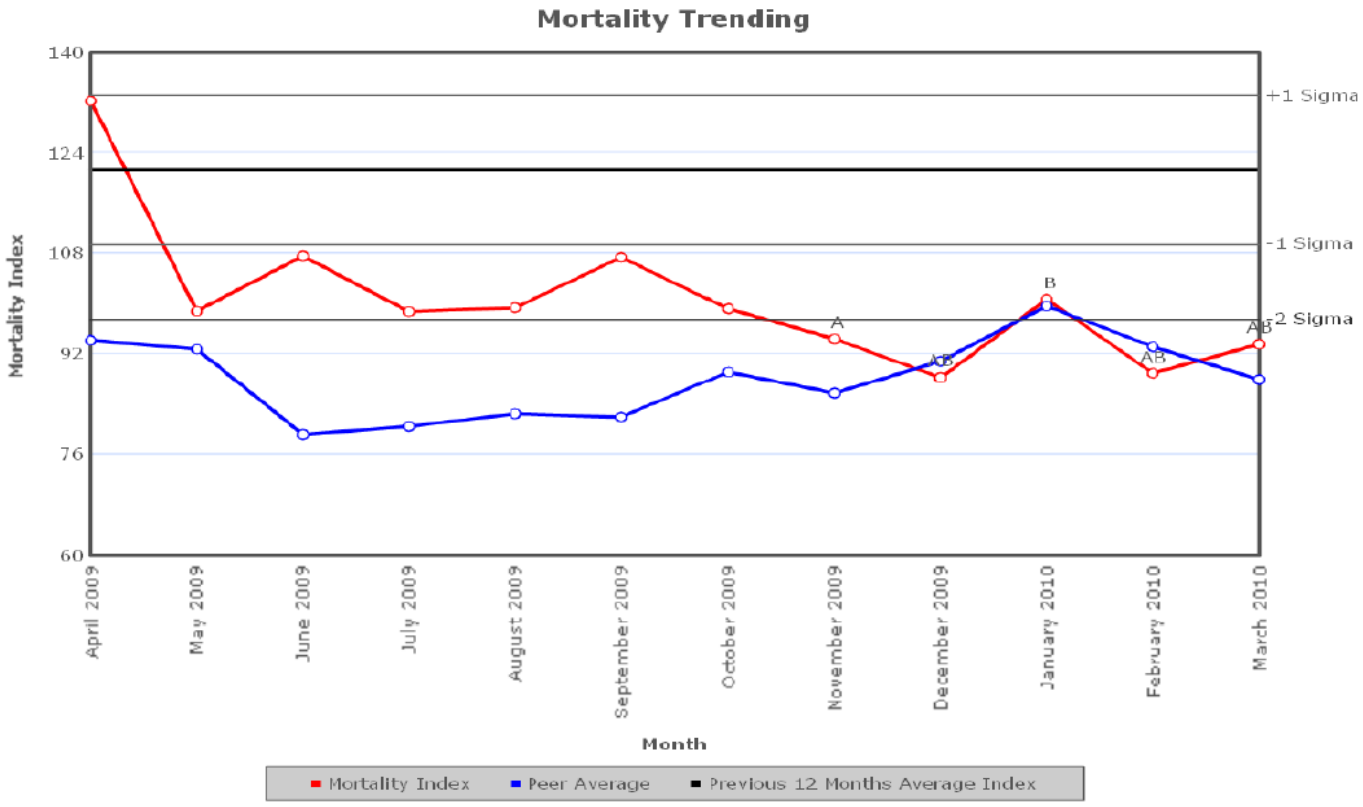
To improve outcomes for our patients and reduce the Trust's Hospital Standardised Mortality Rates (HSMR)

Reduction in mortality

A Trust Mortality Reduction Group has been established which reviews patients' records and collates information to highlight lessons to learn and agree changes in practice. Changes made will be reported in the 2010-2011 Quality Accounts.

Graph 3: - Mortality Trending

There has been a significant reduction in the Risk Adjusted Mortality Index (RAMI). In 2008-2009 it was 124 and for 2009-2010 it was 100. The Trust has also committed to joining the North West Reducing Mortality Quality Improvement Collaborative which commences in April 2010.



Priority 2: Implement the most Clinically Effective Care - Advancing Quality Programme

Why?:

To enhance standards of patient care and management, to improve clinical outcomes and overall patient experience for the four clinical conditions included in the advancing quality programme.

The Trust was selected as a pilot organisation for the implementation of the Regional Advancing Quality programme in 2007. The programme went live in October 2008 with the Trust collecting and reporting on clinical measures as well as service improvement work. The aim of this project is to record and report on agreed clinical measures and improve outcomes for patients with the following clinical conditions.

- Acute Myocardial Infarction
- Heart Failure
- Hip & Knee Replacement Surgery
- Community Acquired Pneumonia

Data is entered retrospectively and based on discharge diagnosis. Advancing Quality is a pilot project so therefore there is no historic data.

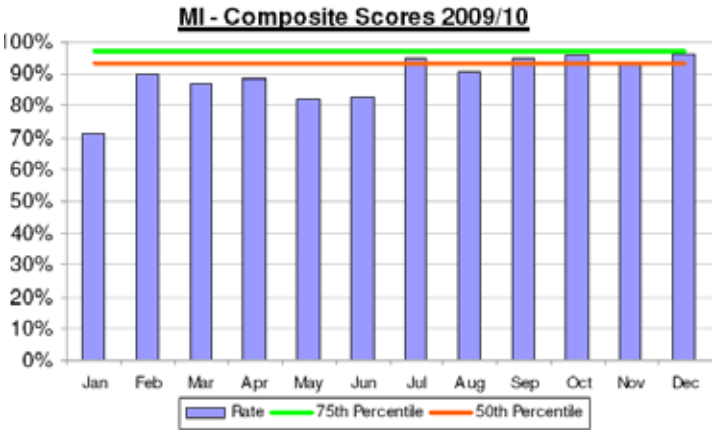
The red line on the following graphs shows the top 50% of the Northwest Trusts and the green line shows the top 25% of the Northwest Trusts.

If a Trust consistently achieves above these lines, then the Trust will be rewarded financially for the high standard of care provided.

Interventions for all patients admitted with Acute Myocardial Infarction

- Aspirin administered within the first 24 hours of admission
- Thrombolytic treatment (if clinically indicated)
- Smoking cessation advice given
- Discharge medications provided

Graph 4: - Acute Myocardial Infarction - Composite Scores

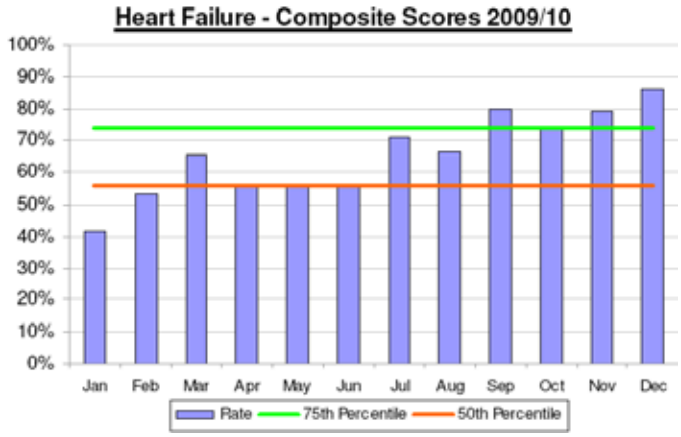


This graph demonstrates that the delivery of these interventions is consistently high for patients diagnosed with Acute Myocardial Infarction.

Interventions for all patients being admitted with Heart Failure

- Investigation – Echocardiogram (ultrasound of the heart)
- Medication on discharge provided
- Smoking cessation advice given
- Written discharge instructions provided for activity, diet, symptom worsening follow-up, medications and weight monitoring

Graph 5: - Heart Failure - Composite Scores

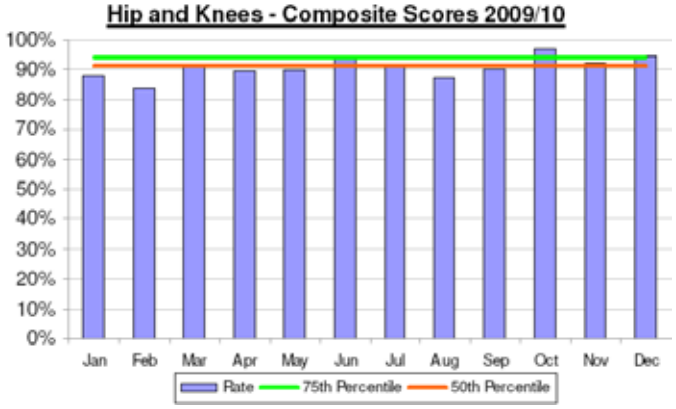


The overall results for heart failure have taken time to improve due to the difficulty in identifying these patients prior to discharge as they can be admitted to a variety of emergency care wards with differing symptoms. The Trust has a designated heart failure nurse assigned to help identify these patients and deliver discharge information.

Interventions for all patients undergoing Hip and Knee Replacement Surgery

- Recognition of medications taken prior to admission
- Anti-coagulant medication administered during admission
- Antibiotic therapy administered during surgery

Graph 6: – Hip & Knee Replacement Surgery - Composite Scores

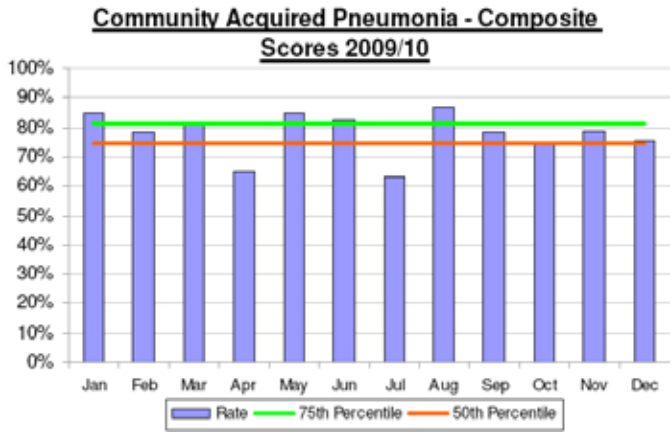


The graph above demonstrates the Trust is delivering consistently high levels of care to patients undergoing hip and knee replacement surgery.

Interventions for all patients being admitted with Community Acquired Pneumonia (CAP)

- Oxygen assessment on arrival
- Recommended antibiotics prescribed to treat CAP
- Antibiotics administered within 6 hours of admission
- Blood cultures (if indicated)
- Smoking cessation advice given

Graph 7:- Community Acquired Pneumonia - Composite Scores



The graph demonstrates overall high compliance with patients receiving a high standard of care when admitted with Community Acquired Pneumonia. Reduced scores can be seen in April and July. This was due to several patients not being offered smoking cessation during their stay.

Summary

Overall, it can be seen that the Trust provides a high standard of care to patients admitted with any one of the four clinical conditions. The first year of Advancing Quality has focused on the process of collecting information from patient records.

The second year will focus on improving care delivery. Early diagnosis is imperative to compliance with these interventions. This allows communication alerts to appropriate healthcare professionals to ensure patients receive the right care at the right time.

Priority 3: Implement the most Clinically Effective Care – Stroke 90:10

Why?:

To enhance standards of patient care and management, to improve clinical outcomes and overall patient experience for patients diagnosed with a stroke.

Stroke 90:10 is a Northwest Collaborative that commenced in January 2009. Its aim is to improve the care and management of patients who have suffered a stroke. The implementation of Stroke 90:10 does this by ensuring patients receive a plan of care that has been clinically proven. This plan of care consists of a care bundle approach. A care bundle is a collection of interventions (usually three to five) that may be applied to the management of a particular condition. The elements in a bundle are best practices based on evidence, and all clinicians should know them. A bundle aims to tie them together into a cohesive unit that must be adhered to for every patient, every time. All the tasks are necessary and must all occur in a specified period and place.

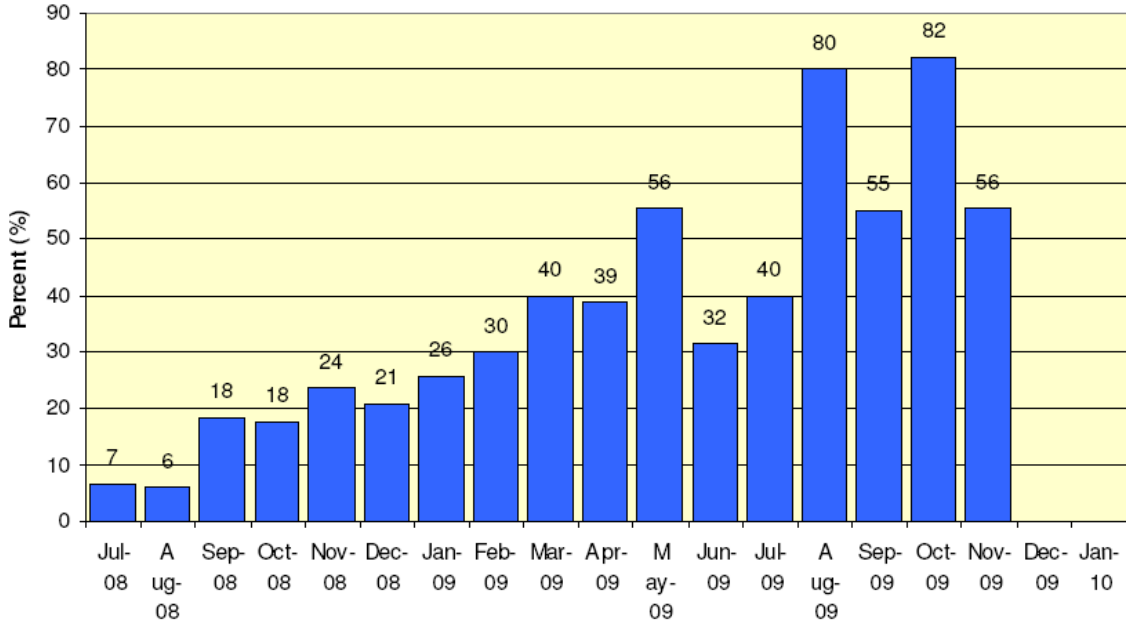
The Trust's aim is that all patients admitted with a diagnosis of a stroke will receive all of care bundles 1 and 2. Stroke 90:10 is a pilot project therefore there is no historic data.

Care bundle 1 was implemented in January 2009 and concentrated on the acute care of stroke patients. Care bundle 2 was implemented in May 2009 focussing on the rehabilitative aspect of stroke care.

Care bundle 1

- CT scan to be undertaken within 24 hours
- Aspirin therapy to be administered within 24 hours
- Weight to be recorded
- Swallow to be assessed within 24 hours

Graph 8: - Results of care bundle 1

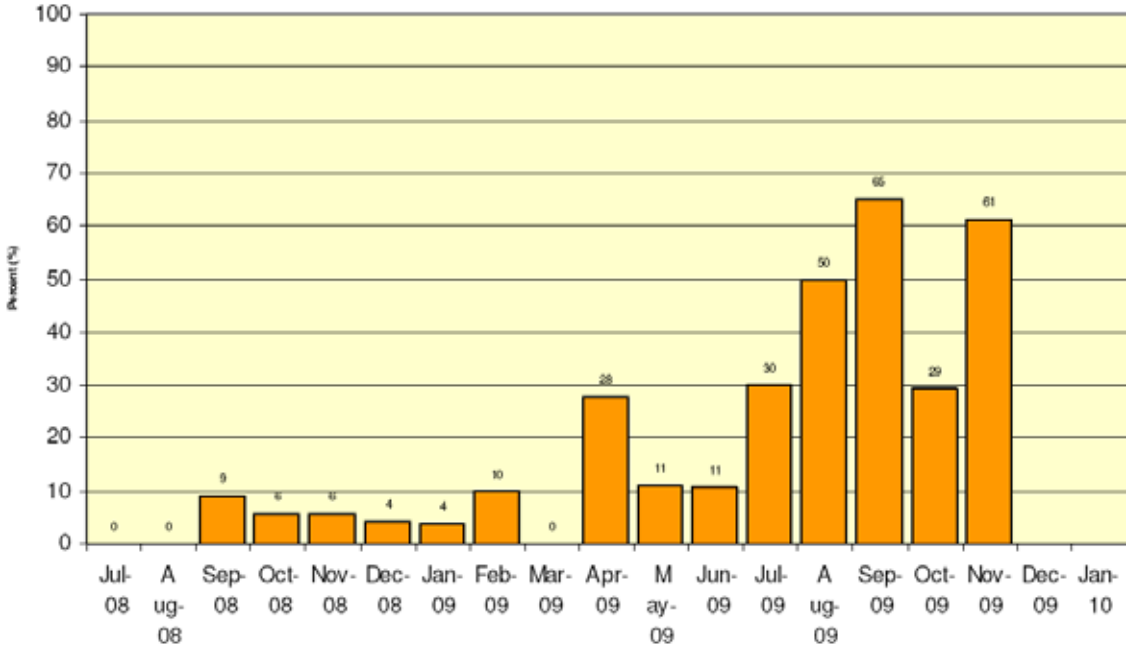


In relation to care bundle 1, the graph shows overall month on month improvement since the introduction of the Stroke 90:10 project in January 2009. Data collection is retrospective and based on discharge diagnosis which means there is no validated data from November 2009. The stroke team will continue to monitor performance and make the necessary changes until it is demonstrated that the improvements are sustained.

Care bundle 2

- Physiotherapy to be commenced within 72 hours
- Occupational Therapy to be commenced within 4 days
- Multidisciplinary goal setting to take place
- Mood Assessment to be undertaken
- 50% of the patients' stay to be in the stroke unit

Graph 9: - Results of care bundle 2



The Stroke 90:10 team within the Trust chose to focus on the acute care in Care Bundle 1 at the start of the project. Care Bundle 2 was implemented in May 2009 and results have improved significantly since then.

In relation to care bundle 2, the graph shows fluctuating results since the introduction of the Stroke 90:10 project. This is predominantly related to patients not always being admitted to the stroke unit. The stroke team will continue to monitor performance and make the necessary changes until it is demonstrated that the improvements are sustained.

The Sentinel Audit is a national audit which measures the care patients receive following the diagnosis of stroke. The audit is in two parts, reviewing the organisational structure and the clinical pathway of the patient.

The improvement initiatives are ongoing in stroke management and care and the Trust is optimistic that it will attain a score of 90 in the Sentinel audit which commences in April 2010.

Review of Performance In Relation To Patient Experience

Priority 1: Improve on the results of the National Patient Surveys

Why?:

To further our commitment to ensuring every patient receives the best possible experience within the Trust

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 us about their experiences.

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

An action group for patient experience monitors progress on action plans developed following patient surveys.

Summary of results from the National Outpatient Survey

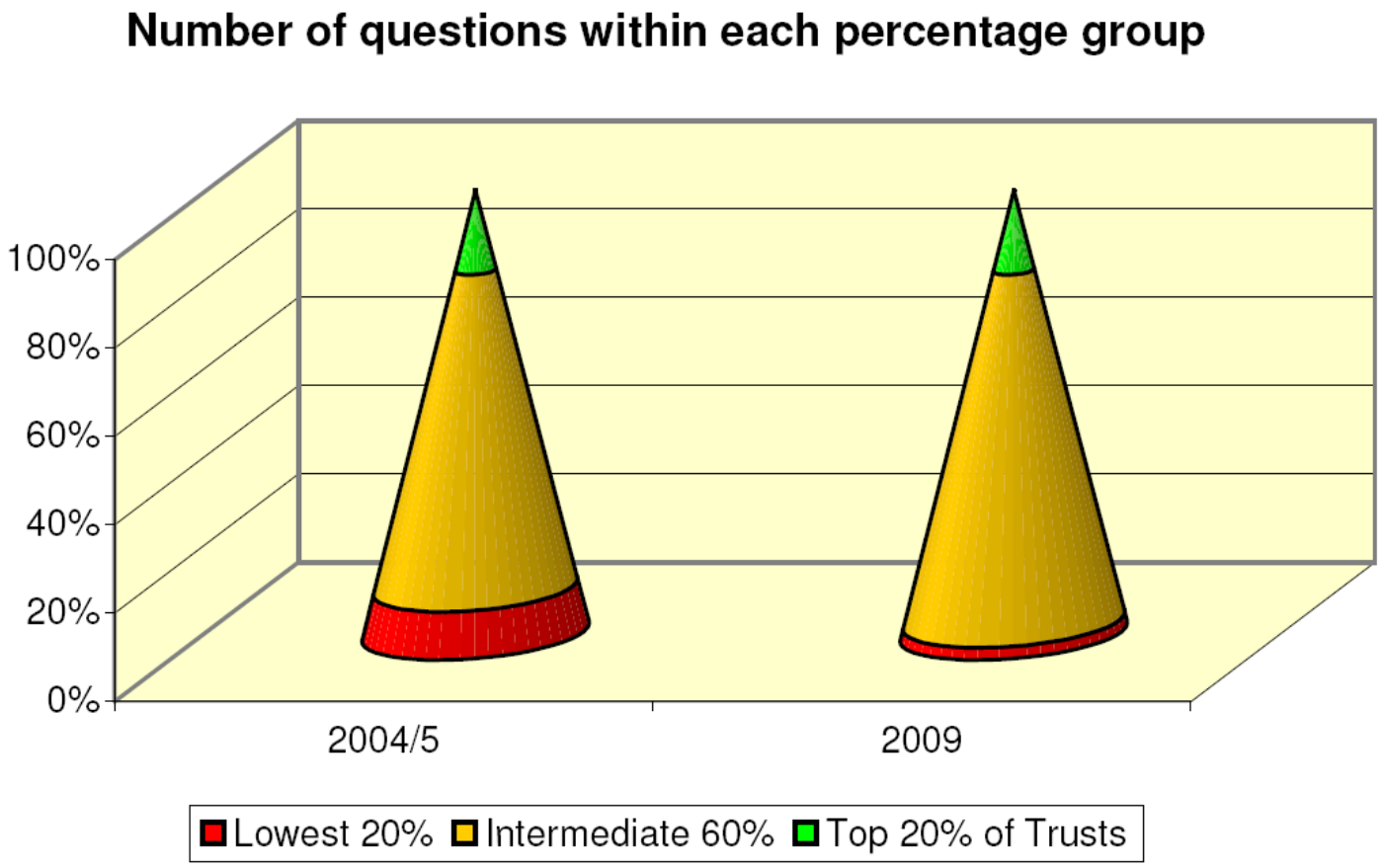
The Trust focuses on key areas to ensure continued improvement in patient satisfaction. Trust scores from the National Outpatient Survey conducted in 2009 demonstrated progress made since the previous survey in 2004.

Figure 5: - Comparisons of results from National Outpatient Surveys

National Outpatient Survey - Mean Rating Scores	2004	2009	Change
Cleanliness of department	80	85	+5
Cleanliness of toilets	77	83	+6
Getting answers to questions from doctors	80	83	+3
Involvement in decisions about care and treatment	82	83	+1
Amount of privacy when discussing treatment	93	94	+1
Amount of privacy when being examined or treated	95	97	+2
Overall were you treated with respect and dignity	93	93	-
Overall rating of care	81	82	+1

These scores are calculated by converting responses to particular questions into scores. For each question in the survey, the individual responses are scored on a scale of 0 to 100. A score of 100 represents the best possible response. Therefore, the higher the score for each question, the better the Trust is performing.

Graph 10: - National Outpatient Survey - Benchmarked number of questions



This shows, there has been progress in improving the Trust's benchmarked scores so that there are less questions in the lowest 20% and more in the top 20% of Trusts.

This reflects the considerable efforts that have been made in the outpatients department to improve the care and treatment on offer to patients.

The following table provides results from the National Patient Survey programme to assess progress against the Public Services Agreement (PSA) targets agreed.

The dimensions are grouped questions with a common theme and show that the Trust has performed higher than the national score on four out of five dimensions.

The Trust has improved on two of the five dimensions since 2004 and is static on two dimensions.

Unfortunately the Trust has dropped one point on one dimension, Safe High Quality, Coordinated Care; however it is still 3 points above the national peer group.

Outpatient survey

Figure 6: – Dimension scores for the Outpatient Survey compared to National benchmark data

Dimensions - Mean Rating Scores	2004*	2009	2009 National Benchmark data
Access and Waiting	69	71 +	69
Safe High Quality, Coordinated Care	86	85 -	82
Betting Information More Choice	79	79 =	77
Building closer relationships	79	79 =	86
Clean, comfortable place to be	71	74 +	68

* survey not conducted nationally since 2004

Improvements achieved

The Trust has a comprehensive range of information available for patients at pre operative assessment appointments, in clinics, wards and departments.

An information leaflet has been produced to promote the leaflet package to patients in GP practices.

Patient Recommendation

Finding a measure that helps the Trust know if it is achieving its aim of being the 'hospital of choice for local people' is quite a challenge. In 2009, the Net Promoter Score (NPS) was included in all of the Trust's local patient surveys. The NPS (Reichheld 2006) offers a way to capture what people will say in terms of 'word of mouth' locally and is a measure to capture whether or not the Trust is the hospital of choice for local people.

In 2009, 1000 patients were asked in local patient surveys if they would recommend the Trust to family and friends based on their experience as a patient: 86% of patients declared that they would recommend the Trust to others.

This question also appears in the Care Quality Commission National Outpatient Survey and 98% of patients said they would recommend the Outpatient Departments to family and friends. (Sample size = 737 patients).

Patient Reported Outcome Measures (PROMS)

Patient Reported Outcome Measures are health questionnaires completed by patients admitted to hospitals for elective hip or knee replacement, hernia repair or varicose vein surgery. The questionnaire is completed before surgery and then six months after operation to measure individual health outcomes.

The National PROMS is run by Northgate Information Solutions in partnership with Quality Health for the Department of Health. The National PROMS commenced in April 2009 with Advancing Quality PROMS transferring over in October 2009.

The Trust started to collect Patient Reported Outcome Measures (PROMS) in Orthopaedics in January 2009 as part of the Advancing Quality project.
Results from these questionnaires suggest that we are operating on patients with more pre-existing healthcare conditions than other Trusts in the Northwest of England.

Table for Compliance for National PROMS

Figure 7: – PROMS completion rates 2009/10

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Hip & Knee Replacement - number of eligible patients	25	32	33	34	36	34	33	37	30	32	32	33	22
Percentage return rate	100	100	100	100	100	100	100	100	100	100	100	94	100
Hernia - number of eligible patients		12	14	19	16	13	19	37	27	30	23	19	44
Percentage return rate	n/a	100	100	100	100	100	90	89	74	77	78	63	82
Varicose Veins - number of eligible patients		7	8	15	3	5	10	29	12	15	20	14	19
Percentage return rate	n/a	100	100	100	100	100	80	100	75	87	90	86	67
MCHFT TOTAL - number of eligible patients	25	51	55	68	55	52	62	103	69	77	75	66	60
Percentage return rate	100	100	100	100	100	100	94	96	86	88	91	83	88

Completion of the PROMS questionnaire is voluntary; hence the return rate is often less than 100%.

Priority 2: Improve Privacy & Dignity for Patients

Why?:

The Trust believes that all its patients, their families, friends and carers have the right to be treated with dignity and respect, maintaining their privacy at all times.

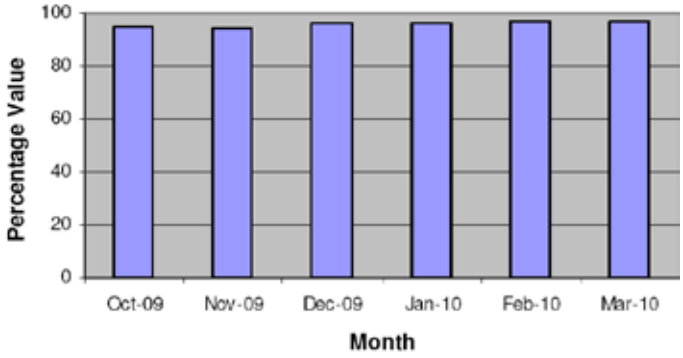
"Never take a person's dignity; it is worth everything to them and nothing to you"
Frank Barron

The Trust has recently published the Mid Cheshire Mission which highlights to staff points to remember when dealing with patients, relatives and the public:

- Always greet people first and with a smile
- Do not leave patients, relatives, staff or the public waiting for assistance
- Always introduce yourself
- Always ask people how they would like to be addressed
- Do not judge others
- Be kind and compassionate
- Find out about people, their lives and stories
- Be sensitive to the needs of others
- Always treat people with dignity and respect
- Remember the privileged position you are in.

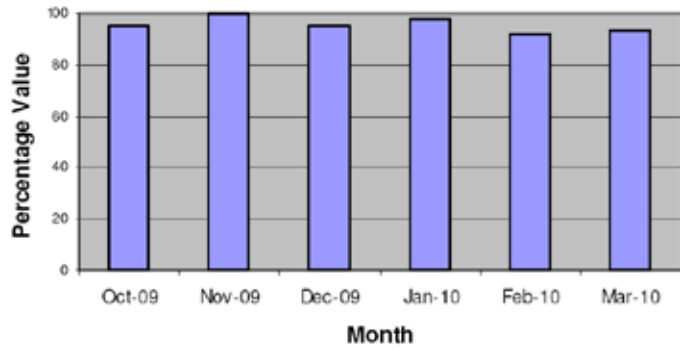
Every month a sample of patients across the Trust are asked the following questions:

Graph 11: - Are you given enough Privacy & Dignity when being treated or examined?



This graph shows that a high volume of patients feel they are treated with Privacy & Dignity.

Graph 12: - During your stay, have you been treated with Dignity and Respect?



This illustrates that the vast majority of patients felt they were treated with Privacy & Dignity during their hospital stay.

The Trust is committed to delivering same sex accommodation and none of our wards have mixed sex bays. Certain assessment areas such as the Emergency Assessment Unit, the Surgical Assessment Unit, Acute Stroke Unit and Ward 1 (Cardiology) do at times contain mixed sex areas due to clinical need. The Trust has invested in privacy screens and privacy doors to help maximise the dignity of our patients

whilst also reducing the risk of spreading infection.

There has also been a great deal of work done at the Trust to improve the quality of care, dignity and respect offered to patients with dementia. These improvements have been recognised as best practice by the Alzheimer's Society, which has published an article in their 'Living with Dementia' magazine highlighting the changes that have been made.
(Follow this link to 'Living with Dementia' magazine www.alzheimers.org.uk)

Examples of changes made include:

- The installation of coloured privacy doors to promote independence and reduce possible barriers to dignity
- The development of communication friendly signs which are suitable for patients with cognitive impairment
- Training for staff in dementia care
- Provision of an activity lounge – where patients with dementia can socialise, engage with staff and other patients and enjoy interactive games

Priority 3: Improve the handling of complaints

Why?:

To ensure patients are satisfied with the handling of any complaint they may have and to be treated fairly.

The NHS Constitution sets out the right for patients to:

- Have their complaint dealt with efficiently, and properly investigated
- Know the outcome of any investigation into their complaint
- Take their complaint to the independent Parliamentary and Health Service Ombudsman if they are not satisfied with the way the NHS has dealt with their complaint.

The new complaints procedure came into effect from April 2009. This focuses on a more responsive handling of complaints with early contact with complainants to identify the issues they want resolving and the outcomes they are looking for.

The new legislation has replaced the previous 25 working day limit with flexible timescales which are agreed with the complainant. This has meant that, wherever possible, the complainant is contacted by telephone to agree the issues within the complaint. Where this is not possible, a letter is sent to the complainant stating the issues identified within the complaint, giving the opportunity for the complainant to respond if any issues have been missed or not included or even just to discuss how the complaint will be progressed.

Figure 8: - Number of Complaints, Referrals to the Ombudsman and Response Times

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

Examples of changes made as a result of complaints

- Visiting times on the orthopaedic unit were changed to provide relatives with the opportunity to speak to a senior member of staff between 14.30 and 16.00 each day

- All patients who have a suspected melanoma are now offered a hospital appointment two to three weeks after their surgery to discuss the results in clinic with their Dermatologist

- Ward folders have been introduced on the maternity wards in response to questions raised by new mums for information on ward facilities. The folders have been developed following consultation with parents at Monks Copperhill Baby Café, Winsford Children Centre, Underwood West Childrens Centre and Community Polish groups.

In a survey conducted in 2009, patients rated their satisfaction in how complaints were handled as follows:

	Target for 2010/11
48% of respondents felt their complaint was resolved satisfactory	65%
47% said they were offered a meeting	75%
10% felt reassured that action would be taken to improve the areas of concern to them	50%
76% said they received a copy of the Trust's Complaints leaflet	90%

Consultation on Quality

The consultation process for the Quality Accounts commenced on 24 October 2009, running through until 11 December, 2009.

The objectives of the consultations were to:

- Ask local people for feedback on the 10 key priorities for the Trust.
- Recruit members of the public as Foundation Trust Members.
- Provide an opportunity for Foundation Trust Governors and staff to talk to members of the public about the quality of services provided.

Through partnership working, the offer was made by the Public Engagement Manager of the Cheshire Police Authority to participate in a joint consultation exercise.

The Police Authority aimed to directly consult with communities in key towns across the policing area in order to gather people's views about public priorities.

In this new initiative, both organisations aimed to out to find out what mattered to the public. The Constabulary Exhibition Vehicle was located in prominent places in Crewe, Northwich, and Sandbach enabling staff and volunteers to engage with members of the public.

Displays were also organised in several local supermarkets including Morrisons in Winsford and Sainsbury's in Crewe with displays at local GP surgeries in Nantwich and within the Trust.

Foundation Trust members involved in monitoring Quality, Patient Information and Research & Development were selected to support the consultation events. Question cards were widely distributed to gain public opinion.

The public were asked to prioritise from a list of 10 areas, and there was also a section for comments. Each event was well attended with approximately 45 applications for Foundation Trust Membership.

The total number of responses received by the Trust was 370. The responses received were varied and the priorities that were chosen are documented in figure 9.

Analysis of Responses

Figure 9: – Priorities of the Public

Group	%	Rank
Infections	77%	1
Cancer	70%	2
Mortality	67%	3
Staff Dev	64%	4
Patients Safety	63%	5
Heart Disease	59%	6
Readmissions	58%	7
Fit for Purpose	49%	8
Finances	49%	9
Prevent Harm	48%	10

As this was the first quality consultation there is no historic data available.

This shows that the public's main priority for the Trust was prevention of Infections.

The majority of respondents regarded all 10 priorities as important for the Trust to monitor and measure.

Readers Panel

The Trust's Readers Panel consists of 50 members of the public and volunteers.

On a monthly basis, the Trust produces information for patients in draft format, which is forwarded to the members of the reader's panel for evaluation and comment. Members were recently asked if they would be interested in reviewing the Quality Account.

The Quality Account 2010/11 was reviewed by 25 members of the Trust's Readers Panel.

Of the 25 draft copies issued 18 sets of comments were received. Overall, the Quality Account was given a positive response for content and presentation; with many feeling it had helped them understand the increasing complexity of the Trust's quality programme.

Suggestions included broad circulation of the document across primary and secondary care to assist understanding the Trust's progress in quality provision.

Statements from Local Involvement Networks (LINk), Overview and Scrutiny Committee (OSC) and Primary Care Trust (PCT)

In High Quality Care for All, published in June 2008, Ministers set out the Governments vision for putting quality at the heart of everything the NHS does.

The key component of the new Quality Framework was a requirement for all providers of NHS services to publish Quality Accounts.

The aim of the Quality Account is to improve public accountability and to engage Boards in understanding and improving quality in their organisations.

The Primary Care Trust, Local Involvement Networks (LINk) and the Overview & Scrutiny Committee (OSC) have important roles in the development of these Accounts and maximising their success.

This Quality Account has been reviewed by the Central & Eastern Primary Care Trust, Cheshire East LINk and the OSCs for Cheshire East and Cheshire West & Chester.

Their comments are documented on the following pages:

14th May 2010

Cheshire East LINk
Response to Mid Cheshire Hospitals NHS Foundation Trust Quality Accounts

1) The CELINk welcomes the opportunity to comment on Mid Cheshire Hospitals NHS Foundation Trust's Quality Accounts document.

2) The CELINk appreciates the constraints on the Trust in the way the document is presented. However the need for clear, simple and concise information which both public and patients can understand is a paramount issue. Bearing that in mind the document could be more user friendly. The document contains too much medical and managerial jargon e.g. stretch targets (p80), CHKS (p.80), acuity Group (p.82), lean methodology (p.92), SBAP (p.96) and gap analysis (p.96). A number of the graphs and tables are not easy to follow.
The trust would benefit from reading the Kings Fund document 'Accounting for Quality in the Local Community'

3) a) The CELINk supports the ten listed priorities for 2010-2011 but feels that they lack detail and time scales.

b) It is not always clear how the aims will be achieved. For example how will the reduction in mortality rates in patients who suffer an AMI be achieved? How will survival rates for patients diagnosed with cancer be reduced? Some performance indicators would be helpful.

c) The use of percentages without giving actual figures is not conducive to a clear understanding of the proposal. Targets again lack detail as to the proposed means of achievement.
(i) For example, there needs to be a target to reduce Novovirus infections, a major source of infections and ward closures with performance indicators to show how it is hoped to be achieved.
(ii)We are surprised at the given impression that the Trust does not know how much of its budget it spends directly on patient care.
(iii) The targets for 2010-2011 quoted under Patient Experience/Complaints on page 115 are disappointingly low.

d) Patient Experience, (Privacy and Dignity)
The CELINk welcomes the Mid Cheshire Mission quoted on page 111 and its attempt to monitor how well staff adhere to the ten points it contains. However it considers the questions asked to be too general and suggests that they should be more specific and focused e.g. Do staff always introduce themselves, especially medical staff? The responses would give a better indication of success if figures, rather than percentages alone were given.

4) A small point but we feel the Glossary would be more appropriate at the beginning of the document.

The above comments are offered from the perspective of a ‘critical friend’.

CELINk hopes to continue to work with MCHFT in its efforts to continue to deliver the best quality of care.

Barrie Towse
Chair Cheshire East LINk Committee

Health & Adult Social Care Scrutiny Committee

1) The draft Quality Account for 2009/10 be received

2) The Committee welcomes the comprehensive information on the quality of care and services included in the report

3) The ten priorities for improvement and performance measures for 2010/11 as the basis for the Trust’s five year improvement strategy be endorsed and progress be reviewed as part of the Quality Account for next year

4) Attention to be drawn to the following issues:

a) Concern that the requirements placed upon Acute Trusts to achieve demanding targets can distract from the quality of outcomes for patients, so the focus on outcomes in the ten priorities for improvement is important

b) Although the hospital operates a comprehensive patient complaints system, broader feedback about patient experience could be obtained from engaging more with their relatives, carers and visitors. Specific work aimed at helping patients with learning disabilities, in partnership with Cheshire and Wirral Partnership NHS Foundation Trust, was noted and welcomed

c) Although mortality rates in patient groups where death is not expected have improved, further effort is required to ensure the Trust continues to do better in this area

d) That the Trust is investing considerable time and effort into patient safety with the aim of eliminating avoidable harm to patients including falls, and that information will be available in future to present a clearer picture of improvements achieved and priority areas for attention

e) The Trust's ongoing efforts to virtually eliminate mixed sex accommodation be supported, recognising this cannot be avoided in a number of clinical settings, and the appointment of a Privacy and Dignity Matron to oversee improvements be welcomed

f) That despite investment, the Trust continues to have fewer doctors and nurses per bed than the national average, and also continues to rely heavily on bank/agency nurses in order to meet demand. The position with nursing staff is kept under regular review through a formal monitoring process and this is being extended to other groups of clinical staff

g) Although the Trust has demonstrated year on year improvements through the National Outpatient Survey, progress over five years for the "overall rating of care" category was only one percent, and the Trust accepted that the priorities for improvement contained in the Quality Account should lead to future improvements to this figure

h) The initiatives taken by the Trust including joint working with the Central and Eastern Cheshire Primary Care Trust (CECPCT) and Cheshire East Council Adult Social Care to reduce the incidence of hospital readmissions be welcomed and it is hoped that this work will result in a reduction in readmissions to enable the Trust to be at or below the national average, rather than above

i) The target relating to reducing the rates of healthcare acquired infections is welcomed as it is noted that this can increase the length of time spent in hospital

j) Issues relating to smoking cessation and breast feeding rates were noted as challenging targets that would require addressing through a partnership approach including the PCT and Cheshire East Council

5) These comments be forwarded to the Mid Cheshire Hospitals Trust for inclusion in their Quality Account and to the CECPCT and Cheshire East LINk for information.

Central & Eastern Cheshire Primary Care Trust

Many thanks for providing the Mid Cheshire Hospitals NHS Foundation Trust (MCHfT) Quality Account for 2009/10.

Central & Eastern Cheshire Primary Care Trust (CECPCT) is required, under the National Health Service (Quality Accounts) Regulations 2010, to provide a statement confirming whether or not it considers MCHfTs Quality Account contains accurate information in relation to the quality of services provided in 2009/10.

CECPCT has reviewed MCHfTs Quality Accounts and has confirmed, where able to do so, the accuracy of the data. Where CECPCT has been unable to validate the data, the Advancing Quality Alliance (AQuA), the Regional Quality Observatory, have been approached to validate information.

CECPCT has not been able to validate all the data in the Quality Account and this is reflected in the statement.

Yours sincerely

Michael Pyrah
Chief Executive

CECPCT's response to Mid Cheshire Hospital Foundation Trust Quality Account.

The PCT has reviewed the information contained in the Quality Accounts and can confirm that the information provided in the following is accurate:

- Commissioning for Quality & Innovation (CQUIN) Framework
- Care Quality Commission Ratings
- Data Quality – (Hospital Episodes Statistics data)

Patient Safety:

- Priority 1 - National Patient Safety Agency (NPSA) – comparison data of patient harm
- Priority 2 – rate of reported patient safety incidents per 100 admissions within trust cluster group during April 2009 – September 2009

Patient Experience

- Priority 1 - Summary of National Outpatient Survey information
  - Patient Reported Outcome Measures
- Priority 2 - Improvement of Privacy & Dignity
- Priority 3 – Improve the handling of complaints

The PCT is unable to validate the data as correct in the following:

Clinical Effectiveness

- Priority 1 – Saving Lives – Reducing mortality rates. The information provided is from C.A.S.P.E Health Knowledge Systems ltd (CHKS) and the information available to CECPCT is via Dr Foster. The data is not comparable
- Priority 2 – Advancing Quality unable to validate the information as a whole as AQuA are unable to verify the data for October, November & December 2009
- Priority 3: Implement the most Clinically Effective Care – Stroke 90:10 (awaiting verification from Aqua)

CECPCT is pleased to note the positive feedback described in the Quality Accounts on the innovative use of funding received in relation to Privacy & Dignity on the use of signage in ward areas. The PCT feel that other examples of outcomes achieved and how lessons learnt have been implemented and changed practice within MCHfT would be useful.

The description of the Commissioning for Quality & Innovations Schemes (CQUIN) is comprehensive it would be useful to see a real example of how the CQUINs have improved quality

CECPCT acknowledges all the work that MCHfT has undertaken in reducing mortality rates and welcomes the involvement with the North West Mortality Quality Improvement Collaborative. In support of this CECPT expects MCHfT, once a new national definition for mortality is introduced, to move over to this as a matter of priority to enable the PCT to confidently validate this data in the future. CECPCT will continue to see this as a high priority.

Key National Priorities

Figure 10: - Quality Overview

Safety Measures Reported		2008-2009	2009-2010	Result
Hospital Falls / injuries (falls / 1000 bed days) *		6.41	6.09%	Improved
Falls assessment risks completed within 24hrs *		83%	96%	Improved
Waterlow tests completed within 24hrs of admission *		98%	93%	Reduced
Nutritional assessment completed within 24hrs of admission		82%	99%	Improved
Performance Indicators				
A & E Waiting Times		98.1%	97.3%	Underachieved
Access to Geniro-urinary medicine (GUM) clinics		99.9%	100%	Achieved
Cancelled Operations	% of cancelled operations	1.19%	1.46%	Underachieved
	% of breaches of the 28 day guarantee	9.5%	14.4%	Underachieved
Ethnic coding data quality		84.1%	85.3%	Achieved
Inpatients waiting longer than 26 week standard		0%	0%	Achieved
Outpatients waiting longer than 13 week standard		0.14%	0%	Achieved
Rapid access chest pain clinic waiting times		100%	100%	Achieved
Patient Experience Measures Reported				
% of patients that would recommend hospital to family / friends		n/a	97%	n/a
Overall how would you rate the care you received **		93%	93%	No change
% of patients who felt they were treated with dignity and respect		97%	96%	Reduced
% patients who had not shared sleeping area with opposite sex		74%	75%	Improved

* monitored monthly

** patients rating their care as excellent, very good and good

Figure 11: - National Priority and National Core Standards

National Targets and Regulatory Requirements	2008-2009	2009-2010	Target	Result
MRSA Bacteraemias	15	8	12	Achieved
Clostridium Difficile Infections	142	117	120	Achieved
Smoking During Pregnancy	22.5%	19.5%	22%	Achieved
Breastfeeding Initiation Rates	59.5%	59.6%	60%	Underachieved
18 week maximum wait from point of referral to treatment (admitted patients)	89.1%	92.8%	90%	Achieved
18 week maximum wait from point of referral to treatment (non-admitted patients)	97.2%	97.6%	95%	Achieved
Maximum wait of 31 days from diagnosis to treatment of all cancers	96.2%	98.4%	96%	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%	Achieved
Maximum waiting time of 31 days for subsequent treatment for all cancers	Target from 09/10	100%	94%	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%	85%	Achieved
Thrombolysis	74.5%	66.7%	68%	Underachieved
Core Standards Submission	Full Compliance			

Nb. There were definitional changes to the cancer targets from January 1, 2009.

Appendices

Appendix 1 - Glossary & Abbreviations

Term	Abbreviation	Description
Advancing Quality	AQ	A programme which reward 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.
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.
Healthcare Associated Infections	HCAI	A generic name to cover infections like MRSA and C-diff.
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.

Term	Abbreviation	Description
Mid Cheshire Hospitals NHS Foundation Trust	MCHFT	The organisation which runs Leighton Hospital, Crewe, Victoria Infirmary, Northwich and Elmhurst Intermediate Care Facility, Winsford
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.
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.

Term	Abbreviation	Description
Reporting & Learning System	RLS	National database that allows learning from reported incidents
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

In the midst of great uncertainty, as a nation, as a National Health Service and as a hospital we continue to do what we do best provide high quality care, with true compassion for our patients, their families and carers and all our service users.

There have been significant achievements in the year. We have halved the number of MRSA Bacteraemia infections from last year and were well under our target. We had lower numbers of Clostridium difficile infections than ever and again performed better than our target. We made significant improvements in reducing hospital mortality rates and ended the year better than our peers. We hit all the year end targets for seeing patients in 18 weeks, all Cancer patients at 2 weeks, 31 days and 62 days. This in a year which saw more patients than ever coming to our hospital, over 350,000 attendances in total. Indeed, in the last 3 months, January to March we had 3 of our busiest ever weeks in A&E and medical emergencies. This put a huge strain on the whole hospital and, as always, staff responded magnificently.

My memory of the year will be the Sunday before Christmas, in the middle of atrocious weather when 300 people descended on A&E in one morning with broken limbs, falls, injuries, fractures, concussions, and a host of other needs. The system was in crisis – and what a fantastic response. Over 50 staff came in on their day off, unpaid, to keep patients safe at a time when they were most in need.

Despite the herculean efforts of the whole Trust (and amazingly achieving the 98% target for A&E in the last quarter) we just underachieved the standard for the year. This has been a huge disappointment. Many changes to practice have been put in place, the appointment of three Acute Physicians most notably, that will enable us to consistently achieve this challenge going forward.

Our main efforts this year have been on developing and improving the quality of care we give to our patients. As well as reducing the mortality rates of patients we have had successful initiatives to reduce the harm caused, reducing number of falls, medication errors, pressure sores and improving the privacy and dignity of care across all areas. The Trust scored quite low in the Stroke Audit in 2008, but since then we have doubled the size of the stroke unit, appointed a new Stroke Consultant and developed bundles of care to improve the quality of outcomes for victims of stroke. The improvements have been staggering and a real credit to the whole stroke team.

The Trust faces significant challenges in the year ahead. The workload continues to increase, targets remain a tough ask in our rural setting, improving Quality to hit our top 10% challenge is demanding, meeting public expectations and dealing with less money in the system are all causes for concern; and yet . . . . despite all the difficult situations, choices and pressures, we continue to care; to put patients at the heart of all we do; to give our time, energy and heart into improving our services and into making our hospitals something that we are proud to serve in.

One of the year's most important publications was the NHS Constitution. This is now enshrined in law and outlines

the guiding principles on which the NHS is based. It gives a specific number of pledges and rights to both patients and staff, as well as laying out the responsibilities we all share in making the NHS work effectively and ensuring resources are used responsibly.

As an organisation we wholeheartedly endorse and uphold the NHS Constitution, it is more than just a document. It's about bringing to life our values, about respect, dignity and compassion. More than anything else we will be uncompromising in our efforts to deliver high quality, safe and effective care and provide services that truly are world class.

Phil Morley
Chief Executive

Chapter 9

Annual Accounts

Foreword to the accounts

These accounts for the year ended 31 March 2010 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.

Phil Morley
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").

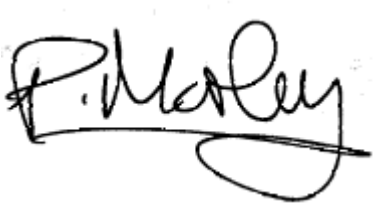
Under the NHS Act 2006, Monitor has directed Mid Cheshire NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs 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.



Philip Morley
Chief Executive

7th June 2010

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 2010 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 2009/10 through 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 Deputy Chief Executive and Director of Nursing, 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 a commissioner representative. The meeting reports directly into a new developed sub-committee of the Board, QuESt (Quality, Effectiveness and Safety Committee) where the information is well 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 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 is assured that proper systems of Information Governance are in place to identify and manage information risks.

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 mitigating actions in place to mitigate them:

Objective Risk	Mitigation
Build influential and well developed relationships regionally and nationally to secure the future of the Trust	Established series of Board to Board meetings with key partners in the economy.
	CEO lead on pathway design group.
	Active member of group considering reconfiguration options across the health economy.
Delivery of Clostridium difficile targets	Cohort ward for CDI patients to reduce risk of organisational transmission and spread. Specific management teams for CDI patients to ensure consistency with management and reduction in movement around the hospital. Ongoing ribotyping for CDI isolates to aid Root Cause Analysis process for the outbreak period.
	Alternative treatment methods for prolonged CDI episodes implemented in collaboration with Consultant Gastroenterologist & Consultant Microbiologist.
	Daily review of CDI cases by Consultant Microbiologist. Monthly review of CDI caseload by CDI Clinical Review Group.
	Enhanced cleaning schedules to ensure environmental hygiene managed appropriately by nursing and domestic staff. Move to clean all inpatient areas with chlorine based agent routinely. Training given by IPCS re cleaning with chlorine. Additional cleaning staff in post and also newly developed Rapid Response Team is about to recruit staff to respond to areas requiring rapid or more thorough cleaning. Cleaning hours and cleaning scores reviewed monthly at the Corporate Environment Group. Increase this year in both the provision of cleaning hours and the cleaning scores for the Trust.

Objective Risk	Mitigation
Delivery of Clostridium difficile targets (continued)	Development of antibiotic audit programme with AB Pharmacist and Microbiologists. Proactive measures by Pharmacy department as part of their overall antibiotic stewardship strategy. Collaborative work with the PCT in relation to AB prescribing in the community.
	Continue with proactive measures that centre around IPC annual work programme. Specific C diff work streams to include review of isolation practices for CDI positive patients, increased training for nursing / medical staff, housekeepers, etc.
	Established governance framework for divisions with comprehensive IPC audit programmes, escalation process for adverse audit results and specific clinical review of practice by the IPCS in line with the Saving Lives Programme.
	Continuation of proactive drive with Bare Below the Elbows by the IPCS. Ongoing review of staff compliance with BBE and corporate image principles.
	Education Programme for 2010/11 to include training sessions at strategic, clinical and practical levels so that all tiers of Infection Prevention are covered in training sessions.
	Continue weekly meeting with HPA, PCT and Trust staff to look at interventions and impact of interventions and to agree next steps. This has included seeking advice from a wide range of external experts.
	Seek contact and advice from organisation that have previously had high profile outbreaks to see if any additional actions can be sought, eg Milton Keynes, Aintree.

Objective Risk	Mitigation
Delivery of MRSA targets	Continue with proactive measures that centre around IPC annual work programme. Specific MRSA bacteramia work streams to include weekly review of all MRSA colonised patients, active declonisation, ANTT training, increased level of cleaning throughout the Trust.
	Additional cleaning staff in post and also newly developed Rapid Response Team is about to recruit staff to respond to areas requiring rapid or more thorough cleaning. Cleaning hours and cleaning scores reviewed monthly at the Corporate Environment Group. Increase this year in both the provision of cleaning hours and the cleaning scores for the Trust.
	Established governance framework for divisions with comprehensive IPC audit programmes, escalation process for adverse audit results, eg hand hygiene audits and specific clinical review of practice by the IPCS in line with the Saving Lives Programme. Local monitoring within divisions in place though divisional governance committees and divisional board reviews. Additionally, monitoring of divisions and corporate implementation of measures will be by the Strategic Infection Control Committee on a quarterly basis.
	Established RCA process led by divisions with evidence of improvement in practice. Specific training by the IPCS ongoing for the completion of RCA's and also for post RCA action planning.
	Continuation of proactive drive with Bare Below the Elbows by the IPCS. Ongoing review of staff compliance with BBE and corporate image principles.
	Education Programme for 2010/11 to include training sessions at strategic, clinical and practical levels so that all tiers of Infection Prevention are covered in training sessions.

Objective Risk	Mitigation
Ensure that the workforce remains safe and fit for purpose	Revised mandatory training and essential training policy in place.
	Regular monitoring of mandatory training attendance at Performance & Finance Committee.
	Plans to link attendance at mandatory training to competency framework.
Develop and implement Trust's Estates Strategy	Action plan agreed with Cheshire Fire & Rescue to address enforcement notices, monitored through Infrastructure Development Committee.
	Full detailed design approved to consider outpatient requirements.
	Major challenge to fund all developments given health economy position and likely future efficiencies required. However, plan for 2010/11 provides funds for essential and committed schemes.
Failure to achieve the planned cost improvement schemes	Close monitoring in place.
	Investment in LEAN support.
	Development of contingency plans.
	Income and Expenditure surpluses and cash balances provide a buffer.

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 fully compliant with the Core Standards for Better Health and has subsequently been 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) Appointment of Equality and Diversity lead officer,

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 has been developed and consulted on,

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.

The Risk Management Team

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 piloted, using "LEAN" principle and practices "right first time", with particular focus on :

a) Theatre productivity;
b) Reducing length of stay;
c) Outpatient efficiency.

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, the Care Quality Commission and its predecessor, the Healthcare Commission, and the Royal Colleges. These have provided further assurance.

The Board has also reviewed recommendations from other high profile reports into the organisations, including the HCC Mid Staffordshire report where a gap analysis of current practices has been undertaken to ensure any similar risks are identified.

The Trust carried out a self-assessment in accordance with the NHS Standards for Better Health core standards and all standards were confirmed as compliant. In addition, a self-assessment was carried out against the NHS Information Governance Toolkit and good compliance at 74%, with internal audit review giving positive 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 are two areas of limited assurance worthy of note.

i) Significant use of non PASA agencies for temporary staffing;
ii) Weaknesses in securing the take up of mandatory training.

Action plans are in place to address these issues as follows :

Non PASA temporary staffing	Plans to reduce bed numbers by reducing length of stay, converting side rooms into bedded areas and reducing admissions.
	Ongoing discussions with other Agencies to reduce costs.
	Increased controls over rostering and approval of non PASA agency staff
Take up of mandatory training	Revised mandatory training policy in place.
	Regular monitoring through Divisional performance review.
	Plans to link attendance at mandatory training to competency framework.

The Board Assurance Framework has also highlighted a number of other risks that are worthy of note as previously discussed.

- Building influential and well developed relationships;
- Deliver all national and local standards;
- Ensure that the workforce remains fit for purpose;
- Develop and implement the Trust's Estates Strategy;
- Failure to achieve planned cost improvements;

I am confident that these risks are being carefully monitored and managed and do not regard them as significant risks.

Signed  date 

P Morley
Chief Executive
Mid Cheshire Hospitals NHS Foundation Trust

Independent Auditors' report to the Board of Governors and Board of Directors of Mid Cheshire Hospitals NHS Foundation Trust

We have audited the financial statements of Mid Cheshire Hospitals NHS Foundation Trust for the year ended 31 March 2010 under the National Health Service Act 2006 ("the Act") 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 35. These financial statements have been prepared in accordance with the accounting policies set out therein. We have also audited the information in the Directors' Remuneration Report that is described as having been audited.

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Mid Cheshire Hospitals NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditors' report and for no other purpose. To the fullest extent permitted by law, we do not, in giving our opinion, accept or assume responsibility to anyone other than the Trust and the Boards, as a body, for this report, or for the opinions we have formed.

Respective Responsibilities of the Accounting Officer and Auditors

The Accounting Officer's responsibilities for preparing the Annual Report, the Directors' Remuneration Report and the financial statements in accordance with directions issued by Monitor – Independent Regulator of NHS Foundation Trusts are set out in the Statement of Accounting Officer's Responsibilities.

Our responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements (including statute and the Audit Code of NHS Foundation Trusts) and International Standards on Auditing (UK and Ireland).

We report to you our opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts and whether the financial statements and the part of the Directors' Remuneration report to be audited have been properly prepared in accordance with the National Health Service Act 2006 and the directions made thereunder by Monitor – Independent Regulator of NHS Foundation Trusts. We also report to you whether in our opinion the information given in the directors' report is consistent with the financial statements.

In addition, we report to you if, in our opinion, the financial statements have not been prepared in accordance with directions made under paragraph 25 of Schedule 7 of the Act, the financial statements do not comply with the requirements of all other provisions contained in, or having effect under, any enactment applicable to the financial statements, or proper practices have not been observed in the compilation of the financial statements.

We review whether the statement on internal control reflects compliance with the requirements of Monitor contained in the NHS Foundation Trust Annual Reporting Manual. We report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the statement on internal control covers all risks and controls. We are also not required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and

control procedures.

We read the other information contained in the Annual Report as described in the contents section and consider whether it is consistent with the audited financial statements. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the financial statements. Our responsibilities do not extend to any further information outside the Annual Report.

Basis of audit opinion

We conducted our audit in accordance with the Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with International Standards on Auditing (UK & Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements and the part of the Directors' Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgements made by the Directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Directors' Remuneration Report to be audited.

Opinion

In our opinion:

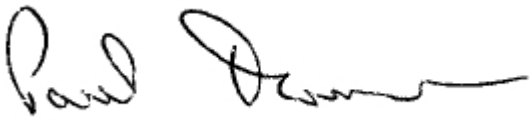
- the financial statements give a true and fair view of the state of affairs of Mid Cheshire Hospitals NHS Foundation Trust as at 31 March 2010 and of its income and expenditure for the year then ended in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts;

- the financial statements and the part of the Directors' Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 2006 and the directions made thereunder by Monitor – Independent Regulator of NHS Foundation Trusts;

- and the information given in the directors' report is consistent with the financial statements.

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 (Senior Statutory Auditor)
For and on behalf of Deloitte LLP
Chartered Accountants
Leeds, UK

Statement of Comprehensive Income for the year ended 31 March 2010

		2009/10	2008/09
	Note	£000	£000
Income from patient care activities	3	**148,320**	137,122
Other operating income	4	**16,182**	14,697
Operating expenses	5-7	**(158,739)**	(151,105)
OPERATING SURPLUS		**5,763**	714
Finance Costs:			
Finance Income	8	**37**	175
Finance expense - financial liabilities	9	**(226)**	(267)
Finance expense - unwinding of discount on provisions		**(30)**	(21)
PDC Dividends paid	29	**(3,586)**	(3,504)
NET FINANCE COSTS		**(3,805)**	(3,617)
SURPLUS / (DEFICIT) FOR THE YEAR		**1,958**	(2,903)
Other comprehensive income			
Revaluation gains and impairment losses property, plant and equipment		**23**	7,706
Increase in the donated asset reserve due to receipt of donated assets		**97**	172
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets		**(127)**	(139)
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**1,951**	4,836

The notes on pages 144 to 190 form part of these accounts.
All revenue and expenditure is derived from continuing operations.

Statement of Financial Position as at 31 March 2010

	Note	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Non-current assets				
Intangible assets	10	**669**	489	299
Property, plant and equipment	11	**108,391**	107,810	107,130
Trade and other receivables	15	**416**	393	419
Total non-current assets		**109,476**	**108,692**	**107,848**
Current assets				
Inventories	14	**3,091**	2,581	2,328
Trade and other receivables	15	**6,938**	6,538	5,726
Cash and cash equivalents	25	**6,053**	4,825	340
Non-current assets held for sale	13	**3**	-	-
Total current assets		**16,085**	**13,944**	**8,391**
Current liabilities				
Trade and other payables	18	**(10,646)**	(10,203)	(9,165)
Borrowings	20	**(1,454)**	(1,831)	(1,729)
Provisions	23	**(577)**	(284)	(284)
Tax Payable	18	**(2,145)**	(1,963)	(1,863)
Other liabilities	19	**(434)**	(237)	-
Total current liabilities		**(15,256)**	**(14,518)**	**(13,041)**
Total assets less current liabilities		**110,305**	**108,118**	**103,201**
Non-current liabilities				
Trade and other payables	18	**(31)**	(101)	(117)
Borrowings	20	**(3,192)**	(3,678)	(4,062)
Provisions	23	**(1,368)**	(953)	(972)
Total non-current liabilities		**(4,591)**	**(4,732)**	**(5,151)**
Total assets employed		**105,714**	**103,386**	**98,050**
Financed by taxpayers equity				
Public dividend capital		**49,946**	49,569	49,069
Income and expenditure reserve		**10,180**	8,088	10,930
Revaluation reserve	24	**43,517**	43,628	35,439
Donated asset reserve		**2,071**	2,101	2,612
Total taxpayers' equity		**105,714**	**103,386**	**98,050**

The financial statements on pages 149 to 196 were approved by the Board and signed on its behalf on 7 June 2010

Chief Executive

Statement of Changes in Taxpayers' Equity as at 31 March 2010

	Public dividend capital (PDC)	Retained Earnings	Revaluation Reserve	Donated asset Reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2009	**49,569**	**8,088**	**43,628**	**2,101**	**103,386**
Retained surplus for the year	-	1,958	-	-	**1,958**
Revaluation gains / (losses) and impairment losses property, plant and equipment	-	(4)	27	-	**23**
Increase in the donated asset reserve due to receipt of donated assets	-	-	-	97	**97**
Reduction in the donated asset reserve in respect of depreciation impairment, and/or disposal of on donated assets	-	-	-	(127)	**(127)**
Transfer of the excess of current cost depreciation to the Income and Expenditure Reserve	-	138	(138)	-	**-**
Public Dividend Capital received	377	-	-	-	**377**
Taxpayers' Equity at 31 March 2010	**49,946**	**10,180**	**43,517**	**2,071**	**105,714**

Statement of Changes in Taxpayer's Equity as at 31 March 2009

	Public dividend capital (PDC)	Retained Earnings	Revaluation Reserve	Donated asset Reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2008	**49,069**	**10,930**	**35,439**	**2,612**	**98,050**
Retained surplus for the year	-	(2,903)	-	-	**(2,903)**
Revaluation gains / (losses) and impairment losses property, plant and equipment	-	-	8,250	(544)	**7,706**
Increase in the donated asset reserve due to receipt of donated assets	-	-	-	172	**172**
Reduction in the donated asset reserve in respect of depreciation impairment, and/or disposal of on donated assets	-	-	-	(139)	**(139)**
Transfer of the excess of current cost depreciation to the Income and Expenditure Reserve	-	37	(37)	-	**-**
Other Transfers between reserves	-	24	(24)	-	**-**
Public Dividend Capital received	500	-	-	-	**500**
Taxpayers' Equity at 31 March 2009	**49,569**	**8,088**	**43,628**	**2,101**	**103,386**

Statement of Cash Flows for the Year Ended 31 March 2010

	2009/10	2008/09
	£000	£000
Cash flows from operating activities		
Operating surplus	5,763	714
Non-Cash income and expense		
Depreciation and amortization	**5,131**	5,115
Impairment and reversals	**8**	7,084
Transfer from donated asset reserve	**(127)**	(139)
Increase in trade and other receivables	**(423)**	(786)
Increase in Inventories	**(510)**	(253)
Increase in trade and other payables	**677**	1,166
Increase in other current liabilities	**197**	237
Increase in provisions	**708**	(19)
Tax paid	**182**	100
Other movements in operating cash flows	**(70)**	(21)
Net cash generated from operations	**11,536**	13,198
Cash flows from investing activities		
Interest received	**37**	175
Payments for intangible assets	**(276)**	(293)
Payments for property, plant and equipment	**(4,794)**	(3,496)
Sales of plant property and equipment	**45**	15
Net cash used in investing activities	**(4,988)**	(3,599)
Cash flows from finance activities		
Public dividend capital received	**377**	500
Capital element of finance lease rental payments	**(1,995)**	(2,015)
Interest element of finance lease	**(226)**	(267)
Public Dividend Capital paid	**(3,573)**	(3,504)
Cash flows from other financing activities	**97**	172
Net cash used in financing activities	**(5,320)**	(5,114)
Increase in cash and cash equivalents	**1,228**	4,485
Cash and Cash equivalents at 1 April	**4,825**	340
Cash and Cash equivalents at 31 March	**6,053**	4,825

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 2009/10 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 Annual Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

1.2 Acquisitions and discontinued operations

Activities are considered to be '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 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

For 2009/10 and 2010/11 only: The NHS charitable funds associated with the foundation trust which are administered via a corporate trustee arrangement are excluded from consolidation in accordance with the accounting direction issued by Monitor.

Joint Ventures

Joint ventures are separate entities over which the Trust has joint control with one or more other parties. Control is defined as having the power to exercise control or as having a dominant influence so as to gain economic or other benefits.

The Trust since 27 March 2009 has been part of the Central Cheshire Urgent Primary Care Consortium providing urgent care facilities on the Leighton hospital

site. The joint venture 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 positiont 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 1.6 Revenue.

Provisions The Trust is party to a number of employer and public liability claims which are detailed in note 23. 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 2010 is £69,923.

Employees Expenses At 31st March 2010 the accrual for outstanding holidays is £720,000 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 80% 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 Retirement benefit 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 in that 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. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

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 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 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

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. 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. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

The scheme provides the opportunity to members to increase their benefits through money purchase additional voluntary contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.8 Property, plant and equipment

Capitalisation

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- individually have a cost of at least £5,000; or
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are and its under single managerial control; or
- form part of the initial equipping and 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.

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 buildings revalued as at 1st April 2008 and 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.

Increases arising on revaluation are taken to the revaluation reserve except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. A revaluation decrease is charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter are charge 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'.

1.9 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.

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is charged to the statement of comprehensive income in the period in which it is incurred. The Trust currently only has research activities which are recognised as an expense.

Following initial recognition, 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.

1.10 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.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the statement of comprehensive income.

Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to the statement of comprehensive income to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.11 Borrowing costs

Borrowing costs are recognised as expenses as they are incurred.

1.12 Donated assets

Donated 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.

1.13 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.

1.14 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.

1.15 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. Leased land is treated as an operating lease.

1.16 Private Finance Initiative (PFI) transactions

The Trust has not entered into any PFI transactions.

1.17 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.

1.18 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.

1.19 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the statement of financial postion date, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury’s discount rate of 2.2% in real terms, only where the time value of money is significant.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arsing from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.20 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 23. 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 2009/10 relates to the Trust’s contribution to the Clinical Negligence Scheme for Trusts.

1.21 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.

1.22 EU Emissions Trading Scheme

The Trust is exempt from participating in the EU emissions trading scheme.

1.23 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 postion date, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of ore or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the statement of comprehensive income and the carrying amount of the asset is reduced directly, or through a provision for

impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the statement of comprehensive income to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.24 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.

1.25 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.

1.26 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.

1.27 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.

1.28 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 24 to the accounts.

1.29 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 forecast cost of capital utilised by the NHS foundation trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held with the Office of the Paymaster General. Average relevant net assets are calculated as a simple mean of opening and closing relevant net assets. A note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year.

1.30 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 34 is compiled directly from the losses and compensation register which is prepared on a cash basis.

1.31 Accounting Standards

The following standards and interpretations have been adopted by the European Union but are not required to be followed until 2010/11. The expected impact on the Trust's financial statements has not yet been considered.

- IAS 27 (Revised) Consolidated and separate financial statements
- Amendment to IAS 32 Financial Instruments: Presentation on classification or rights issues
- Amendments to IAS 39 Eligible Hedged Items
- IFRS3 (Revised) Business Combinations
- IFRIC 17 Distributions to Non-Cash Assets to Owners
- IFRIC 18 Transfer of Assets from Customers

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 meeting.

The Trust receives 91% 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:

	2009/10	2008/09
	£000	£00
Elective Income	**26,083**	25,980
Non Elective Income	**61,037**	56,492
Outpatient Income	**26,773**	26,852
A & E Income	**5,882**	5,816
Other NHS Clinical Income	**25,880**	19,394
Income from activities (before private patient income)	**145,655**	134,354
Other non-protected clinical income	**2,392**	2,325
Private patient income	**273**	263
Total Activity Income	**148,320**	137,122

The elective and non elective income reflects the levels of incomplete spells as at 31st March 2010. The movement in year impacting on the recognised income is £502,000, of which £507,000 is due to a change in price and a reduction of £5,000 due to a change in volume.

Included in Other NHS Clinical Income is £182,000 which relates to the Trusts share of the income generated by the Central Cheshire Urgent Primary Care Consortium joint venture

Injury Cost Recovery income included in 'Other non-protected clinical income' is subject to a provision for doubtful debts of 7.8% 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

			Base Year
	2009/10	2008//09	2002/03
	£000	£000	£000
Private patient income	**273**	263	257
Total patient income	**145,746**	134,648	79,862
%	**0.2%**	0.2%	0.3%

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 2009/10.

4. Other Operating Income

	2009/10	2008/09
	£000	£000
Education and training	**5,218**	5,176
Charitable and other contributions to expenditure	**41**	78
Transfers from donated asset reserve in respect of depreciation on donated assets	**127**	139
Non-patient care services to other bodies	**7,890**	6,630
Other	**2,861**	2,674
Profit on disposal of other tangible assets	**43**	0
Gain on asset held for sale	**2**	-
Total other operating income	**16,182**	**14,687**

4.1 Operating Lease Income

	2009/10	2008/09
Operating Lease Income	**£000**	£000
Rents recognised in the period	**36**	12
Total	**36**	12
Future minimum lease payments due		
Not later than one year	**36**	35
Later than one year but not later than five years	**64**	98
Later than five years	**191**	192
Total	**291**	325

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:

	2009/10	2008/09
	£000	£000
Employee expenses - staff	**112,042**	102,446
Supplies and services - clinical	**11,771**	11,512
Depreciation on property, plant and equipment	**5,015**	5,016
Amortisation on intangible assets	**116**	99
Impairments of property, plant and equipment	**8**	7,084
Premises	**6,078**	6,022
Drug Costs	**8,037**	7,161
Clinical negligence	**2,741**	1,833
Other	**1,844**	1,172
Consultancy services	**94**	139
Supplies and services - general	**2,195**	1,927
Printing, stationery, travel and recruitment advertising	**1,912**	1,969
Services from other NHS Trusts	**1,031**	1,096
Directors' costs	**845**	723
Non-Executives Costs	**131**	114
Services from other NHS bodies	**2,156**	156
Transport	**567**	568
Auditors' remuneration	**82**	53
Services from Foundation Trusts	**523**	933
Purchase of healthcare from non NHS bodies	**39**	77
Provision for impairment of receivables (including provision against Road Traffic income)	**159**	138
Legal Fees	**105**	84
Hospitality	**47**	76
Redundancies	**381**	-
Training Courses and Conferences	**582**	457
Patient Travel	**21**	27
Insurances	**112**	111
Other services	**91**	40
Losses, ex gratia and special payments	**9**	57
Loss on disposal of other property, plant and equipment	**5**	15
Total	**158,739**	151,105

Included above is £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:

	2009/10	2008/09
	£000	£000
Fees payable to the company's auditors for the audit of the company's annual accounts	62	53
Total audit fees	62	53
Other services	20	-
Total non-audit fees	20	-

5.3 Operating Leases

5.3.1 Arrangements containing an operating lease

	2009/10	2008/09
	£000	£000
Minimum lease payments	295	314
Total	295	314

There are no significant leasing arrangements included in the above.

5.3.2 Arrangements containing an operating lease

Future minimum lease payments due:	2009/10	2008/09
	£000	£000
Not later than one year	161	290
Later than one year and not later than five years	113	231
Later than five years	-	-
Total	274	521
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 2010	Other Remunera-tion	Superan-nuation Contribu-tions	Total Emolu-ments 2010	Total Emolu-ments 2009	Benefits in Kind* 2010	Benefits in Kind* 2009
		£000	£000	£000	**£000**	**£000**	£00	£00
Board								
Moran J	Chairman	45	-	-	**45**	**34**	-	-
Wood A	Acting Chairamn (to 30/06/08)	-	-	-	**-**	**6**	-	-
Godfrey V	Non-Executive (from 01/05/09)	12	-	-	**12**	**9**	-	-
Hopewell D	Non-Executive	15	-	-	**15**	**15**	-	-
Wood A	Senior Independent Director and Deputy Chairman (from 01/07/09)	15	-	-	**15**	**18**	-	-
Chandler M	Non-Executive	12	-	-	**12**	**12**	-	-
Craig WD	Non-Executive	12	-	-	**12**	**12**	-	-
Dunn D	Non-Executive (from 01/05/09)	10	-	-	**10**	**-**	-	-
Morley P	Chief Executive	147	-	21	**168**	**160**	151	164
Goodwin D	Director of Finance (until 31/03/09)	-	-	-	**-**	**110**	-	47
Oldham M	Director of Finance (from 01/04/09)	97	-	14	**111**	**-**	47	-
Alcock R	Director of Workforce and Service Development	88	-	12	**100**	**99**	49	49
Bullock T	Chief Operating Officer and Director of Nursing	107	-	15	**122**	**114**	-	-
Frodsham D	Director of Business Development	89	-	12	**101**	**96**	63	26
Dodds P	Medical Director	144	16	22	**182**	**171**	-	-
Total Board Members Remuneration		**793**	**16**	**96**	**905**	**856**	**310**	**286**
Employers NI					**87**	**82**	-	-
Total Board Members Remuneration including Employers NI and Superannuation					**992**	**938**	310	-

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5.4 (A) Senior Manager remuneration and benefits - Emoluments (cont.)

Name	Title	Gross Pay 2010	Other Remunera-tion	Superan-nuation Contribu-tions	Total Emolu-ments 2010	Total Emolu-ments 2009	Benefits in Kind* 2010	Benefits in Kind* 2009
		£000	£000	£000	**£000**	**£000**	£00	£00
Associate Directors' and Board Secretary Costs								
Oldham M	Director of Finance Designate (until 31/03/09)	-	-	-	**-**	**84**	-	36
Ennis A	Director of Service Development	71	-	10	**81**	**72**	-	-
Park J	Board Secretary (to 31/12/08)	-	-	-	**-**	**56**	-	52
Total Associate Directors' and Board Secretary Remuneration		**71**	**-**	**10**	**81**	**212**	**-**	**88**
Employers NI					**7**	**18**	**-**	**-**
Total Associate Directors' and Board Secretary Remuneration including Employers NI and Superannuation					**88**	**230**	**-**	**-**
Total "Senior Employees"		**864**	**16**	**106**	**986**	**1,068**	**310**	**374**
Employees NI					**94**	**100**	**-**	**-**
Total Senior Employees inc Employers NI and Superannuation					**1,080**	**1,168**	**310**	**374**

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

Name	Title	Real increase in pension and related lump sum at age 60	Total accrued pension at age 60 at 31 March 2010	Total accrued lump sum at age 60 at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2009	Real Increase in Cash Equivalent Transfer Value
		£000	£000	£000	£000	£000	£000
Board Members							
Morley P	Chief Executive	7	47	141	784	683	47
Bullock T	Chief Operating Officer & Director of Nursing	26	35	104	554	409	87
Dodds P	Medical Director	24	49	146	893	749	75
Oldham M	Director of Finance	17	29	89	448	313	84
Alcock R	Director of Workforce and Development	3	25	76	355	312	19
Frodsham D	Director of Business Development	6	24	71	445	376	35
Associate Directors							
Ennis A	Director of Service Development	17	25	76	432	331	59

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

	2009/10	2008/09
	£000	£000
Salaries and wages	**91,232**	83,600
Social Security Costs	**5,928**	5,867
Employer contributions to NHS Pensions Authority	**10,146**	9,369
Agency and contract staff	**5,581**	4,332
Total	**112,887**	103,168

6.2 Average number of persons employed

	Total 2009/10 Number	Other permanent employees Number	Directors Number	Other Number	Total 2008/09 Number
Medical and Dental	**271**	271	-	-	270
Administration and Estates	**653**	646	7	-	611
Healthcare Assistants and other support staff	**433**	433	-	-	363
Nursing, midwifery and health visiting staff	**499**	799	-	-	760
Scientific, therapeutic and technical staff	**402**	402	-	-	415
Bank and agency	**241**		-	214	196
Other	**283**	283	-	-	271
Total	**3,055**	2,834	7	214	2,886

6.3 Employee Benefits

Other than at note 5.3(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 2009/10 there was 1 (2008/09: 6) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £4,242 (£330,735). The cost of these ill-health retirements will be borne by the NHS Business Services Authority – Pensions Division.

7. Better Payment Practice Code

7.1 Better Payment Practice Code - measure of compliance

	2009/10		2008/09	
	Number	**£000**	Number	£000
Total Non NHS trade bills paid in the year	**48,076**	**78,266**	47,182	74,510
Total Non NHS trade bills paid within target	**46,278**	**76,273**	44,779	73,049
Percentage of Non NHS trade bills paid within target	**96%**	**97%**	95%	98%
Total NHS trade bills paid in the year	**2,271**	**23,909**	2,390	17,252
Total NHS trade bills paid within target	**2,126**	**22,752**	2,282	15,110
Percentage of NHS trade bills paid within target	**94%**	**95%**	95%	88%

7.2 The Late Payment of Commerical Debts (Interest) Act 1998

The Trust had no interest payable for the year ended 31 March 2009 under the Late Payment of Commercial Debts (Interest) Act 1998.

8. Finance Income

	2009/10	2008/09
	£000	£000
Interest on loans and receivables	**37**	175
Total	**37**	175

9. Finance Costs

9.1 Finance Cost - Interest Expense

	2009/10	2008/09
	£000	£000
Interest on obligations under finance lease	**226**	267
Total	**226**	267

9.2 Impairment of Assets

	2009/10	2008/09
	£000	£000
Loss or damage from normal operations	8	-
Unforeseen Obsolescence	-	10
Changes in market price	-	15,591
Total	8	15,601

10. Intangible Fixed Assets

	Total 2010
	£000s
Gross cost at 1 April 2009	806
Reclassifications	20
Additions purchased	276
Gross cost at 31 March 2010	1,102
Amortisation at 1 April 2009	317
Provided during the year	116
Amortisation at 31 March 2010	433
Net book value	
Total purchased at 1 April 2009	489
Total purchased at 31 March 2010	669

Prior year:

	Total 2009
	£000s
Gross cost at 1 April 2008	517
Reclassifications	(4)
Additions purchased	293
Gross cost at 31 March 2009	806
Amortisation at 1 April 2008	218
Provided during the year	99
Amortisation at 31 March 2009	317
Net book value	
Total purchased at 1 April 2009	299
Total purchased at 31 March 2010	489

The reclassification is the transfer from tangibles assets under construction to intangibles.

All intangible assets are classed as software and licenses.

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 constrcution & payments on account	Plant & Machinery	Transport	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	**9,280**	**83,685**	**3,783**	**726**	**21,365**	**52**	**3,742**	**228**	**122,861**
Additions - purchased	-	3,734	139	123	1,179	-	339	-	5,314
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)
Cost or valuation at 31 March 2010	9,280	88,058	3,922	171	20,334	16	4,031	228	126,040
Accumulated depreciation at 1 April 2009	-	1,699	75	-	11,361	43	1,805	68	15,051
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)
Accumulated depreciation at 31 March 2010	**-**	**3,286**	**157**	**-**	**11,714**	**14**	**2,375**	**103**	**17,649**

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11.1 Tangible fixed assets at the statement of financial position date comprise the following elements (cont)

	Land	Buildings excluding dwellings	Dwellings	Assets under constrcution & payments on account	Plant & Machinery	Transport	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net Book Value									
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
NBV total at 1 April 2009	**9,280**	**81,986**	**3,708**	**726**	**10,004**	**9**	**1,937**	**160**	**107,810**
Net Book Value									
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	-	1,663	-	-	403	-	-	-	2,071
NBV total at 31 March 2010	**9,280**	**84,772**	**3,765**	**171**	**8,620**	**2**	**1,656**	**125**	**108,391**

Prior year:

	Land	Buildings excluding dwellings	Dwellings	Assets under constrcution & payments on account	Plant & Machinery	Transport	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2008	**4,026**	**89,919**	**4,491**	**4,193**	**20,085**	**52**	**3,838**	**228**	**126,832**
Additions - purchased	-	1,086	330	691	2,733	-	73	-	4,913
Additions - donated	-	17	-	-	155	-	-	-	172
Impairments charged to revaluation reserve	-	(18,053)	(1,037)	-	(14)	-	-	-	(19,104)
Revaluation surpluses	5,254	6,796	-	-	-	-	-	-	12,050
Transferred to disposal group as asset held for sale	-	-	-	-	(213)	-	-	-	(213)
Reclassifications	-	3,955	(1)	(4,158)	(12)	-	220	-	4
Disposals	-	(35)	-	-	(1,369)	-	(389)	-	(1,793)
Cost or valuation at 31 March 2009	9,280	83,685	3,783	726	21,365	52	3,742	228	122,861
Accumulated depreciation at 1 April 2008	-	7,789	-	-	10,306	32	1,542	33	19,702
Provided during the year	-	1,571	75	-	2,672	11	652	35	5,016
Impairments recognised in operating expense	-	(3,499)	-	-	(4)	-	-	-	(3,503)
Revaluation surpluses	-	(4,173)	-	-	-	-	-	-	(4,173)
Transferred to disposal group as asset held for sale	-	-	-	-	(213)	-	-	-	(213)
Reclassifications	-	46	-	-	(46)	-	-	-	-
Disposals	-	(35)	-	-	(1,354)	-	(389)	-	(1,778)
Accumulated depreciation at 31 March 2009	**-**	**1,699**	**75**	**-**	**11,361**	**43**	**1,805)**	**68**	**15,051**

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Prior year (cont):

	Land	Buildings excluding dwellings	Dwellings	Assets under constrcution & payments on account	Plant & Machinery	Transport	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net Book Value									
NBV - Purchased at 1 April 2008	4,026	79,791	4,491	4,193	3,532	-	1,587	47	97,667
NBV - Finance Lease at 1 April 2008	-	85	-	-	5,889	20	709	148	6,851
NBV - Donated at 1 April 2008	-	2,254	-	-	358	-	-	-	2,612
NBV total at 1 April 2008	**4,026**	**82,130**	**4,491**	**4,193**	**9,779**	**20**	**2,296**	**195**	**107,130**
Net Book Value									
NBV - Purchased at 31 March 2009	9,280	80,243	3,708	724	3,759	-	1,505	41	99,260
NBV - Finance Lease at 31 March 2009	-	49	-	-	5,839	9	432	119	6,448
NBV - Donated at 31 March 2009	-	1.694	-	2	406	-	-	-	2,102
NBV total at 31 March 2009	**9,280**	**81,986**	**3,708**	**726**	**10,004**	**9**	**1,937**	**160**	**107,810**

In 2008/09 the land and buildings under went a revaluation by DTZ who are professionally qualified valuers. The valuation was carried out on a modern equivalent valuation basis.

11.2 Analysis of tangible fixed assets

	Land	Buildings Excluding Dwellings	Dwellings	Assets under Construction and payments on account	Plant & Machinery	Transport	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
Total at 31 March 2010	**9,280**	**84,772**	**3,765**	**171**	**8,620**	**2**	**1,656**	**125**	**108,391**

	Land	Buildings Excluding Dwellings	Dwellings	Assets under Construction and payments on account	Plant & Machinery	Transport	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value									
Protected 31 March 2009	8,686	78,376	-	-	-	-	-	-	87, 061
Unprotected 31 March 2009	595	3,610	3,708	726	10,004	9	1,937	160	20,749
Total at 31 March 2009	**9,280**	**81,986**	**3,708**	**726**	**10,004**	**9**	**1,937**	**160**	**107,810**

11.3 Economic life of property, plant and equipment

	Min. Life	Max. Life
Land		
Buildings excluding dwellings	4	89
Dwellings	28	48
Assets under construction	15	89
Plant & machinery	3	10
Information Technology	3	10
Furniture and Fittings	5	10

11.4 Assets held at open market value

At the statement of financial postion date there was no land, buildings or dwellings valued at open market value.

12. Finance Lease Assets

12.1 Net book value of assets held under finance leases and hire purchase contracts at the statement of financial position date

	Land	Buildings excluding dwellings	Dwellings	Assets under constrcution & payments on account	Plant & Machinery	Transport	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	**-**	**213**	**-**	**-**	**10,884**	**52**	**1,349**	**173**	
Additions - purchased	-	-	-	-	1,134	-	-	-	
Disposals	-	-	-	-	(625)	(36)	(41)	-	
Cost or valuation at 31 March 2010	-	213	-	-	11,393	16	1,308	173	
Accumulated depreciation at 1 April 2009	-	164	-	-	5,044	43	917	54	6,222
Provided during the year	-	36	-	-	1,767	6	248	29	2,096
Disposals	-	-	-	-	(627)	(35)	(40)	-	(702)
Accumulated depreciation at 31 March 2010	**-**	**200**	**-**	**-**	**6,184**	**14**	**1,125**	**83**	**7,606**

Net Book Value									
NBV - Purchased at 1 April 2009	-	49	-	-	5,840	9	432	119	6,449
NBV - Donated at 1 April 2009	-	-	-	-	-	-	-	-	-
NBV total at 1 April 2009	**-**	**49**	**-**	**-**	**5,840**	**9**	**432**	**119**	**6,449**
Net Book Value									
NBV - Purchased at 31 March 2010	-	13	-	-	5,209	2	183	90	5,497
NBV - Donated at 31 March 2010	-	-	-	-	-	-	-	-	-
NBV total at 31 March 2010	**-**	**13**	**-**	**-**	**5,209**	**2**	**183**	**90**	**5,497**

Prior year:

	Land	Buildings excluding dwellings	Dwellings	Assets under constrcution & payments on account	Plant & Machinery	Transport	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2008	**-**	**248**	**-**	**-**	**9,776**	**52**	**1,721**	**173**	**11,970**
Additions - purchased	-	-	-	-	1,716	-	17	-	1,733
Disposals	-	(35)	-	-	(608)	-	(389)	-	(1,032)
Cost or valuation at 31 March 2010	-	213	-	-	10,884	52	1,349	173	12,671
Accumulated depreciation at 1 April 2009	-	163	-	-	3,884	32	1,012	25	5,116
Provided during the year	-	36	-	-	1,768	11	294	29	2,138
Disposals	-	(35)	-	-	(608)	-	(389)	-	(1,032)
Accumulated depreciation at 31 March 2010	**-**		**-**	**-**	**5,044**	**43**	**917**	**54**	**6,222**

Net Book Value									
NBV - Purchased at 1 April 2009	-	85	-	-	5,892	20	709	148	6,854
NBV - Donated at 1 April 2009	-	-	-	-	-	-	-	-	-
NBV total at 1 April 2009	**-**	**85**	**-**	**-**	**5,892**	**20**	**709**	**148**	**6,854**
Net Book Value									
NBV - Purchased at 31 March 2010	-	49			5,840	9	432	119	6,449
NBV - Donated at 31 March 2010	-								
NBV total at 31 March 2010	**-**	**49**			**5,840**	**9**	**432**	**119**	**6,449**

13. Non-Current Assets for Sale and Assets in Disposal Groups

Non-current assets for sale and assets in disposal groups 2009/10	Total
	£000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2009	-
Plus assets classified as available for sale in the year	3
NBV of non-current assets for sale and assets in disposal groups at 31 March 2009	3

A Harmonic Scalpel generator has been transferred to non-current assets for sale due to surplus to requirements. 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.

There were a number of assets held for sale in 2008/09, however the net book value of these items was nil.

14. Inventories

	2010	2009	2008
	£000	£000	£000
Materials	**3,091**	2,581	2,328
Total	**3,091**	2,581	2,328

15. Trade and Other Receivables

	2010	2009	2008
	£000	£000	£000
Current:			
NHS receivables	**4,401**	3,946	2,811
Provisions for impaired receivables	**(191)**	(174)	(85)
Prepayments	**752**	743	784
Other receivables	**1,976**	2,023	2,216
Total current trade & other receivables	**6,938**	6,538	5,726
Non-current:			
Other receivables	**451**	426	455
Provision for impaired receivables	**(35)**	(33)	(36)
Total non-current trade and other receivables	**416**	393	419
Total trade and other receivables	**7,354**	6,931	6,145

15.1 Provision for impairment of receivables

	2009/10	2008/09
	£000	£000
At 1 April	**207**	121
Increase in provision	**165**	155
Amounts utilized	**(140)**	(52)
Unused amounts reversed	**(6)**	(17)
At 31 March	**226**	207

Included above is a provision of £120,000 which is based on 7.8% on the outstanding receivables from the Compensation Recovery Unit. Also provided is £80,000 for services provided to another NHS organisation.

15.2 Ageing of receivables

Ageing of impaired receivables	31 March 2010	31 March 2009
	£000	£000
Up to three months	**36**	29
In three to six months	**37**	29
Over six months	**153**	149
Total	**226**	207

Ageing of non impaired receivables past their due date	31 March 2010	31 March 2009
	£000	£000
Up to three months	**1,389**	830
In three to six months	**39**	41
Over six months	**14**	38
Total	**1,442**	909

16. Other Financial Assets

The Trust had no other financial assets as at 31 March 2010 or 31 March 2009.

17. Other Current Assets

The Trust had no other current assets as at 31 March 2010 or 31 March 2009.

18. Trade and Other Payables

18.1 Trade and other payables at the statement of financial position date are made up of

	2010	2009	2008
	£000	£000	£000
Current:			
NHS Payables	**2,696**	2,554	2,302
NHS Pensions	**1,270**	1,192	1,067
Trade Payables Capital	**714**	1,032	1,176
PDC Payable	**13**	-	-
Other payables	**135**	178	136
Other Trade payables	**3,049**	2,827	2,728
Accruals	**2,769**	2,420	1,756
Total Trade and other payables	**10,646**	10,203	9,165
Taxes Payable	**2,145**	1,963	1,863
Total Taxes Payable	**2,145**	1,963	1,863
Non-current:			
Other payables	**31**	101	117
Total non-current trade and other payables	**31**	101	117
	12,822	12,267	11,145

19. Other Liabilities

	2010	2009	2008
	£000	£000	£000
Current:			
Deferred income	**434**	237	-
Total	**434**	237	-

20. Borrowings

	2010	2009	2008
	£000	£000	£000
Current:			
Obligations under finance lease	**1,454**	1,831	1,729
Total current borrowings	**1,454**	1,831	1,729
Non-current:			
Obligations under finance lease	**3,192**	3,678	4,062
Total non-current borrowings	**3,192**	3,678	4,062

21. 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 five 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 2010	31 March 2009
	£000	£000
Total long term borrowing limit set by Monitor	**31,000**	19,000
Working capital facility agreed by Monitor	**11,000**	11,000
Total Prudential Borrowing limit	**42,000**	30,900
Long term borrowing at 1 April	**5,509**	5,791
Net actual borrowing (repayment) in year - long term	**(863)**	(282)
Long term borrowing at 31 March	**4,646**	5,509
Working capital borrowing at 1 April	**-**	-
Net actual borrowing (repayment) in year - working capital	**-**	-
Working capital borrowing at 31 March	**-**	-

The five ratio tests and the Trust's performance against them is set out below;

Financial Ratios	Actual 2009/10	Approved 2009/10	Actual 2008/09	Approved 2008/09
Maximum debt / Capital Ratio	**3.7%**	**4.1%**	**0%**	**0%**
Minimum Dividend cover	**3.0x**	**3.3x**	**3.0x**	**3.1x**
Minimum Interest cover	**48.2x**	**63.9x**	**-**	**-**
Minimum Debt Service cover	**4.9x**	**6.1x**	**-**	**-**
Maximum Debt Service to Revenue	**1.4%**	**1.2%**	**0%**	**0%**

The approved financial ratios are those submitted to Monitor as part of the Trust's 2009/10 financial plans.

The ratios in the comparative year 2008/09 are based on no debt being held under UK GAAP rules.

22. Finance Lease Obligations

Minimum Lease Payments	**2009/10**	**2008/09**
	£000	**£000**
Gross liabilities	**5,031**	6,018
of which liabilities are due		
not later than 1 year	**1,613**	1,981
later than 1 year but not later than 5 years	**3,407**	3,713
later than five years	**11**	324
Finance charges allocated to future periods	**(385)**	(509)
Net lease liabilities	**4,646**	5,509
not later than 1 year	**1,454**	1,785
later than 1 year but not later than 5 years	**3,181**	3,411
later than five years	**11**	313

Present Value of Minimum Lease Payments	**2009/10**	**2008/09**
	£000	**£000**
Gross liabilities	**4,646**	5,509
of which liabilities are due		
not later than 1 year	**1,454**	1,785
later than 1 year but not later than 5 years	**3,181**	3,411
later than five years	**11**	313
Net lease liabilities	**4,646**	5,509
not later than 1 year	**1,454**	1,785
later than 1 year but not later than 5 years	**3,181**	3,411
later than five years	**11**	313

23. Provisions for Liabilities and Charges

	Current			Non-Current		
	2010	2009	2008	**2010**	2009	2008
Legal Claims	**70**	100	113	**-**	-	-
Pensions	**104**	84	81	**1,368**	953	972
Other	**403**	100	90	**-**	-	-
Total	**577**	**284**	**284**	**1,368**	**953**	**972**

	Legal Claims	Pensions	Other	Total
	£000	**£000**	**£000**	**£000**
At 1 April 2009	**100**	**1,037**	**100**	**1,237**
Change in the discount rate	-	-	-	**-**
Arising during the year	34	492	403	**929**
Utilised during the year	(22)	(87)	-	**(109)**
Reversed unused	(42)	-	(100)	**(142)**
Unwinding of discount	-	30	-	**30**
At 31 March 2010	70	1,472	403	**1,945**
Expected timing of cash flows:				
Not later than 1 year	70	104	403	**577**
Later than 1 year and not later than 5 years	-	393	-	**393**
Later than five years	-	975	-	**975**
At 31 March 2010	70	1,472	403	**1,945**

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.

£33,000 is included in the provision of the NHSLA at 31 March 2010 in respect of the ELS liabilities of the Trust (for which NHSLA is administratively responsible but the Trust has legal liability (2008/09: £9,750).

Financial responsibility for all other clinical negligence claims transferred to the NHS Litigation Authority (NHSLA) on 1 April 2002.

£22,049,268 (2008/09: £16,408,612) is included in the provision of the NHSLA at 31 March 2010 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 28.

24. Revaluation Reserve

Movements on reserves in the year comprised the following:

	Total - 2010
	£000
Revaluation reserve at 1 April 2009	**43,628**
Prior Period Adjustment	**-**
Revaluation reserve at 1 April 2009 as restated	**43,628**
Revaluation gains / (losses) and impairment losses property, plant and equipment	27
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	**(138)**
At 31 March 2010	**43,517**

Prior period:

	Total - 2009
	£000
Revaluation reserve at 1 April 2008	**35,439**
Prior Period Adjustment	**-**
Revaluation reserve at 1 April 2009 as restated	**35,439**
Revaluation gains / (losses) and impairment losses property, plant and equipment	8,250
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	**(37)**
Movements on other reserves	(24)
At 31 March 2009	**43,517**

25. Cash and Cash Equivalents

	31 March 2010	31 March 2009
	£000	£000
At 1 April	**4,825**	340
Net change in year	**1,228**	4,485
At 31 March	**6,053**	4,825
Broken down into:		
Cash at commercial bank and in hand	**4,805**	3,623
Cash with Government Banking Service	**1,247**	1,202
Other current investments	**1**	-
Cash and Cash equivalents as in SoFP	**6,053**	4,825
Bank overdraft	**-**	-
Cash and Cash equivalents as in SoCF	**6,053**	4,825

The other current investments relates to the Trust's share of the cash balance held by the Central Cheshire Urgent Primary Care Consortium joint venture.

26. Capital Commitments

Commitments under capital expenditure contracts at the statement of financial position date were £372,000 (2008/09 : £730,000).

The commitments are for Management Information Patient Level Costing £160,000, Maternity System £90,000, Digital Dictation £28,000, Fire Measures £12,000 and Generators Synchronisation £82,000.

27. Post Balance Sheet Events

There are no post balance sheet events requiring disclosure.

28. 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 2009/10 accounts. A prudent estimate of the amount involved, inclusive of legal cost is:

	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

	Clinical Negligence	Other Legal	Total
	2009	2009	2009
	£000	£000	£000
Total value of contingent disputed claims	10,372	**448**	10,820
Amount recoverable under insurance arrangements in the event of these claims being successful - payable by NHSLA	(10,372)	**(290)**	(10,662)
Net contingent liability	-	**158**	158

29. 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 £3,573,000, however based on actual average relevant net assets this figure should be £3,586,000 and, as such, an accrual of £13,000 has been added.

30. 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	Expenditure
	£000	£000
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	-	-
Value of Transactions with board members 2008/09	-	-
Value of Transactions with key staff members 2008/09	-	-
Value of transactions with other related parties 2008/09		
Department of Health	7,423	-
Other NHS Bodies	135,516	-
Charitable Funds	335	-
Subsidiaries/Associates/Joint Ventures	-	-
Other	-	27,939
NHS Shared Business Services	-	-

Related Party Balances

	Income	Expenditure
	£000	£000
Value of balances (other than salary) with board members at 31 March 2010	-	-
Value of balances (other than salary) with key staff members at 31 March 2010	-	-
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2010	80	-
Value of balances (other than salary) with related parties in respect of doubtful debts written of in year at 31 March 2010	(39)	-
Value of balances with other related parties 31 March 2010		
Department of Health	-	-
Other NHS Bodies	4,401	3,592
Charitable Funds	15	13
Subsidiaries/Associates/Joint Ventures	-	-
Other	126	2,180
Value of balances (other than salary) with board members at 31 March 2009	-	-
Value of balances (other than salary) with key staff members at 31 March 2009	-	-
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2009	39	-
Value of balances (other than salary) with related parties in respect of doubtful debts written of in year at 31 March 2009	-	-
Value of transactions with other related parties at 31 March 2009		
Department of Health	67	-
Other NHS Bodies	3,156	2,554
Charitable Funds	52	7
Subsidiaries/Associates/Joint Ventures	-	-
Other	-	2,763
NHS Shared Business Services	-	-

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.

31. 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.

31.1 Market Risk

31.1(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

31.1(ii) Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

31.2 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.

31.3 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 it's 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.

31.4 (i) Financial assets by category

	Total	Loans and receivables	Available for sale
	2010	2010	2010
	£000	£000	£000
Trade and other receivables excluding non financial assets (at 31 March 2010)	**6,602**	6,602	-
Other Investments (at 31 Mar 2010)	**37**	37	-
Non current assets held for sale and assets held in disposal group excluding non financial assets (at 31 March 2010)	**3**	-	3
Cash and cash equivalents (at bank and in hand)	**6,053**	6,053	
Total at 31 March 2010	**12,695**	12,692	3

	Total	Loans and receivables	Available for sale
	2009	2009	2009
	£000	£000	£000
Trade and other receivables excluding non financial assets (at 31 Mar 2009)	**6,188**	6,188	-
Cash and cash equivalents (at bank and in hand)	**4,825**	4,825	
Total at 31 March 2009	**11,013**	11,013	-

All financial assets are denominated in Sterling.

31.4 (i) Financial assets by category

	Total	Other financial liabilities
	2010	2010
	£000	£000
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**

	Total	Other financial liabilities
	2009	2009
	£000	£000
Obligations under finance leases (31 Mar 2009)	**6,018**	6,018
Trade and other payables excluding non financial assets (31 Mar 2009)	**10,304**	10,304
Provisions under contract	**1,237**	1,237
Total at 31 March 2009	**17,559**	17,559

All financial assets are denominated in Sterling.

31.5 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 2009.

32. Third Party Assets

The Trust held £1,301 cash at bank and in hand at 31 March 2010 (£990 at 31 March 2009) 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.

33. Limitation on Auditors Liability

The Trust's external auditor has a limitation on its liabilities up to £5 million.

34. Losses and Special Payments

There were 125 cases of losses and special payments totalling £138,200 approved during 2009/10. These have been prepared on an accruals basis. During 2009/10 there have been no individual cases which have exceeded £100,000.

35. IFRS Transition

	Retained earnings	Revaluation reserve	Donated asset reserve	PDC
	£000	£000	£000	£000
Taxpayers' equity at 31 March 2009 under UK GAAP:	**8,500**	**43,225**	**2,101**	**49,569**
Adjustments for IFRS changes:				
Employee Benefits	**(690)**	**-**	**-**	**-**
Leases	**(445)**	**403**	**-**	**-**
Adjustments for:				
Incomplete spells	**723**	**-**	**-**	**-**
Taxpayers' equity at 1 April 2009 under IFRS:	**8,088**	**43,628**	**2,101**	**49,569**

	Retained earnings	Revaluation reserve	Donated asset reserve	PDC
	£000	£000	£000	£000
Taxpayers' equity at 31 March 2008 under UK GAAP:	**11,964**	**34,476**	**2,612**	**49,069**
Adjustments for IFRS changes:				
Employee Benefits	**(698)**	**-**	**-**	**-**
Leases	**(387)**	**440**	**-**	**-**
Adjustments for:				
Reversal of negative revaluation reserve	(523)	523	-	-
Incomplete spells	**574**	**-**	**-**	**-**
Taxpayers' equity at 1 April 2008 under IFRS:	**10,930**	**35,439**	**2,612**	**49,069**

Deficit for 2008/09 under UK GAAP	**(2,965)**
Adjustments for:	
Leases	**(95)**
Employee benefits	**8**
Adjustments for:	
Incomplete Spells	**149**
Deficit for 2008/09 under IFRS	**(2,903)**

The adjustments for employee benefits is the accrual for holiday pay earned by employees which they have not taken but to which they remain entitled, at the end of the financial year.

In line with IAS 17 Leased Assets, the Trust has undertaken a review of the Trust's leases. This has resulted in a reclassification of the leases from operating to finance leases.

An adjustment has been made for incomplete spells, which relates to the income for an admission of a patient and once the patient's treatment has begun but not complete. Previously the income was recognized on completion of the spell only.

The adjustment in 2008/09 relating to the reversal of negative revaluation reserves was to align the Trust policies with the FT Annual Reporting Manual.

Appendices

Appendix 1

Composition of Governors

The names of the Governors and details on their constituency, whether they are elected or appointed and the duration of their appointments.

Name	Constituency	Elected / Appointed	Unexpired Term
Ames, Tracey	Public – Vale Royal	Elected	1 year
Amson, Derek	Patient & Carers – Principal Carer of a Patient Aged 15 Years or less	Elected	1 year
Baynham, Michael	Public – Vale Royal	Elected	1 year
Blount, Betty	Staff & Volunteers – Clinical Support Staff	Elected	1 year
Bowles, Brian	Patients & Carers – Patients	Elected	1 year
Carr, Susan	Mandatory Appointee – Central & Eastern Cheshire PCT	Appointed	1 year
Cooper, Christine	Public – Crewe & Nantwich	Elected	1 year
Dibben, Nigel (1)	Patients & Carers – Patients	Elected	1 year
Duncan, James (2)	Public – Crewe & Nantwich	Elected	Resigned from Council
Dunn, Dennis (3)	Non Mandatory Appointee – Manchester Metropolitan University	Appointed	Resigned from Council
Dunning, John	Non Mandatory Appointee – Congleton Chamber of Commerce, South Cheshire Chamber of Commerce, and Warrington Chamber of Commerce & Industry	Appointed	1 year
Fairhurst, Gill	Public – Vale Royal	Elected	1 year
Forsyth, Bill (4)	Non Mandatory Appointee – GP Leads in Central & Eastern Cheshire PCT area	Appointed	Resigned from Council
Gardner, Brian	Non Mandatory Appointee – Congleton District Voluntary Action, Crewe & Nantwich Voluntary Action & Voluntary Action Vale Royal	Appointed	1 year
Gray, Stuart (2)	Public – Crewe & Nantwich	Elected	1 year

Name	Constituency	Elected / Appointed	Unexpired Term
Hadfield, Michael	Public – Crewe & Nantwich	Elected	1 year
Hopkins, Colin	Staff & Volunteers – Medical & Dental Practitioners	Elected	1 year
Howell, Betty (5)	Mandatory Appointee: Cheshire East Council	Appointed	Resigned from Council
Keenay, Lynne	Public – Crewe & Nantwich	Elected	1 year
Lakey, Lorna	Staff & Volunteers – Registered Volunteers	Elected	1 year
Lyons, John	Patient & Carers – Patients	Elected	1 year
Macaulay, Brenda	Patients & Carers – Patients	Elected	1 year
Machin, Peter (6)	Patient & Carers – Principal Carer of a Patient Aged 16 Years or more	Elected	Resigned from Council – Position Vacant
Mawdsley, Harry	Public – Congleton	Elected	1 year
McClure, Adam (7)	Staff & Volunteers – Non Clinical Support Staff	Elected	Resigned from Council - Position Vacant
Nimmo, Peter	Staff & Volunteers – Representative of Recognised Staff Organisations and Trade Unions	Elected	1 year
Parkinson, Charlie	Mandatory Appointee: Cheshire West & Chester Council	Appointed	1 year
Paul, Neil (4)	Non Mandatory Appointee – GP Leads in Central & Eastern Cheshire PCT area	Appointed	1 year
Pordes, Philippa	Staff & Volunteers – Qualified Nursing & Midwifery Staff	Elected	1 year
Ritchings, Andrew	Staff & Volunteers – Other Professionally Qualified Staff	Elected	1 year
Smart, Jane	Non Mandatory Appointee – Cheshire Community Voice	Appointed	1 year
West, Hazel	Public – Vale Royal	Elected	1 year
West-Burnham, Joss (3)	Non Mandatory Appointee: Manchester Metropolitan University	Elected	1 year
Wood, Newland(1)	Patients & Carers – Patients	Elected	Not applicable
Yates, Diane	Public – Congleton	Elected	1 year

As at 31 March 2010, the Trust had 2 appointed Governor vacancies and 2 elected Governor vacancies.

Notes :

(1) Mr Nigel Dibben was appointed to the Patient & Carers Constituency – Patient in September 2009 replacing Mr Newland Wood. Sadly Mr Newland Wood passed away in May 2009. Mr Wood will be greatly missed by all on the Council of Governors and at the Trust for the enthusiastic support he provided.

(2) Mr James Duncan resigned from the Public Constituency of Crewe & Nantwich in December 2009. Mr Duncan has been replaced by Mr Stuart Gray who commenced in post in March 2010.

(3) Mr Dennis Dunn was appointed as a Non Executive Director of the Trust on 1 May 2009 and resigned from his role as Governor (Appointed Governor: Manchester Metropolitan University). Mr Dunn was replaced by Dr Joss West-Burnham who was appointed in September 2009.

(4) Dr Bill Forsyth resigned from the Council of Governors in November 2009. Dr Forsyth was an appointed Governor: GP Leads in Central & Eastern Cheshire Primary Care Trust Area. Dr Forsyth was replaced by Dr Neil Paul who was appointed in January 2010.

(5) Cllr Betty Howell was appointed as the Governor representative for Cheshire East Council and Cllr Charlie Parkinson as the Governor representative for Cheshire West & Chester Council following the disbandment of Cheshire County Council on 31 March 2009. The appointments were made with effect from September 2009. Unfortunately, Cllr Howell resigned from the Committee and following ratification by Cheshire East Council in March 2010, Cllr Howell is to be replaced by Cllr David Cannon.

(6) Mr Peter Machin resigned from the Council of Governors in July 2009. Mr Machin was a representative of the Patient & Carers Constituency – Principal Carer of a Patient aged 16 Year or More. This post is currently vacant.

(7) Mr Adam McClure resigned from the Council of Governors in August 2009. Mr McClure was a representative of the Staff & Volunteers Constituency – Non-Clinical Support Staff. This post is currently vacant.

In line with the Trust's Constitution which notes 'A vacancy that arises during the tenure of an elected governor will be offered to the candidate who received the next highest number of votes after those elected in the same class and constituency in the most recent election. If the election was uncontested, or if none of the previous candidates is willing to serve as a governor, a further election will be held', Mr Nigel Dibben and Mr Stuart Gray were appointed under the category of the candidate who received the next highest number of votes. The Trust have commenced the election process for the Governor vacancies in the Constituency of Staff & Volunteers – Non Clinical Support Staff and Patient & Carers – Principal Carer of a Patient Aged 16 years or more.

Appointed Governor vacancies were filled by way of a nomination from the named organisations.

Appendix 2

Directors' Expertise and Experience

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 Liverpool and Sefton Health Partnerships and 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. 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, in Liverpool and 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.

Mike works with engineering and technology companies for whom he undertakes strategic business development, often as an integral part of their management team. He also works with university spin-outs specialising in very early stage market development.

Educated 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 now on Crewe Station.

He is Chair of the Environment Africa Trust, 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.

His interests include going to the theatre, his classic car, target rifle shooting, and 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 MBE, Non Executive Director

Dennis Dunn is Pro Vice Chancellor and Dean of the Manchester Metropolitan University (MMU) in Cheshire. Formerly a Governor of the MCFT, Dennis brings to the Board his expertise in education, skills and training. 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 educational development.

His own education has included undergraduate studies at MMU and post-graduate studies at Lancaster University and he undertakes visiting professor engagements at universities in Australia and the Czech Republic.

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 an equally passionate advocate for the developments 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

Reorganisation 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
Deputy Chief Executive Director of Nursing

Tracy has worked in the Health Service for 23 years, and completed her nurse training at the Royal Bolton Hospital.

Since qualifying, she has worked in a number of roles and across a variety of healthcare sectors. She has 18 years' clinical experience, and moved from the role of Ward Manager to Clinical Risk Manager in 1999.

In 2000, Tracy expanded her role to include co-ordination of Clinical Governance activities and acting as Business Manager for the Medical Director.

The latter post included the day-to-day operational management of several diverse

departments, e.g. Bed Management, Medical Illustration, Postgraduate Centre, Clinical Audit, and Complaints, as well as general administration, performance activities and budgetary control.

Tracy joined the NHS Modernisation Agency in 2002 to support zero-starred NHS Trusts. During this time, she gained experience of working in Acute, Primary Care, Ambulance and Mental Health Trusts, and was subsequently appointed as Associate Director for the Performance Development Team.

In 2004, Tracy became an Account Manager to the Performance Support Team that helps challenged NHS organisations to become Foundation Trusts.

Tracy is an Associate for the Healthcare Commission, and has undertaken clinical governance reviews in acute and primary care trusts.

Dr Paul Dodds,
Medical Director

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,
Director of Performance & Service Planning

Denise has worked in the NHS for over twenty-eight years, including eight 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

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 in 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.

Appendix 3

Board of Directors

Name	Position	Board of Directors	Appointments & Remuneration	Audit	Charitable Funds
Mr Philip Morley	Chief Executive	Attended 13 of 13 meetings	Attended 1 of 1 meeting		
Mrs Rachel Alcock	Director of Workforce & Organisational Development	Attended 12 of 13 meetings			
Mrs Tracy Bullock	Deputy Chief Executive Director of Nursing	Attended 12 of 13 meetings			
Dr Paul Dodds	Medical Director	Attended 13 of 13 meetings			
Mr Andy Ennis	Director of Service Development	Attended 12 of 13 meetings			
Mrs Denise Frodsham	Director of Performance & Service Planning	Attended 11 of 13 meetings			L - attended 5 of 6 meetings
Mr Mark Oldham	Director of Finance & Strategic Planning	Attended 12 of 13 meetings		L - attended 6 of 6 meetings	
Mr John Moran	Chairman	Attended 13 of 13 meetings	Attended 1 of 1 meeting		
Mr Michael Chandler	Non Executive	Attended 13 of 13 meetings	Attended 1 of 1 meeting	Attended 6 of 6 meetings	
Mr William Craig	Non Executive	Attended 12 of 13 meetings	Attended 1 of 1 meeting	Attended 5 of 6 meetings	
Mr Dennis Dunn	Non Executive Director - Appt 01/05/2009	Attended 7 of 13 meetings	Attended 1 of 1 meeting	Appointed to Committee in May 2009 therefore attended 2 of 5 meetings	Attended 2 of 6 meetings
Mrs Valerie Godfrey	Non Executive Director - Appt 01/05/2009	Attended 12 of 13 meetings	Attended 1 of 1 meeting	Attended 5 of 6 meetings	C - attended 6 of 6 meetings
Mr David Hopewell	Non Executive Director	Attended 12 of 13 meetings	Attended 1 of 1 meeting	C - attended 6 of 6 meetings	
Dr Alan Wood	Non Executive Director Senior Independent Director	Attended 13 of 13 meetings	Attended 1 of 1 meeting		

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Board of Directors (cont.)

Name	Infrasture Development	Patient Experience Committee	Performance & Finance Committee	Strategic Integrated Governance Committee	Executive Workforce	Special Interests
Mr P Morley						
Mrs R Alcock				Attended 8 of 10 meetings	C - attended 3 of 3 meetings	
Mrs T Bullock			C - attended 7 of 11 meetings	Attended 9 of 10 meetings		
Dr P Dodds				C - attended 10 of 10 meetings		
Mr A Ennis		L - appointed as Lead in November 2009 - attended 2 of 3 meetings				
Mrs D Frodsham		L - stepped down as Lead in November 2009 - attended 4 of 4 meetings				
Mr M Oldham	C - attended 6 of 6 meetings		Attended 10 of 11 meetings		Attended 1 of 3 meetings	
Mr J Moran						
Mr M Chandler	Appointed to Committee in July 2009 - attended 3 of 9 meetings		Attended 1 of 1 meeting - stepped down from Committee in May 2009			Risk Management, Marketing, Technology and Innovation, Human Resources
Mr W Craig				Attended 10 of 10 meetings	Attended 3 of 3 meetings	
Mr D Dunn				Attended 2 of 9 meetings - stepped down from Committee in February 2010		
Mrs V Godfrey		C - attended 6 out of 6 meetings				Complaints Review Panel, Patient and Public Involvement
Mr D Hopewell			Appointed to Committee in May 2009 - attended 9 of 10 meetings			
Dr A Wood	Attended 3 of 6 meetings - stepped down from the Committee		Attended 9 of 11 meetings	Appointed to Committee in February 2010 - attended 1 of 1 meeting		Business Management and Process Innovation

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