Medway NHS
NHS Foundation Trust

Medway NHS Foundation Trust

Annual Report and Accounts 2010/11

Medway NHS Foundation Trust

Annual Report and Accounts 2010/11

Presented to Parliament pursuant to Schedule 7,

Paragraph 25(4) of the National Health Service Act 2006

Contents

Appendix 1 – Medway NHS Foundation Trust Quality Account

Chairman's welcome

As another year passes I am pleased to bring you our annual report 2010/11 which presents our performance, quality report and financial accounts. This year, with a change of government and plans to radically change the way in which national health services are provided, the NHS is in the news headlines even more than usual. Over the coming years the NHS will be expected to do more with less and the financial pressures will be particularly felt in the acute sector. However, as this report on the past year demonstrates, we are determined that the quality of our service to our patients and the community will not be compromised.

The Board's focus throughout the year has been to build on the improvements we have already made to deliver excellent, safe patient care and treatment, and given changes in the economic and political environment, we have been putting plans in motion to explore a successful and sustainable future for provision of excellent local hospital services. Despite the changes and financial constraints, our priority is and will remain to be to put the needs of our patients at the forefront of everything we do.

I am pleased to report that throughout the year we have kept to our commitment to improve care. With the help of our staff, volunteers, governors and members, we have made some significant achievements and improvements to be proud of. This includes our excellent progress in eliminating healthcare associated infections, developing new services closer to people's homes and, for the third consecutive year, we were pleased to be named as one of the top 40 hospitals by CHKS. You can read more about the Trust's work and the highlights of our year later on in this report.

Our Annual General Meeting 2010 was another success. At the well attended meeting, the Trust's new chief executive, Mark Devlin, presented his vision for the Trust and our senior governor, Pam Gibbon, gave an overview of their work. Our team of governors have continued to do an excellent job in representing the community to the Trust and the Trust to the community. Our governors provide an invaluable link between the Trust and our staff, partners and local communities across Medway, Swale and beyond. They scrutinise our performance, hold me and the Board of Directors to account and play a critical role in the appraisal and appointment of non-executive directors. They have also worked hard to increase our membership. Further details of some of the work of our governors during the past year can be found in this report.

I would also like to mention some changes to the Trust Board in the period. I would like to say farewell to Andrea Penman who joined the Trust's Board of Directors in May 2002 as a non-executive director. On behalf of the Board I would like to thank Andrea for all her valuable work at the Trust over the past eight years. I would also like to welcome Patrick Johnson who joined the Trust in April 2010 as the director of operations and deputy chief executive, Martin Jamieson, non-executive director and Andrew Brown, director of human resources at Dartford & Gravesham NHS Trust who has been seconded to cover Medway's HR business. Dr Gray Smith-Laing took up the post of substantive medical director in May 2010.

Chief executive's message

A year at Medway

When I joined the Trust in April 2010, I realised that Medway Maritime had the potential to become an excellent hospital. Twelve months later, having met many of the individuals and teams that provide care, save lives and improve the quality of life of thousands of patients each week, I remain absolutely convinced that the future potential of this hospital to impact positively on the health of people in Medway and Kent, is far greater than we have realised in the past.

During my first year as chief executive, one of my main priorities has been to ensure we continue building on quality improvements across the Trust. Provision of safe, effective and timely care has remained our top priority, and we have also been concentrating more on issues around the areas of care and treatment that have an impact on the overall experience patients have when they come to Medway Maritime Hospital. Over the past year, the Trust has been working to improve further, the privacy and dignity of patients and the hospital's environments and facilities, but we know that there is more that we could and should do. To address this, last year our director of nursing set-up a Patient Experience Committee whose remit is to look at a number of areas around patient and visitor experience to ensure these areas of our business do not get overlooked. This includes work around staff attitude, signage, access to wheelchairs, car parking and the development of the patient pledge which reinforces our promise to the people we serve.

Leading in patient safety

In February, we were really pleased to announce that our hospital had been free from MRSA bloodstream infections for a whole year. The Trust is extremely proud to have achieved the greatest reduction in MRSA bloodstream infections in the South East Coast region. This

is down to our high standards, the resources we have put into infection prevention and control and the hard work of staff across our hospital. We are really pleased to be making these significant changes in the way we care for our patients and we will continue with this commitment to ensure our very high standards are maintained.

Operational performance

In terms of operational performance, I am pleased to report that the Trust met all the national waiting time and treatment standards and we remain committed to ensuring that these standards are sustained and where possible, improved upon.

The long harsh winter brought a surge of activity with some challenging periods where availability of beds became limited. However, we provided care and treatment for every single patient that came to our doors and I am very proud of the way in which staff pulled together with vigour and commitment, often facing huge challenges to get to work themselves during the snow. Despite a challenging winter, we were very pleased to learn that performance of our emergency department was the best in the Kent and Medway region which again, is testament to the Trust's staff.

Financial matters

Achieving a healthy financial position, with surpluses to reinvest, has proved increasingly difficult as the external financial environment has started to tighten. As a result, work on improving efficiency and eliminating duplication and waste has been a strong focus throughout the year. Despite valiant efforts and more than 90 percent of savings plans having been achieved, the Trust was unable to recover from losses incurred early in 2010/11. These were further affected by severe weather disruption in December and for the second year in succession, the Trust has returned a deficit financial position. This state of affairs has resulted in the financial regulator of foundation trusts, Monitor, escalating its involvement and as a result, the Trust is now considered to be in significant breach of its terms of authorisation. This is a serious but precautionary measure on behalf of Monitor who has asked for independent assurance of the Trust's recovery plans and financial governance arrangements for 2011/12. The Trust is working closely with Monitor to provide that assurance and return to an acceptable financial risk rating as soon as possible.

We know that the economic context for the NHS is set to become tougher and the Trust has been working hard to put action plans in place to account for tighter finances next year, and to ensure we begin the new financial year in a better position than we did in 2010 – putting

us onto a stronger financial footing for the rest of the year.

In terms of the changes that will affect us financially, we know that the prices we are paid for the work that we do and the volume of work are both planned to decrease, resulting in an overall savings challenge totalling around £17 million. Of this, £4 million relates to work that we will no longer be required to do by the Primary Care Trust, and £13 million relates to a decrease in the amount we will be paid for the work we will do. The challenge for us therefore is two fold; a) to resize our capacity to meet lesser demand in some areas and b) to continue to do our existing work in a more efficient way. These changes will not be uniform across all services; for example, although activity in our emergency department and outpatients may decrease because more of these services are being offered in the community, other services such as maternity and children's services are predicted to grow.

Exploring the future

With significant changes and challenges for the Trust in mind, over the last year there has been a large element of innovative thinking to ensure that under the current economic environment, and with the proposed changes to the NHS under the government's Health and Social Care Bill, we can continue to provide excellent healthcare, to the highest standards for local people. You may be aware that in March this year Medway NHS Foundation Trust and Dartford & Gravesham NHS Trust, which runs Darent Valley Hospital, announced plans to explore the feasibility of integrating the two organisations. Over the past year, successful collaborative working has been taking place between the trusts in both clinical and non-clinical areas; this includes work in urology, pathology and information technology. This has shown there are more efficient and cost effective ways in which we can work. However, the decision to explore a longer-term partnership arises for a number of reasons.

Underpinning the decision to explore integration, is our belief that joining the two trusts could lead to a strengthening of services at both hospitals as well as in the region as a whole. For example, we can improve patient experience and care through sharing best practice, and we can maximise the use of each hospital's facilities and estate, increasing the scope and range of services we provide. A stronger, integrated organisation could allow for improved access to specialist services too, preventing the need for local patients to make long and expensive journeys to hospitals in London. Essential services, like emergency departments and maternity, will remain local to both Medway and Dartford – the purpose of integration would be to build on the range and quality of local services we already have.

If the two organisations come together there will be a need for fewer managers, one Board of Directors and fewer support staff, resulting in savings that can be put directly back into patient care. Inevitably, certain job positions will no longer be needed but this does not mean that every member of staff affected will face redundancy. We are a large organisation and we will be doing everything we can to redeploy the staff affected and to make the changes we need through natural staff turnover, for example retirement and those leaving to move on to other jobs. Our plans do not in any way involve reducing the number of nurses or doctors who deliver patient care.

Feasibility testing is currently underway and within this work we are examining all the services offered by each of the trusts taking account of specialist expertise, service quality and financial performance to identify the options available to us. We will also be looking at ways in which we could harness the cultural strengths of both hospitals to ensure we lay the foundations for an excellent and thriving organisation. The entire process will be open to scrutiny – we will consult with staff, patients, the public, governors, GPs, commissioners, LINks and local authorities. Any decision will be subject to a thorough process requiring approval from the Department of Health and Monitor, the Foundation Trust's regulator.

Embracing change

Times are changing and you will know that across North Kent and Medway our populations are growing, as are their increasingly complex healthcare needs. Exploring ways to modernise local hospital services within the challenging economic environment is a necessity, not an option, if we are to deliver twenty-first century healthcare.

It is likely that the forthcoming year will bring some of the most significant changes the Trust has seen. Although elements of the future remain unpredictable and there will undoubtedly be some testing times, I am confident that the communities we serve will continue to receive excellent healthcare, and if the integration with Dartford & Gravesham NHS Trust proceeds, an even better range of specialist services.

On a closing note

I must thank our staff, volunteers, members and governors for their dedication. The latest NHS staff survey puts us in the top 20 percent of hospitals for staff believing that the work they do makes a difference to patients and for working in effective teams. I know that with your continued support, we will continue to do an excellent job and make even more people proud that Medway Maritime is their local hospital.

Directors' report

About us

Medway NHS Foundation Trust is one of four hospital trusts in Kent. It serves a population of over 250,000 in Medway and around 130,900 in Swale. The Medway towns incorporate the areas of Gillingham, Chatham, Rochester, Strood and Rainham and healthcare needs in the region are higher than in other parts of Kent. The Trust employs 3,855 members of staff and is supported by 700 volunteers, 26 governors and we currently have 9,892 members of our Foundation Trust.

The Trust is committed to bringing its patients healthcare services in line with some of the best in the country. The Medway Maritime Hospital site is now home to a Macmillan Cancer Care unit, the West Kent vascular centre, a state-of-the-art obstetrics theatre suite, the neonatal intensive care unit, a foetal medicine centre, a dedicated stroke unit and the West Kent centre for urology.

We have a new vision for Medway NHS Foundation Trust – as a centre of effective, modern healthcare delivery for the growing communities we serve. It is our aim that the Trust will become recognised as a high-performing provider of core and specialist health services with a distinctive, patient centred and responsive philosophy. The communities and patients who rely upon us deserve nothing less.

We really value the benefits of foundation trust status and the opportunities it offers. Over the past few years, we have built valuable relationships with our local community to improve the standards of our services further. We are proud to have a dedicated team of governors who are committed to seeing the Trust excel and our membership base is steadily increasing.

The hospital has five main clinical directorates under which individual services sit. These are:

- adult medicine and A&E
- surgery and anaesthetics
- children and women
- diagnostics
- facilities and clinical support services

Financial performance

In what was an extremely challenging year financially, the Trust faced significant pressure on its resources, most notably in temporary staffing costs and clinical supplies to deliver above plan levels of clinical activity. The Trust returned a deficit of £3.5m compared with a planned surplus of £2.0m. Plans for next year (2011/12) include the achievement of a retained surplus of £1.2m, in a year where capacity will be reduced and associated costs removed. This will require a reduction in costs of eight percent, which is higher than in previous years.

The Trust's capital investment programme this year amounted to £7m and included expenditure on projects such as the completion of a combined heat and power (CHP) plant and the replacement of the site backup generators. In terms of external validation of its performance, Monitor assigns risk ratings of between one and five to all foundation trusts, with one being the lowest performance and five the highest. In 2010/11 Medway NHS Foundation Trust scored a 'two'. We are planning and committed to improve to a 'three' in 2011/12.

Highlights of the year

Patient Experience Committee

The experience patients have when they access our services is very important to us. To ensure improvement of patient experience remains high on the agenda, last year the director of nursing set-up a Patient Experience Committee to look at all areas of the patient pathway – from before the point at which a patient enters our site, through treatment to leaving hospital. Over the coming year, work will continue to improve facilities for both patients and visitors and to ensure the Trust meets its patient pledge.

As a way of measuring the experience patients have when they come to Medway Maritime Hospital, in March we launched the new WOW awards. Nomination forms are made available to patients and visitors, and when they feel they have received outstanding treatment, care or experience – delivered by an individual member of staff or team, they can nominate them. We believe it is important to identify and reward those individual members of staff or teams who deliver excellent patient experience as this can help to raise our standards further across the entire organisation.

Combating MRSA

We operate a 'zero tolerance' approach to infections like MRSA and we were very proud to announce in February that there had been no MRSA bloodstream infections at Medway

Maritime Hospital for a year.

Since 2008, every single patient has been screened on admission for MRSA, with the exception of women using our maternity services for normal deliveries and children (although high risk patients are identified and screened in these groups). This ensures that patients who carry the bacteria are identified and managed appropriately, to prevent the spread of infection within hospital wards.

There has been a wide-range of measures across the Trust which have led to this success including a specialist MRSA ward and improved management of devices such as urinary catheters and drips. Hand hygiene (hand washing or alcohol hand rub) by staff, patients and visitors remains the simplest and most effective measure we can adopt to reduce the spread of infection.

Supporting organ donation

There are over 8,000 people in this country waiting for life saving organs. Unfortunately the stark fact is that three of these people die every day waiting – some because the organs never come and some because whilst waiting, their health deteriorates to a point where they would not survive an operation. This number will increase steeply over the next decade due to an ageing population, an increase in kidney failure and scientific advances resulting in more people being suitable for a transplant.

Last year, the Trust set up its first Organ Donation Committee to encourage everyone – staff, patients and visitors – to talk more openly about organ and tissue donation and to consider joining the Organ Donor Register. We are also training our medical staff so that they feel able to talk to relatives about it and last October, the Trust organised a special tree-planting ceremony to honour all those who have donated their organs and by doing so, saved the lives of others.

Dermatology services at Borough Green

Last September, the Trust brought dermatology services closer to the community.
The West Kent Dermatology Unit, which is provided by Medway NHS Foundation Trust, relocated from Pembury Hospital to new modern facilities at the Borough Green Medical Practice.

The premises at Borough Green Medical Centre provide an efficient, pleasant, modern

setting for both patients and staff, with the added benefit of good road access and excellent parking facilities. The new unit boasts two large and immaculate consulting rooms, one treatment room and a minor procedure room. The minor procedure room provides three minor operation sessions a week.

Mark Devlin, chief executive of Medway NHS Foundation Trust, said: “This is a very exciting time for us at Medway – to be working closely with our primary care partners NHS West Kent, to bring our patients the services they need, closer to home.

“It is as a result of this successful collaboration that the people of West Kent and beyond will have access to a wealth of clinical expertise in the heart of their community.”

May’s baby boom

Last May saw the highest number of babies born in one month in the hospital’s history. A staggering 434 babies were born – that is around 15 every day.

Medway Maritime Hospital is home to the largest single-site maternity unit in the whole of Kent. In addition to the delivery suite which caters for natural births, the department has a birthing pool for mums who prefer a water birth.

For more complicated births that require surgical intervention, such as a caesarean section, there is the brand new, state-of-the-art obstetrics theatre suite which opened in December 2009. The suite comprises two theatres and a three-bedded recovery bay.

Karen McIntyre, Head of Midwifery at Medway NHS Foundation Trust said: “We’re thrilled that so many mums from across Medway, Swale and further afield in Kent are choosing to bring their babies into the world with us at Medway.”

Orthotics centre of excellence

People in Medway and Swale experiencing painful muscle and joint problems can be assured that when they come to Medway Maritime Hospital for their treatment, they are being treated in the only centre of excellence in the south east region.

Medway Maritime Hospital’s orthotics department and plaster theatre have been awarded the status of centre of excellence for its training of staff and its customer services. This prestigious accolade has been announced by Breg, a supplier of specialist orthopaedic devices designed to aid people with musculoskeletal conditions. It means that other trusts

from around the country can come and visit the department in Medway and learn from our expertise to improve the services they offer.

The department also boasts the shortest waiting time in the whole country for an appointment to be fitted with an orthotic device.

Hospital @ Home' service

The Trust has been piloting a new service which enables patients to continue their inpatient treatment at home, rather than stay in hospital. Patients who are stable but still need some form of treatment such as oxygen, blood monitoring or medication, can receive the inpatient care they need from nurses and physiotherapists in their home. The service runs seven days a week, from 8am to 6pm, and outside those hours patients can call and speak to a member of staff who can offer medical advice or re-admit them to hospital if necessary.

Louise Dennington, Senior Sister for Hospital @ Home, explained: "Patients are only discharged with the agreement of their consultant, and although they are being cared for at home, they are still under the care of their consultant. Since the service started, over 240 patients have received 1800 days of their care in their own homes rather than in a hospital ward.

"The feedback we've received so far from patients has been very positive. They are more at ease when they are in their own surroundings which helps them recuperate faster, but they are still able to access the inpatient care that they need."

Same sex accommodation

The Trust is pleased with the progress it has made in eliminating mixed-sex accommodation. At the end of March 2011, 88 percent of patients were in same-sex accommodation.

Same-sex accommodation means:

- a ward that is occupied by men only or women only and has its own washing and toilet facilities,
- single rooms with same-sex toilet and washing facilities (preferably en-suite), or
- multi-bed bays or rooms (sleeping areas) occupied solely by men or women, with their own same-sex toilet or washing facilities.

Patients should not have to pass through opposite-sex accommodation, toilets or washing facilities to reach their toilet and washing facilities.

We take the privacy and dignity of our patients very seriously and we believe in being open and honest about when we are caring for patients in same-sex bays, and when we are not. This is why we have introduced same-sex patient crosses.

The crosses are displayed at the entrance to each ward and show each time a bay contains patients of both sexes. The days of the month are clearly marked on the cross and show our performance in providing single-sex accommodation.

Most people accept that providing fast, effective patient care is sometimes more important than providing same-sex accommodation. This may include situations where patients need urgent care, highly specialised or high-tech care.

Future developments

Medway NHS Foundation Trust will continue to develop its range of general and specialist services. The Trust aspires to continue with its development of its sub-regional vascular surgical and interventional radiology service which has the potential to widen its current scope further and incorporate patients from Maidstone, Pembury, Dartford and Gravesham.

The West Kent centre for urology has been introduced jointly with Dartford & Gravesham NHS Trust and this service will be extended into other parts of the area. The Trust has also been shortlisted as a site of one for three ‘level 2’ trauma units in Kent and Medway which is subject to business case approval.

The specialties of maternity, paediatrics and gynaecology continue to grow. Medway provides a main ‘level 3’ neonatal intensive care service for Kent and Medway, and is on track to be the major maternity hospital of Kent. The Trust is pleased to be working in partnership with King’s College Hospital NHS Foundation Trust with the provision of a foetal medicine service. It is anticipated that there will be further developmental opportunities in paediatric surgery to attract patients who would otherwise need to travel to London for treatment.

In the areas of general and adult medicine, the Trust provides a successful sub-regional dermatology service across Medway, Swale and West Kent, and there is similar potential in neurology and rheumatology. There are possibilities in cardiology of joint working with Dartford to expand the coverage of our cardiac angiography and angioplasty services.

Partnership working is a fundamental principle which underpins all that Medway does. The Macmillan Cancer Care Unit was a successful joint venture with Macmillan Cancer Support, and provides a model on which other services could develop in the future.

Trends and factors

The population statistics provided below are the most current figures available. The overall population for 2009 for Medway and Swale are 254,800 and 130,900 respectively. Details are provided in table 1 below:

Table 1

Medway			Swale		
Total	Male (%)	Female (%)	Total	Male (%)	Female (%)
254,800	49.3	50.7	130,900	49.5	50.5

(Source: ONS mid-year estimates 2009, Kent & Medway Public Health Observatory)

The number of people within the 0-16 and the 65+ age groups is shown in table 2 below:

Table 2

Age group	Medway	%	Swale	%	Kent %
0-16	55,109	21.6	28,492	21.8	20.6
65+	35,194	13.8	21,205	16.2	17.9

(Source: ONS mid-year estimates 2009, Kent & Medway Public Health Observatory)

Projections

According to the trend based population series (source: Medway Council Population Projections, November 2010), the Medway population by 2028 will be 279,600. Older people account for the larger increase, growing by 47 percent or +20,400 which represents 81 percent of the overall population growth. It is estimated that there will be an increase by just over one percent (+1,700) in the working age population. The number of children is expected to rise to 54,500 by 2028.

Medway is predicted to have a lower rate of population growth than England (+11 percent) and the South East (+12 percent).

Population projections for Swale (source: Demography and Social Trends, Swale Borough Council, undated) anticipate growth to 140,400 by 2026 (growth of +9.3 percent on 2006 levels), although this increase is slightly below that of Kent (+12 percent). When the

population projections are broken down into broad age groups it becomes apparent that Swale will face significant increases in residents aged 44-65 and 65-84. The 65-84 and 85+ age ranges are estimated to be 27,500 (+9,900 on 2006 levels) and 5,200 (+2,900) respectively by 2026. The number of those within the 0-15 age group is expected to rise from its 2006 level of 26,200 to 26,500 by 2026, an increase of 1.1 percent.
The Trust is aware of the impact population growth will have on the future demands of healthcare provision. Medway NHS Foundation Trust is committed to partnership working and engages with other health and social care organisations to respond innovatively to these local demographic changes.

Principle risks and uncertainties

The controls and assurances for managing risk are contained in the Board Assurance Framework (BAF) and the corporate risk register which supports this.

During 2010/11, the Trust's Board Assurance Framework has been subject to a great deal of scrutiny and revision in order to identify the principal risks to the achievement of the Trust's strategic objectives, to ensure that it meets the requirements of the Board.

The Board Assurance Framework is reviewed and updated monthly by the head of governance and risk and the lead executive for each of the annual corporate objectives that he or she 'owns'.

The corporate risk register also underwent significant change both in its design and the processes for managing the identified risks. The corporate risk register is scrutinised each month by the clinical executive group (CEG) and thereafter recommended to the Board. Two directorate risk registers are also reviewed each month by the CEG and this ensures that each directorate's risk register is reviewed by the CEG three times a year.

Until February 2011, both the BAF and the corporate risk register were monitored by the Board of Directors on a monthly basis at the Board meeting. The Board were assured that there was sufficient challenge and robust monitoring processes in place and determined that they would, from March, review each on an alternating bi-monthly basis at the Board meeting.
In summary, the main risks identified by the Trust during the year, and the key controls in place to mitigate those risks are as follows:

Adult inpatient bed capacity

Adult inpatient bed capacity has been the most frequently cited top risk on the risk register – occupancy has not been below 90 percent and has on occasions been over 100 percent which meant that the Trust had almost consistently been in 'amber-red' escalation. A significant piece of work has been going on to improve patient pathways, promote early discharge planning and we are continuing to work closely with our partners to avoid unnecessary delays. The introduction of the ‘Hospital @ Home’ initiative within the medical directorate has proven to be very successful and plans are now underway to extend this to surgical patients and the Swale population. Despite these challenges a significant amount of progress has been made in eliminating mixed-sex accommodation across the hospital, and there have been only a few occasions where, due to increased demand on the Trust’s bed capacity, it has not been possible to provide same-sex accommodation.

Information technology infrastructure and continuity planning

The current information technology (IT) infrastructure has reached the end of its useful life and poses a risk to business continuity. Plans have been adopted to minimise this risk and the Trust agreed a significant investment in an IT Infrastructure 'refresh' project during 2010/11. A new IT strategy was formally adopted by the Board at its April 2011 meeting.

Finance

Financial matters are covered in other areas of this report.

Clinical equipment and diagnostic infrastructure

The directorate management teams have taken their responsibilities in relation to managing risk very seriously. Following support and challenge in relation to the nature of the risks identified on their risk registers, it emerged that there were a number of diagnostic and clinical equipment items that were coming to the end of their effective life. This required significant capital expenditure to purchase new equipment following a detailed risk based assessment.

Recognising and responding to the issue of deteriorating patients

Identifying deterioration in a patient's condition is an essential part of managing their care. In order to ensure that the risk of deterioration is minimised, a number of initiatives have been implemented, including:

- implementation of the ‘preventing patient deterioration’ project
- monthly observation audits which are consistently achieving 97 to 98 percent

- monthly analysis of the ‘Global Trigger Tool’ findings which have not demonstrated any emerging themes
- establishment of a mortality review group and a medical director presentation on hospital standardised mortality rate (HSMR) to the Board
- the patient safety manager has implemented monthly learning from serious untoward incidents (SUIs) with F1 clinicians, who are newly qualified doctors

The reduction in the number of SUIs/incidents relating to deteriorating patients, and those who deteriorate where no action taken, is encouraging. The Board endorsed the recommendation to reduce the likelihood of the risk recurring.

Going concern

Trust directors have reasonable expectation that Medway NHS Foundation Trust has adequate resources to continue to operate for the foreseeable future. For this reason it continues to adopt going concern basis in preparing its accounts.

Relationships

The Trust has good relationships with its stakeholders and is committed to maintaining and developing these. We have continued to keep in touch with our local MPs, partners and authorities.

Quality of care

As part of a routine compliance review, all four of the Trust’s registered sites, which include Medway Maritime Hospital, Preston Skreens, Woodlands Special Needs Nursery and the dermatology clinic based in Borough Green, were visited by the Care Quality Commission in February 2011. The Trust was found to be fully compliant will all of the Commission’s ‘Essential Standards of Quality and Safety’ at the main hospital site, at the dermatology clinic and at Woodlands Nursery; the CQC did make some suggestions to help improve services and practice further.

At Preston Skreens, which provides short-term special care for children with severe learning disabilities, the CQC expressed two ‘moderate’ concerns in connection with the management of medicines and the maintenance of records. The Trust has already implemented changes to practice to address these concerns and will be inviting the CQC to review evidence of those changes in due course. Our full Quality Account can be found in appendix 1.

Handling complaints

The Trust aims to provide excellent standards of care and treatment to all of its patients. To assist us in delivering this to a high standard, we avidly encourage feedback from patients and their friends and relatives on their experience in the form of comments, compliments, concerns and complaints. This information helps us to recognise areas of good practice, as well as areas where improvement is needed.

Over the last 12 months the complaints department has successfully implemented the revised complaints procedure that was introduced in 2009. The complaints team has evolved and is now led by the clinical nurse lead for complaints in a substantive position. The administration system has been completely reviewed and overhauled to improve the complaints process. The complaints team is cohesive with a vision to improve the experience patients have, by investigating concerns raised in an open and honest manner.

The Trust embraces the complaints process and acknowledges that it is integral to:

- improve the patient experience
- share good experiences
- engage with patients and other service users
- resolve patient concerns in an open, honest and efficient way
- minimise risk for the Trust
- minimise unnecessary costs (financial and time)
- identify areas for further improvement

Patient feedback shows that they want:

- an honest investigation into their concerns
- a sincere apology
- a full explanation of why things went wrong
- a timely response
- staff to listen to their concerns
- the opportunity to talk to those involved
- to prevent a similar experience happening to other patients
- small gestures of goodwill

The complaints team use the parliamentary and Health Service Ombudsman's principles for guidance:

- getting it right
- being customer focused
- being open and accountable
- acting fairly and proportionately
- putting things right
- seeking continuous improvement

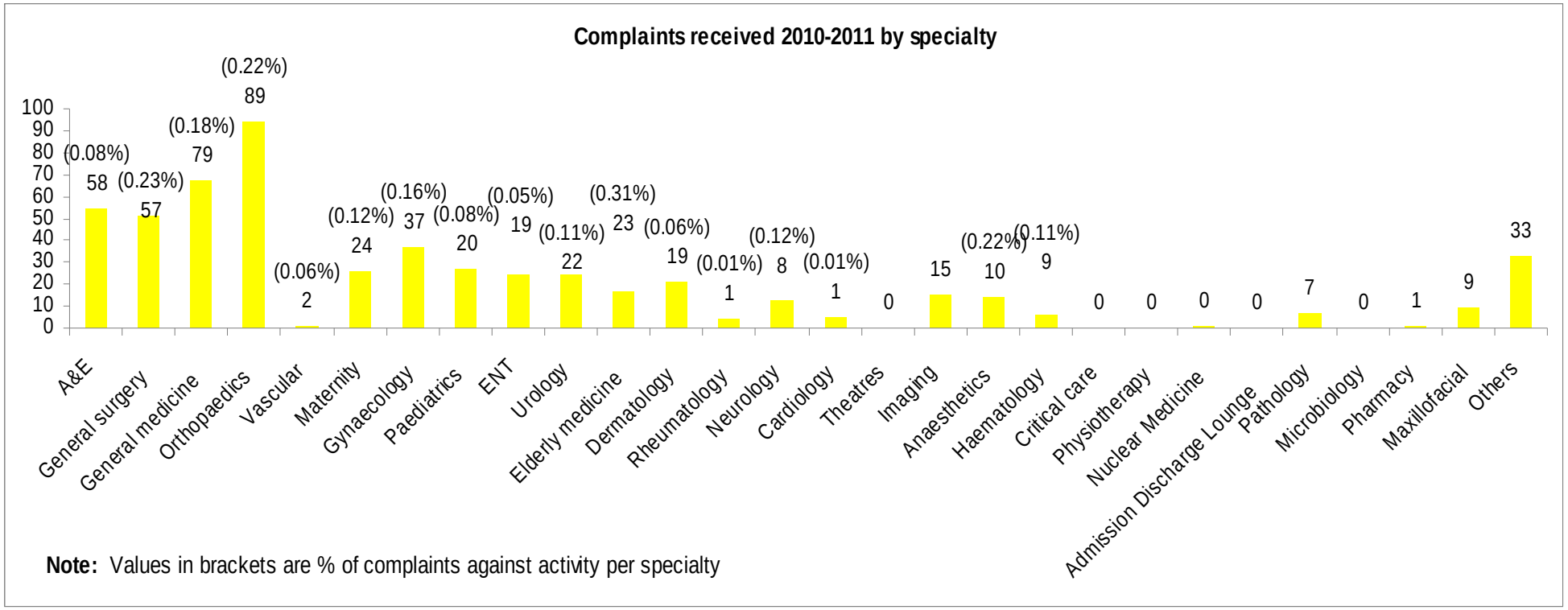
Complaints received during 2010/2011

A total of 552 complaints were received during 2010/11 compared to 569 in 2009/10, representing a three percent improvement. The complaints team is focused on resolving matters quickly, with consent of the complainant, if using the formal complaints process is unsuitable or not what they require. The number of complaints is only 0.13 percent of overall hospital activity.

Themes of complaints

There were 250 complaints relating to clinical care and treatment. Of these, 36 were related to A&E, 36 to general medicine, 43 to orthopaedics and 30 in relation to general surgery. The trends within these were failure to diagnose, particularly fractures, and a lack of nursing care. Elderly care received only ten complaints relating to clinical care and treatment.

A breakdown of complaints by service for 2010/11 is shown in the graph below.



Attitude of staff

There were 47 complaints relating to staff attitude. The main areas for this were A&E (six) and paediatrics (eight). There has been some formal management of nursing staff in A&E with staff being refocused on customer care. Although there were similar numbers of complaints relating to staff attitude in the paediatric department, no specific staff group was responsible. However, individual cases are addressed with the relevant managers so that appropriate action can be taken. Our maternity department and elderly care department only had one complaint relating to staff attitude.

Communication

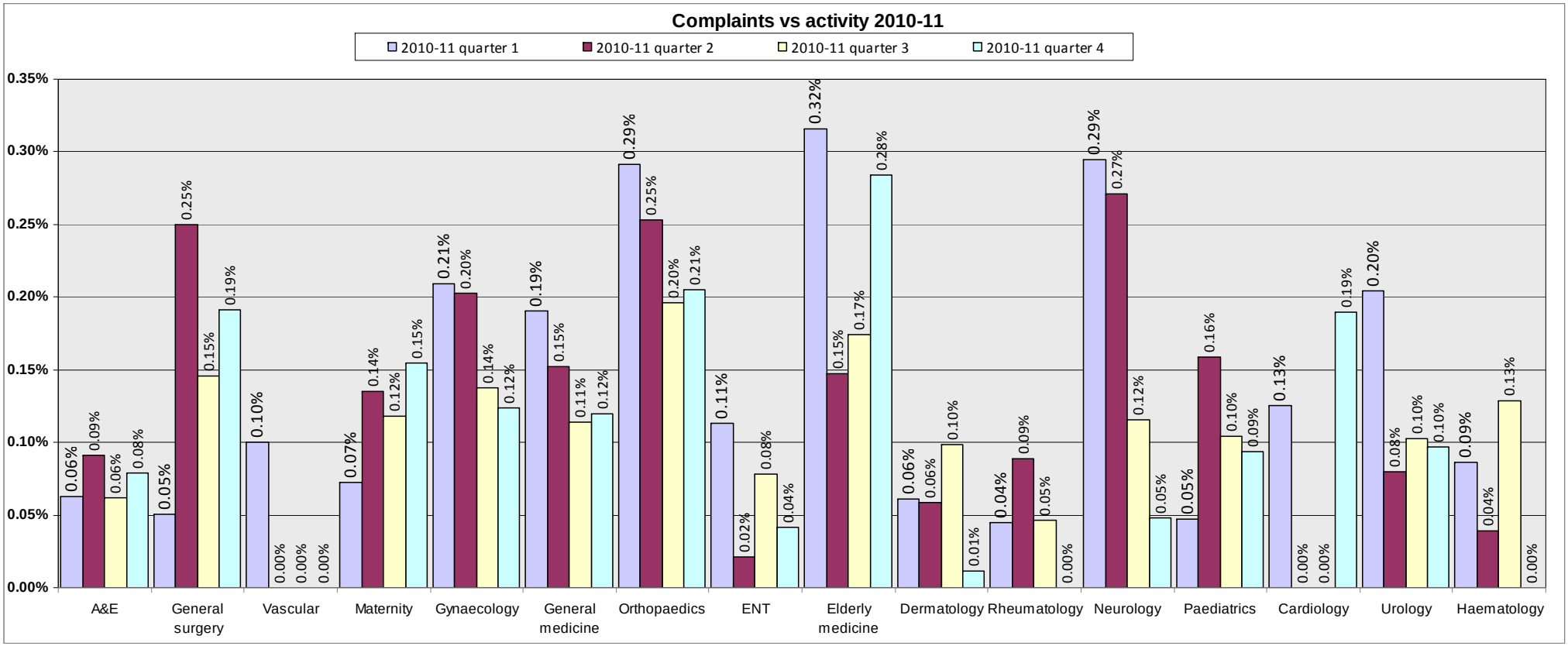
There were 74 complaints relating to communication/information to patients. The main areas of poor communication were orthopaedics (11), gynaecology (seven), and dermatology (seven).

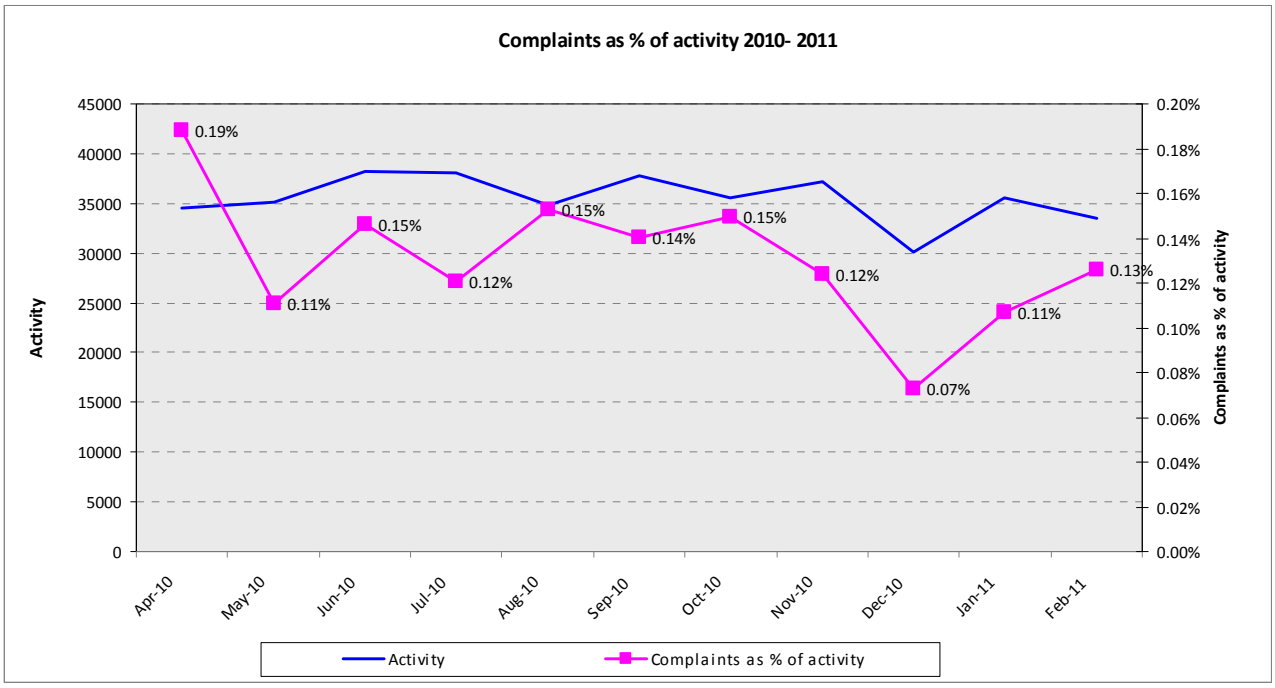
Many communication issues relate to telephone calls not being returned and promises to ring patients back not being honoured. This appears to be a general problem within the organisation and is being addressed. Audiology is a particular problem where patient calls are not answered or patient messages are not returned. To help resolve this, an automated voicemail service is due to be installed to assist with dealing with priority enquiries and redirecting calls if necessary to the appropriate person. Paediatrics only had one complaint relating to communication and A&E received just two.

Nine complaints received relate to delivery suite triage. Although these represent less than two percent of the total complaints received, the Trust has consistently received complaints concerning this department each month. The head of nursing is currently working to improve the experience of women attending the delivery suite.

There have been nine complaints which relate to foetal medicine and reflect a trend within this department. The management and staff working in this area have reflected on their practice and complaints have reduced significantly over the last five months.

All directorates analyse all their complaints to see if there are any particular themes or trends and the directorates report their actions to the head of patient experience and to the Quality and Safety Committee.


Complaints vs activity 2010-11
2010-11 quarter 1
2010-11 quarter 2
2010-11 quarter 3
2010-11 quarter 4
0.35%
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
A&E
General surgery
Vascular
Maternity
Gynaecology
General medicine
Orthopaedics
ENT
Elderly medicine
Dermatology
Rheumatology
Neurology
Paediatrics
Cardiology
Urology
Haematology



Response times

Wherever possible, we aim to respond to complaints within 25 working days. This can be negotiated with the complainant and the Trust is always flexible in its approach to responding to complainants needs. Between 1 April 2010 to 31 March 2011 the Trust responded to 422 of the 552 (76 percent) complaints within this timescale, compared to 375 (66 percent) in the previous year.

Parliamentary and Health Service Ombudsman

During 2010/11 15 files were requested by the Ombudsman's office. Of these, seven cases are not being investigated further, one case (from 2009) has produced recommendations to the Trust after being upheld, six were returned for further local resolution after the Trust advised that this was possible and two are pending a decision.

Principles for remedy

Based on the Ombudsman's 'principles for remedy' the Trust has offered and held more local resolution meetings in an attempt to remain customer focused. This demonstrates that we are open to listening to feedback from patients and focused on learning from poor experiences. It is evident that some patients do not feel listened to at the time or cannot find staff members who will listen or resolve their issues at the time. Some patients/relatives mention in their letters that they are 'reluctantly making a complaint'.

Sustainability and climate change

The Trust recognises that due to the scale and diversity of its operations, it has the potential to affect the environment significantly. Our strategy considers the environmental impact of our buildings and activities both locally, on the community in Medway and Swale, and globally, through carbon emissions and procurement options.

In 2007, the Trust participated in phase two of the Carbon Trust's NHS Carbon Management Programme and developed the carbon management plan (CMP) which identifies energy reduction measures. As a result of these initiatives, we have reduced our energy consumption by 11 percent. From September 2010, the Trust has been participating in the 10/10 campaign and we are confident that we will at least match the 10 percent reduction target in our measured 12 month period. The new combined heat and power (CHP) plant, commissioned in June 2010, will be the major element in producing the carbon savings.

A snap-shot of its operational success is demonstrated from the January 2011 figure when the unit generated 729MWh (megawatthours) of electricity, or 65 percent of the total site consumption, and reduced our global carbon dioxide emissions by 129 tonnes or approximately 1500 tonnes per annum. Other improvements include the continued upgrade of lighting control throughout the hospital, made possible through an interest free loan from the Department of Energy and Climate Change.

The estates returns information collection (ERIC) is another driver, encouraging NHS facilities to improve on their sustainability performance. The Trust has recently approved the implementation of a draft sustainable development management plan (SDMP) which encompasses relevant elements of ERIC. The SDMP will sit beside our existing CMP and will act as guidance for the Trust to align us with the national NHS strategy 'Saving Carbon, Improving Health' as well as providing a long-term approach to sustainability issues.

Valuing our staff

We are one of Kent's largest employers, with around 3,855 staff from a variety of backgrounds. Sixty-five percent of our staff are clinical comprising 29 percent qualified nursing, 11 percent medical and dental, three percent allied health professionals, and 22 percent other clinical. Thirty-five percent of staff are in non-clinical staff groups incorporating 13 percent maintenance and 22 percent administrative and clerical staff.

Work force statistics

Ethnicity

	Number of staff	Percentage
White	2,988	77.5%
Asian	397	10.3%
Black or black British	131	3.4%
Mixed	67	1.74%
Other	272	7.06%
Total	**3,855**	**100%**

Age

	Number of staff	Percentage
16 - 20	48	1.25%
21 - 25	297	7.7%
26 - 30	392	10.17%
31 - 35	428	11.10%
36 - 40	486	12.61%
41 - 45	524	13.59%
46 - 49	503	13.05%
50 - 55	606	15.72%
56 - 60	384	9.96%
61 - 64	154	3.99%
65+	33	0.86%
Total	**3,855**	**100.00%**

Gender

	Number of staff	Percentage
Female	3,151	81.74%
Male	704	18.26%
Total	**3,855**	**100%**

Staff survey

The Trust took part in the eighth national staff survey and analysis of the 2010 data shows the Trust compares most favourably with other trusts in England for training in health and safety, percentage of staff suffering work related injuries in the last 12 months and staff having equality and diversity training and effective team working.

The Trust compared less favourably with staff working extra hours and commitment to work life balance. These issues are being addressed by the improving working lives group – details about their work is at the end of this section.

The result for staff experiencing bullying and harassment, abuse or violence from other staff

was a cause for concern. Ensuring staff treat each other with dignity and respect at work is really important to us. We are committed to promoting a culture where bullying and harassment should not be tolerated under any circumstance, and offer a number of accessible channels for reporting bullying and harassment and for getting confidential support.

A very small proportion of our staff make formal complaints of bullying and harassment and all complaints of this nature are taken seriously. We recognise that some members of staff may feel uncomfortable about raising their concerns and we have encouraged staff to report incidents. We have recently introduced a personal harassment contact service to provide an additional support mechanism for staff.

We are developing our plans in response to the staff survey results within the Trust and will be considering further measures to address reported incidents of harassment, bullying and violence.

Breakdown of top four staff survey results

Staff survey results	**2009/10**		**2010/2011**		**Trust deterioration/ improvement**
	Trust	National average	Trust	National average	
Response rate	33%	55%	33%	55%	-18%
Top four ranked scores					
Staff receiving health and safety training in last 12 months	91%	78%	92%	80%	+1%
Staff suffering work-related injury in last 12 months	17%	17%	13%	16%	+4%
Staff having equality and diversity training in last 12 months	58%	35%	68%	41%	+10%
Effective team working (out of 5)	Not avail*	Not avail*	3.76	3.69	-
Bottom four ranking scores					
Staff working extra hours	74%	65%	75%	66%	-1%
Staff experiencing harassment, bullying or abuse from staff in last 12 months	Not avail*	Not avail*	20%	15%	-
Staff experiencing physical violence from staff in last 12 months	Not avail*	Not avail*	3%	1%	-
Trust commitment to work-life balance (out of 5)	3.44	3.40	3.24	3.38	-0.20

* Due to changes to the format of the survey questions this year, comparisons with the 2009 score are not possible

Equality, diversity and human rights

The Trust is committed to continuously improving the patient experience and treatment outcomes of the diverse community it serves. We will achieve this partly through developing and harnessing the skills of a diverse workforce to improve its understanding of what is important to people who use services based on their needs and preferences.

The Trust recognises that this requires giving due regard to ethnicity, gender, disability, age, religion or belief, sexual orientation, gender reassignment, pregnancy and maternity and marriage and civil partnership, collectively known as protected characteristics, in relation to care, treatment and support.

The Trust has responded positively to the changing legislative and regulatory framework, notably the Equality Act 2010, within which it needs to operate. This requires a more proactive and systemic approach to how we deliver equitable outcomes and promote human rights.

The Trust published a revised Single Equality Scheme for 2011 – 2014 in March 2011. The scheme sets out the Trust's commitment to taking equality, diversity and human rights into account in everything we do and supports the Trust's strategic objectives, legislative responsibilities and the requirements of its regulators. It also delivers a coherent plan for embedding equality, diversity and human rights into the work of the Trust and ensuring that we have in place the systems needed to monitor progress and report on our outcomes and achievements. The equality and fairness steering group monitors progress against the Single Equality Scheme action plan. This group is the overarching committee that ensures the Trust meets its legal duties and healthcare regulations. The main aim of the group, which reports into the Trust's clinical executive group, is to make a positive contribution to the equality, diversity and human rights agenda.

The Trust also published a 'Corporate Equality Impact Assessment' programme for 2010/2011. The annual programme identifies priority impact assessments for the year and is designed to improve both the quality and scope of impact assessments undertaken. Impact assessments from the programme are quality assured by the equality impact assessment sub-group that was established during 2010. This group reports into the equality and fairness steering group.

The equality and fairness steering group also scrutinises annual diversity monitoring reports

and takes remedial action where necessary. The Trust has recently enhanced its workforce reports and developed patient reports covering access to services, how patients experience services and complaints to ensure compliance with the single equality duty.

Equality impact assessments and diversity monitoring reports show how the Trust's policies, processes and practices affect both staff and service users and are published on the Trust website.

Equality, diversity and human rights training both online and face-to-face continues to be delivered.

An annual equality report provides an overview of equality, diversity and human rights progress over the year and provides assurance to the Board that the Trust meets its legislative duties, as well as, relevant CQC requirements.

The above activities demonstrate our commitment to delivering equality of opportunity for all service users, carers, staff and the wider communities, ensuring this commitment is at the heart of Medway NHS Foundation Trust.

Improving working lives

The improving working lives (IWL) standard is a commitment by the Trust to create a well managed flexible working environment which supports staff, and respects the need to develop a healthy work/life balance. We believe that every member of staff has a right to work in an organisation that commits to caring for and developing its staff. At Medway NHS Foundation Trust our staff are our greatest asset and we realise that improving their work/life balance contributes to enhanced patient care.

The Trust has continued to reward the commitment and hard work of staff who go that extra mile to improve the experience patients have when they use our services, through the team and employee of the month awards. These awards are presented by the chief executive, chairman and IWL group members in the workplace.

The IWL group have recently held the annual awards night where a number of individuals and teams were presented with awards to highlight the amazing work undertaken and also to celebrate long service commitments to the Trust. A staff member commented that "the awards night demonstrates a key commitment the Trust has to rewarding its staff". The

agenda for the coming year includes:

- continuing to highlight and reward the excellent work undertaken by our staff teams

- working with the Trust Board to develop an action plan and implement any findings to improve the results of the staff survey

- develop an effective work plan to improve the working lives of our staff

- continue to review the action plans of the Boorman Report and the staff pledges of the 'NHS Constitution'. The Boorman Review published its interim report on 19 August 2009, setting out emerging findings and initial recommendations on NHS staff health and wellbeing

The Trust will provide support and opportunities for staff to maintain their health, wellbeing and safety, and is keen to engage staff in decisions that affect them and the services they provide, individually, and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

Regulatory ratings

As a foundation trust, we are required to provide Monitor, the foundation trusts' regulatory body, with quarterly reports on our performance. In 2010/11 the Trust's declarations to Monitor, compared with our performance in 2009/10 and our expectations as set out in the 2010/11 annual plan, were as follows:

	Annual plan 2009/10	**Q1**	**Q2**	**Q3**	**Q4**
Financial risk rating	4	3	3	3	3
Governance risk rating	Green	Green	Amber	Amber	Amber

	Annual plan 2010/11	Q1	Q2	Q3	Q4
Financial risk rating	3.2	2	2	2	2
Governance risk rating	Green	Amber-green	Amber-green	Amber-green	Amber-green

Finance risk ratings

During 2010/11 the Trust had planned to deliver a cumulative financial risk rating of three at the end of quarter three and quarter four, and a financial risk rating of three for the financial year as a whole, supported by a planned surplus of £2m. The Trust was therefore disappointed to deliver an unplanned financial risk rating of two for quarter three and quarter four, and a financial risk rating of two for the financial year as a whole and a corresponding deficit of £3.5m.

Medical staffing costs were affected by the usage of agency and locum staff partly caused by difficult to recruit to vacancies at consultant level and vacancies resulting from gaps in rotas unfilled by junior doctors in training. The premium paid to agencies to cover these roles was significantly higher than planned during the course of the financial year. Nurse agency costs were also significantly higher than planned in the first quarter of the year. Expenditure caps for usage and a reduction in the number of beds during the year significantly reduced the need for agency nursing thereafter.

The poor weather in December 2010 led to an unplanned reduction in clinical income of £1.2m without an equivalent reduction in cost, as the hospital continued to provide services but patient numbers were reduced due to the impact of snow and ice on travel conditions.

Whilst the Trust delivered £13.6m of its £15m savings programme, a 91 percent success rate, the fact that the plan was heavily weighted towards the end of the financial year meant that slippage against the target was evident towards the end of quarter three and continuing through quarter four, which left little time for corrective action.

The Trust was also impacted non-recurrently by final agreements with its commissioners regarding contractual issues related to the 2009/10 financial year, and a decision to provide against a contractual issue outstanding at the end of 2010/11, which has subsequently been resolved.

The unplanned financial risk rating of two, against a planned financial risk rating of three, at the end of quarter three, led to the Trust being found in significant breach of its terms of authorisation by Monitor. The Trust has taken actions to address issues raised by Monitor and has submitted an annual plan for 2011/12 which returns the Trust to a financial risk rating of three, and a delivers a surplus for the financial year.

Governance risk ratings

The Trust's consistent 'amber-green' governance risk rating throughout 2010/11 arose from the CQC's assessment of the Trust's compliance with the CQC's 'Essential Standards of Quality and Safety'.

On initial registration in April 2010, the CQC imposed four conditions on the Trust's registration. The issues which led to the imposition of these conditions were, essentially, unsatisfactory levels of child protection and Mental Capacity Act training, clinical audit arrangements and governance arrangements. The CQC additionally expressed one 'major', four 'moderate' and one 'minor' concern about the Trust. Under the provisions of the 2010/11 Compliance Framework, the existence of these conditions meant that the Trust was automatically risk rated as amber-green for governance.

The Trust addressed these areas of practice in line with the CQC's required timescale and in quarter three, the four conditions were removed from the Trust's registration and the concerns were all either downgraded or removed, leaving the Trust with one moderate concern and four Minor concerns. The Compliance Framework allocates one point to the existence of moderate concerns, meaning that the Trust's governance risk rating remained at amber-green for quarter three, despite the significant improvement in its performance against the CQC standards.

The Trust underwent a full planned compliance review by the CQC at all four of its registered locations (Medway Maritime Hospital, Preston Skreens Children's Unit, Woodlands Special Needs Nursery and the dermatology clinic based in Borough Green) in February 2011. The Trust was found to be compliant with all 'Essential Standards of Quality and Safety' at the hospital site, Woodlands Special Needs Nursery and the Trust's dermatology clinic at Borough Green Medical Centre. Two non-compliances were identified at Preston Skreens Children's Unit, leading to the expression of two moderate concerns by the CQC, but an action plan to address these issues has been developed and implemented and all required changes have already been made. The Trust will need to provide evidence, in due course,

that these changes have been fully embedded and the CQC will re-review levels of compliance at Preston Skreens in a few months.

The CQC also issued some suggestions for improvement and to ensure maintained compliance with the 'Essential Standards of Quality and Safety' at the hospital site and the Trust's dermatology clinic at Borough Green Medical Centre – these are expressed on the CQC's website as 'minor concerns'. Although they do not indicate non-compliance with the essential standards, the Trust has been acting on these suggestions and an action plan to ensure that they are followed through has been developed. Several of the suggestions have already been implemented in full and evidence of these improvements has been sent to the CQC for consideration.

The review reports also confirm that the areas of previous concern to the CQC (including the leadership of governance and learning lessons from incidents) have been fully addressed to the CQC's satisfaction, and the associated concerns have been removed from the Trust's registration.

The CQC's compliance review was a routine review, carried out at all trusts every two years. The Trust was subject to no regulatory activity on the part of the CQC or Monitor during 2010/11.

Board of Directors

As a foundation trust, the Trust is run by a Board of Directors, comprising of a non-executive chairman and up to six other non-executive directors and up to six executive directors.

The Board meets monthly and its role is to determine the overall corporate and strategic direction of the Trust and ensure the delivery of the Trust's goals.

The Board of Directors is responsible for the day to day running of the hospital and delivering its key objectives and longer term strategic aims.

The Board of Directors has reserved powers to itself covering:

- regulation and control
- appointments and dismissals, of committees and members of committees that are directly accountable to the Board, executive directors, company

secretary
- strategy, plans and budgets
- policy determination
- audit
- annual report and accounts
- monitoring

The Board delegates some of its powers to its committees. The arrangements for delegation are set out in the Trust's standing orders. The constitution and terms of reference of these committees and their specific powers are approved by the Board of Directors. The committees are all advisory and some have decision making powers. The Board also approves the appointments to each of the committees which it has formally constituted.

Decisions delegated to the Board of Directors

An executive committee consisting of the executive directors meets weekly and is chaired by the chief executive. Its purpose is to ensure that the objectives agreed by the Board are delivered and to analyse the activity and performance of the Trust against the business plan to ensure that duties are appropriately delegated to the senior management team and actions monitored. It also ensures that the key information from external bodies is discussed, actions identified and messages disseminated appropriately across the organisation.

The Board has given careful consideration to the range of experience and skills required for running an NHS foundation trust and confirms that, since the appointment of the sixth non-executive director (John Sands) during the financial year 2009/10, it has a very good balance in place. However, it will continue to analyse its skills during the next financial year to ensure this remains the case.

Directors of Medway NHS Foundation Trust during 2010/2011

Vernon Hull	Non-executive director and chairman
Graham Clayden	Non-executive director
Adrian Horwood	Non-executive director and deputy chairman
[4]Martin Jamieson	Non-executive director
Chuba Ofili	Non-executive director
[4]Andrea Penman	Non-executive director
John Sands	Non-executive director
Colin Wilby	Non-executive director
[3]Andy Brown	Interim director of human resources
[1]Mark Devlin	Chief executive
[4] Patrick Johnson	Director of operations/deputy chief executive
[3] Cheryl Lee	Director of human resources
Jacqueline McKenna	Director of nursing
[5]Jeremy Moon	Director of finance
[5]Steve Orpin	Interim director of finance
[2] Gray Smith-Laing	Medical director
[1] Jane Sutherland	Interim director of operations

1. Jane Sutherland stood down as interim director of operations on 25 April 2010; Patrick Johnson was appointed as interim director of operations on 26 April 2010.On 30 June 2010 Patrick was appointed director of operations/deputy chief executive on a permanent basis

2. Gray Smith-Laing was appointed as interim medical director from 8 October 2009 and was appointed as medical director in May 2010

3. Cheryl Lee, director of human resources, went on maternity leave from 5 May 2010 to 28 March 2011 when she was seconded to the transition team. Andy Brown was seconded on an interim, part-time basis from Dartford & Gravesham NHS Trust from June 2010 and is continuing in this role while Cheryl Lee is on secondment

4. Andrea Penman was non-executive director until December 2010 when she stood down due to work commitments. Martin Jamieson was appointed non-executive director on 22 December 2010 to fill this vacancy

5. Jeremy Moon, director of finance was seconded as project director to the transition team on 1 April 2011 and Steve Orpin has been appointed interim director of finance while Jeremy Moon is on secondment.

The performance of the Board is evaluated by annual appraisal and any skills gaps are reviewed by the Nominations and Remuneration Committee which also has responsibility for reviewing the size, structure and composition of the Board on an annual basis, and makes recommendations to the Board and Council of Governors for change. Directors have individual appraisals and professional development reviews. Development sessions have also been introduced after some Board meetings. The Board also held three Board away days during the year in order to consider strategy and development issues.

Vernon Hull
(Chairman and Non-executive director)
Vernon has worked in post 16 education since 1972. His most recent post was as director of the Gateway Knowledge Alliance, which was established by all the major further and higher education institutions in Kent, as well as the local education authorities, to promote the learning and skills needs required by the Thames Gateway development in North Kent.

Vernon had a leading role on local politics in Medway for a number of years, including seven years as deputy leader of Rochester upon Medway Council and two years as deputy leader of the new Medway Council. As the chair of the Council's Economic Development Committee, he played a leading role in the regeneration of Medway following the closure of the Naval Dockyard. Vernon also stood for Parliament in Medway in 1983 and 1987. He has served on a number of educational and charity boards including Kent TEC, the Learning and Skills Council and the Rochester Bridge Trust.

In November 2004 Vernon was appointed chairman of Medway NHS Trust and played a lead role in the hospital's successful application to become a foundation trust in April 2008.

The chair has no other significant commitments and there have been no changes during the year.

Appointment: 1 November 2004. Reappointed on 1 April 2008 for one year. Re-appointed on 1 April 2009 for three years.
Membership of committees: Nominations and Remuneration Committee.

Graham Clayden
(Non-executive director)
Graham was until recently a reader in paediatrics at King's College London (KCL) and honorary consultant paediatrician for Guy's and St Thomas' NHS Foundation Trust. He was chair of the KCL School of Medicine Board of Examiners and a Sub Dean for student admission of undergraduate medicine.

Graham is a member of numerous professional associations, including the British Medical Association, a founder of the British Paediatric Computer and Information Group, British Education Research Association and a past member of the governing body of the Institute of Medical Ethics to name but a few.

He also has experience on the councils of the Royal College of Physicians as Censor and on the Royal College of Paediatrics and Child Health, as officer for examinations and is assessment consultant to the Institute of Directors' Board of Examiners.

Appointment: 1 April 2007
Membership of committees: Nominations and Remuneration Committee, Quality Committee, Local Clinical Excellence Awards (chairman).

Adrian Horwood
(Deputy chairman and non-executive director)
Adrian retired from banking in 2004 after a career spanning 33 years. He spent the last 25 years in strategic and management roles in Kent covering all aspects from general management, HR, operational and financial, advising both personal and commercial clients.

He is currently involved with MidKent College and Chatham Maritime Estates (an estate management company) as a Trustee and non-executive director and with the Salvation Army in a leadership capacity. Adrian also works with the Kent, Surrey and Sussex Deanery as a lay advisor on matters relating to recruitment to various specialities both on a national and local basis.

Appointment: 1 November 2005
Membership of committees: Nominations and Remuneration Committee, Integrated Audit Committee (chair), Performance and Investment Committee, Charitable Funds Committee.

Martin Jamieson

(Non-executive director)

Starting as a sales and marketing professional, Martin has worked within the pharmaceutical and medical device industry for the majority of his career. For the past 16 years he has held a number of managing director roles within Smiths Group (a FTSE 100 company), notably as managing director for Portex Limited and Smiths Medical International Limited, which both have their headquarters in Kent. Throughout this period Martin was responsible for the commercial activity, manufacturing operations and research and development for the business in over 100 international markets. These included Europe, USA, Japan and increasingly China and India. As a result, he has extensive experience of a large number of healthcare systems across the world, not least the NHS. Outside Martin's daily working life he has been deputy and then chairman of the Confederation of British Industry (CBI) in the South East. For over ten years, Martin was also a director of the Smiths Industries pension fund.

Martin has recently joined the Country Land and Business Association (CLA) as director general. The CLA is a lobbying organisation whose 35 thousand members own or manage over 50 percent of the land assets in England and Wales.

Appointment: 22 December 2010

Membership of committees: Quality Committee and Nominations and Remuneration Committee.

Chuba Ofili

(Non-executive director)

Chu has extensive experience of the public, private, community and voluntary sectors. His roles have included business planning and development, economic policies, implementation of legislation, review and programme/project leadership, commercial advice, human resourcing and commissioning of services, works and goods.

He has served on various boards and panels including the independent monitoring board of HMP Blakenhurst, the board of East Potential (formerly Network East Foyers) and the Employer and Practitioner (organisation and employment) Advisory Panel at the London Metropolitan University Business School. He is on the NHS SEC NEDs Development Board.

Appointment: 1 August 2007

Membership of committees: Performance and Investment Committee, Nomination and Remuneration Committee, Quality Committee, Charitable Funds Committee

Andrea Penman

(Senior independent director and non-executive director until December 2010)

Andrea worked as a Board director for a major real estates company in the city for nine years responsible for providing estates, projects and facilities management services to many 'blue chip' organisations throughout London. Prior to this, Andrea pursued a career at the London Stock Exchange where she managed their portfolio of buildings across London for over ten years. In 1996 Andrea set up the Facilities Management Network a consultancy company providing advice and recruitment services to a number of international surveying practices and other city and West End clients (specialising in quality assurance, process mapping and project management) within the estates and facilities management environment.

In April 2000 Andrea became a Justice of the Peace for Her Majesty's Courts Service in Kent and is both a mentor of new magistrates and an appraiser; she is also a member of the Lord Chancellor's Advisory Committee.

Appointment: 21 May 2002 – December 2010 (appointment extended on 20 May 2006 for a further four years and then appointment extended from May 2010 for a further year).
Membership of committees: Quality Committee (chair), Nominations and Remuneration Committee, Integrated Audit Committee.

John Sands

(Non-executive director)

John’s business background is in social housing in the local authority and voluntary sectors. He has worked in London, Essex and Kent. Until his retirement in 2009, John was chief executive of mhs homes group, the largest social landlord in Kent. He has a particular interest in PR and marketing and the development of great customer service.

Among his other activities, John is chair of Gallions Housing Association and a member of the finance committee of the Dean and Chapter of Rochester Cathedral.

Appointment: 7 July 2009
Membership of committees: Integrated Audit Committee, Nomination and Remuneration

Committee, Quality Committee (chair from January 2011), Patient Safety Committee, Patient Experience Committee.

Colin Wilby

(Non-executive director)

Colin has a varied business background in manufacturing industries, working for large companies, including Lucas, Associated British Foods and Nestle, in personnel, operations and general management roles. Most recently, Colin was managing director of a business unit within RHM plc, based in Gillingham.

Colin now holds a portfolio of roles, including non-executive appointments with Kent Probation, the Royal Institution of Chartered Surveyors and the Office of the Independent Adjudicator for Higher Education. He is also chair of the Independent Remuneration Panel for Tonbridge and Malling Borough Council, Sevenoaks District Council and Tunbridge Wells Borough Council.

Appointment: 1 July 2007

Membership of committees: Performance and Investment Committee (chair), Integrated Audit Committee, Nomination and Remuneration Committee.

Andy Brown

(Interim director of human resources)

Originally from Bristol, Andy's human resources career in the NHS started at the Bromley Health Authority in 1995. He moved to Royal Brompton & Harefield NHS Trust in 2000. He has since furthered his NHS career in acute and specialist hospitals. Since June 2008 he has been the director of human resources at Dartford & Gravesham NHS Trust. He has been seconded part-time from Dartford since June 2010 to cover maternity leave of the substantive director of human resources, Cheryl Lee.

Mark Devlin

(Chief executive from 1 April 2010)

Mark began his management career in 1991 as a business manager in the Belfast City Hospital having joined the NHS as a graduate management trainee in Northern Ireland in 1989. He progressed through general management positions covering a wide range of clinical services and hospital settings in London. He became project director for the first ambulatory care and diagnostic centre at the Central Middlesex Hospital in 1997 and led one

of the major divisions of the Royal Free Hospital from 1998 to 2001. He was deputy chief executive of Northwest London Hospitals until 2005, when he was appointed chief executive of Dartford & Gravesham NHS Trust. He worked in Dartford until 2010 when he became chief executive of Medway NHS Foundation Trust.

Patrick Johnson
(Interim director of operations from 26 April 2010, director of operations/deputy chief executive from 30 June 2010)
Patrick is a chartered accountant and has significant experience having worked in managing director and chief operating officer roles associated with the NHS over the last four years, most recently at the Royal Berkshire NHS Foundation Trust. Prior to this, he had extensive private sector experience in a number of sectors including finance, distribution and business services for several major European companies.

Cheryl Lee
(Director of human resources)
Cheryl Lee has worked in human resources for almost all of her career, working in both the private and public sector. Cheryl joined the Trust in 2004 and she became a Board member in 2007. Her role includes responsibility for the strategic workforce and organisational development agenda.

Jacqueline McKenna MBE
(Director of nursing)
Jacqueline trained as a registered nurse at King's College Hospital and had a successful clinical career in gynaecology. Jacqueline achieved a Masters in Medical Science in Clinical Nursing in 1995.

Jacqueline has been the director of nursing at the Medway NHS Trust since 2000, having previously been the director of nursing at Southmead, Bristol from 1997. She implemented the first British model of shared governance which improves staff involvement in 1994, and won the HSJ award for patient safety in 2005 for the development of the Medway Nursing and Midwifery Accountability System – a performance management tool for nursing which is now being implemented by a number of trusts in England. She is currently studying for a PhD at Greenwich University.

Jeremy Moon

(Finance director)

Jeremy trained as a chartered accountant with Touche Ross & Co and qualified in the mid 1980s. He worked for B.E.T plc, a multinational conglomerate, until 1992 when he joined the NHS. He was appointed as director of finance of the Kent and Sussex Weald NHS Trust in 1994 and joined Medway NHS Trust in 2000.

He is a graduate of London University, having read geography at the School of Oriental and African Studies.

Gray Smith-Laing

(Medical director from May 2010)

Gray qualified with honours at The Royal Free Hospital, London in 1973 and has undertaken training in all aspects of general medicine and gastroenterology.

He joined Medway NHS Foundation Trust in 1984 and specialises in all types of gastrointestinal and liver disease. He remains a true 'general physician', with a major interest in endoscopic retrograde cholangio pancreatography (ERCP) and other therapeutic endoscopic procedures. In addition, he has previously undertaken management roles; he was clinical director of medicine for over ten years up to 2005 and deputy medical director of the Trust in 2006. He was appointed as interim medical director from 8 October 2009 and appointed as medical director on a permanent basis in May 2010

Board of Directors' interests

Under the terms of the Trust's constitution, the Board of Directors are individually required to declare any interest, as soon as they become aware of it, which may under the terms of the constitution, conflict with their appointment as a director of Medway NHS Foundation Trust. During the year, none of the directors have disclosed details of company directorships or other material interests that would conflict with their appointment as a director, or with their management responsibilities.

A register of the directors' interests is available to the public via the Trust's website **www.medway.nhs.uk** or on request from the company secretary.

In compliance with paragraph c.1.11 of the 'Monitor Code of Governance for NHS Foundation Trusts', no executive director holds more than one non-executive directorship of an NHS foundation trust or other organisation of comparable size and complexity.

Arrangements for the termination of appointment of a non-executive director are set out in the Trust's constitution. All non-executive directors are considered to be independent by the Board of Directors.

Since becoming a foundation trust, non-executive directors have been appointed for a period of three years.

Attendance at Board of Directors' meetings in 2010/11

Name	Title	
Vernon Hull	Chairman	14 out of 14
Andy Brown	Interim director of human resources	9 out of 13
Graham Clayden	Non-executive director	12 out of 14
Mark Devlin	Chief executive	13 out of 14
Adrian Horwood	Non-executive director	12 out of 14
Martin Jamieson	Non-executive director	3 out of 3
Patrick Johnson	Director of operations/deputy chief executive	14 out of 14
Cheryl Lee	Director of human resources	1 out of 1
Jeremy Moon	Director of finance	14 out of 14
Jacqueline McKenna	Director of nursing	13 out of 14
Chuba Ofili	Non-executive director	14 out of 14
Andrea Penman	Non-executive director	10 out of 11
John Sands	Non-executive director	13 out of 14
Gray Smith-Laing	Medical director	14 out of 14
Jane Sutherland	Interim director of operations (to 6 April 2010)	1 out of 1
Colin Wilby	Non-executive director	13 out of 14

Committees of the Board

Integrated Audit Committee

Members	Committee role	Attendance
Adrian Horwood (Non-executive director)	Chairman	6 out of 6
Andrea Penman (Non-executive director)	Member	4 out of 5
John Sands (Non-executive director)	Member	6 out of 6
Colin Wilby (Non-executive director)	Member	6 out of 6

The Integrated Audit Committee (IAC), which consists of not less than three non-executive directors of the Trust, meets on a bi-monthly basis and provides the Board with an independent and objective view on its financial and non-financial systems, financial and non-financial information and compliance with laws, guidance and regulations governing the NHS.

Its main responsibility is to provide the Board with assurances in respect of governance, risk management and internal control, and that effective systems across the whole of the organisation's activities (both clinical and non-clinical) support the achievement of the organisation's objectives.

At the commencement of each IAC meeting, a private session is held between the non-executive directors, the internal and external auditors and the counter-fraud specialists.

Internal auditors report to every meeting of the IAC to provide relevant assurances regarding the adequacy and effectiveness of internal controls. The IAC carries out an annual review of the adequacy of internal audit. External auditors report to every meeting of the IAC to provide progress reports and actions taken as part of the annual audit plan. They also contribute to discussions on systems and processes.

Counter fraud specialists report to every meeting of the IAC to provide an update on current or new fraud cases and actions taken as a result of those cases.

The IAC sets itself a rolling work plan, which it has continued to meet. It also carries out an annual self-assessment.

The IAC has produced an annual report which has been presented to the Board and to the Council of Governors.

During the year the IAC was able to satisfy the Board and Council of Governors that they could be assured that the information they received in the following areas was robust and reliable:

- the work of the internal auditors, South Coast Audit
- the work of the local counter fraud specialist
- the work of the external auditors, PKF
- the management of the Trust's charitable funds

- the work of the Board's Performance and Investment Committee
- the compilation of the Trust's annual accounts
- the preparation of the Trust's final annual report as an acute foundation trust
- the preparation of the statement of internal control
- the work of the internal clinical audit

In addition to these assurances, the committee was proactive in other areas and has worked closely with the Quality Committee to ensure that the work was complementary. In 2010, the IAC advised the Board that the strategy for the identification and management of risk across the Trust be highlighted as a concern. This has this has subsequently been improved through development of the Board Assurance Framework and links to the risk register. It also advised the Board and the Council of Governors on the issues with the completion of the Board Assurance Framework.

The IAC provides a report to the Board of Directors after every meeting.

Quality and Safety Committee (until November 2010)

Members	**Committee role**	**Attendance**
Andrea Penman (Non-executive director)	Chairman	4 out of 4
John Sands (Non-executive director)	Member	1 out of 1
Graham Clayden (Non-executive director)	Member	3 out of 4
Chuba Ofili (Non-executive director)	Member	4 out of 4
Patrick Johnson (Executive director)	Member	3 out of 4
Jacqueline McKenna (Executive director)	Member	4 out of 4
Gray Smith-Laing (Executive director)	Member	2 out of 4

Quality Committee (from January 2011)

Members	Committee role	Attendance
John Sands (Non-executive director)	Chairman	3 out of 3
Graham Clayden (Non-executive director)	Member	2 out of 3
Martin Jamieson (Non-executive director)	Member	2 out of 2
Chuba Ofili (Non-executive director)	Member	2 out of 3
Mark Devlin (Executive director)	Member	3 out of 3
Patrick Johnson (Executive director)	Member	1 out of 3
Jacqueline McKenna (Executive director)	Member	2 out of 3
Gray Smith-Laing (Executive director)	Member	2 out of 3

The Quality Committee (QC), which consists of no less than three non-executive directors of the Trust and four executive directors (whose membership of the committee commenced in January 2010), meets on a monthly basis and sets the strategic direction for managing governance and risk. It is also regularly attended by the head of quality and risk, director of infection, prevention and control and the chairman of the Patient Safety Committee.

The QC oversees the development of all risk and governance activities within directorates and other support departments, in order to underpin the Trust's reputation and performance, as well as assuring the Board of the organisation's compliance with national and local statutory requirements. The committee also receives and responds to CQC reports.

At each meeting of the QC, it receives and gives guidance or actions on:

- reports on serious untoward incidents
- corporate risk register on which it makes recommendations for any changes to the Board
- infection control report

The QC provides a report to the Board of Directors after every meeting on its activities which includes reports on infection control and the corporate risk register.

Performance and Investment Committee

Members	Committee role	Attendance
Colin Wilby (Non-executive director)	Chairman	12 out of 12
Adrian Horwood (Non-executive director)	Member	10 out of 12
Chuba Ofili (Non-executive director)	Member	12 out of 12
Mark Devlin (Chief executive)	Member	10 out of 12
Patrick Johnson (Director of operations/deputy chief executive)	Member	10 out of 11
Jeremy Moon (Executive director)	Member	12 out of 12
Jane Sutherland (Interim director of operations)	Member	1 out of 1

The Performance and Investment Committee, consisting of three non-executive directors and three executive directors, meets on a monthly basis and provides the Trust Board with a detailed and objective view on the resource utilisation and planning performed by the Trust including income and expenditure, cash flow and balance sheet management, business development and service improvement plans in the form of business cases. It scrutinises performance management in detail each month and reports to the Board on an exception basis.

In particular, over the past year the Performance and Investment Committee has reviewed and challenged the current and future profitability of several specialities, for example; vascular, haematology, community paediatrics, cardiology and orthodontics. They considered business cases for investment in a midwifery led unit, MRI, replacement generators and the combined heat and power plant. They received reports on trends in service line reporting and the development of patient level information costing systems; the longer term economic prospects; downside modelling and the current contract with local primary care trusts. In addition, the committee considered and debated the operational and financial position of the Trust.

Remuneration report

In July 2009, the terms of reference for the Personnel and Remuneration Committee were reviewed and revised. In line with best practice, the Board agreed that this committee be replaced with a Nominations and Remuneration Committee, whose membership consists of all the non-executive directors.

The Nominations and Remuneration Committee reviews and makes recommendations to the Board of Directors on the composition, balance, skill mix and succession planning of the Board and recommends the appointment of executive directors. It also has delegated authority for setting the overall remuneration and benefits, including pensions as well as arrangements for the termination of employment, for the chief executive and the executive directors.

Remuneration levels for senior managers were recommended by an independent consultant, who referred to the information provided by Foundation Trust's Network on executive pay and the NHS chief executive and directors' salary survey, as well as a review of other similar posts advertised in the South East region. The remuneration recommendations span April 2008 to April 2011 with market reviews taking place every three years and cost of living increases being undertaken annually. Any cost of living increase will be considered against very senior managers (VSM) and Agenda for Change benchmarks. Remuneration levels are not split into basic salary and performance related pay, but this is being considered for future years. For the purposes of the remuneration report, senior managers are defined as those with voting rights at a Trust Board meeting.

In the last financial year, the Nominations and Remuneration Committee has recommended the appointment of the deputy chief executive/director of operations, medical director, director of governance and risk and the interim director of human resources (to cover maternity leave).
During the year, one new non-executive director, Martin Jamieson, was appointed. He replaced Andrea Penman.

The membership of the group is comprised of the following:

Nominations and Remuneration Committee

Members	Committee role	Attendance
Vernon Hull	Chairman	6 out of 6
Graham Clayden	Member	5 out of 6
Adrian Horwood	Member	5 out of 6
Martin Jamieson	Member	1 out of 1
Chuba Ofili	Member	6 out of 6
Andrea Penman	Member	4 out of 5
John Sands	Member	5 out of 6
Colin Wilby	Member	6 out of 6

Performance is reviewed annually at appraisal against objectives. Objectives are agreed at the appraisal and progress is reviewed at monthly one to one meetings.

Executive directors hold substantive contracts with six month notice periods. Any contract termination would need to be approved by the Trust's Nominations and Remuneration Committee.

Salary and pension entitlements of senior managers

The tables for remuneration and pensions benefits have been audited as referred to in the independent auditors' report. All other information in the remuneration report has not been audited.

	2010/11			2009/10		
Name and title	Salary (bands of £5000) £000	Other remuneration (bands of £5000) £000	Benefits in kind Rounded to the nearest £100	Salary (bands of £5000) £000	Other remuneration (bands of £5000) £000	Benefits in kind Rounded to the nearest £100
Mr Vernon Hull, Chairman	40-45	-	-	40-45	-	-
Mr G Clayden, Non-executive Director	10-15	-	-	10-15	-	-
Mrs A Penman, Non-executive Director	10-15	-	-	10-15	-	-
Mr A Horwood, Non-executive Director	10-15	-	-	10-15	-	-
Mr C Wilby, Non-executive Director	10-15	-	-	10-15	-	-
Mr C Ofili, Non-executive Director	10-15	-	-	10-15	-	-
Mr J Sands, Non-executive Director	10-15	-	-	5-10	-	-
Mr M Jamieson, Non-executive Director	0-5	-	-	-	-	-
Mr M Devlin, Chief Executive	150-155	-	-	-	-	-
Mr P Johnson, Director of Operations and Deputy CEO	125-130	-	-	-	-	-
Mr J Moon, Director of Finance	110-115	-	-	110-115	-	-
Dr G Smith-Laing, Medical Director	25-30	170-175	-	10-15	65-70	-
Mrs J McKenna, Director of Nursing	100-105	-	-	100-105	-	-
Miss C Lee, Director of Human Resources	5-10	-	-	90-95	-	-
Mrs J Sutherland, Interim Director of Operations	5-10	-	-	90-95	-	-

Name and title	Real increase in pension and related lump sum at age 60 (bands of £2500) £000	Total accrued pension and related lump sum at age 60 at 31 March 2011 (bands of £2500) £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Real Increase in Cash Equivalent Transfer £000
Mr M Devlin, Chief Executive	57.5-60	165-167.5	558	-	125
Mr P Johnson, Director of Operations and Deputy CEO	0-2.5	5-7.5	63	-	16
Mr J Moon, Director of Finance	0-2.5	105-107.5	504	525	-48
Miss C Lee, Director of Human Resources	0-2.5	30-32.5	64	77	-17
Mrs J McKenna, Director of Nursing	(0)-(2.5)	115-117.5	452	492	-65
Dr G Smith-Laing, Medical Director	30-32.5	315-317.5	Note a	Note a	Note a

a) Dr G Smith-Laing has reached the age of 60 and hence a CETV figure is not provided by the Pension's Agency.
b) The information in the above table has been provided by the NHS Pension's Agency.
c) In the budget in June 2010, it was announced that the up-rating (annual increase) of public sector pensions would change from the Retail Prices Index (RPI) to the Consumer Prices Index (CPI) with the change expected from April 2011. As a result the Government Actuaries Department undertook a review of all transfer factors. The new CETV factors have been used in the above calculations and are lower than the previous factors used. Therefore the value of CETV's for some members have fallen since 31/03/2010.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004/05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme.

They also include any additional pension benefit accrued to the member as a result of their

purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV – this reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Signed: M Devlin, Chief Executive Date: 6th June 2011

Council of Governors

The Council is made up of elected and appointed governors who provide an important link between the Trust, local people and key stakeholder organisations. They share information and views that can influence and shape the way hospital services are provided by the Trust, and they work together with the Trust's Board of Directors to ensure that the foundation trust delivers high quality healthcare within a strict framework of governance – whilst achieving financial balance and planning for the future.

There are 26 governors on the Council of Governors, 19 of whom are elected public and staff member representatives and seven are nominated by partner organisations.

Constituencies

There are three public constituencies that make up the catchment area for the Trust. Medway and Swale are the main two constituencies, with the third covering the rest of England and Wales. The third constituency is specifically designed for the catchment population that use the specialist services which are provided to anyone in England and Wales.

Governors serve on the Trust's Council of Governors, working as a team with governor colleagues but specifically representing one particular class in their own membership community. The public governors each represent a constituency. Medway constituency has nine public governors; Swale constituency has four public governors and the rest of England and Wales has one public governor.

The staff governors are elected to represent staff in each directorate of which there are five in the Trust. Stakeholder governors are nominated by their organisation to sit on the Council and link back to their organisation. Please see the breakdown of governors listed below:

The Trust's partner organisations are NHS Medway; NHS Eastern and Coastal Kent; Medway Council; universities; League of Friends; and Kent County Council.

Role of a governor

Governors are required to attend regular meetings of the Council of Governors – normally seven a year which includes the members' annual meeting.

The governors have some specific statutory requirements to fulfil on an annual basis as well as some generic responsibilities. These include to:

- appoint or remove the chairman and non-executive directors
- approve the appointment of the chief executive
- decide on remuneration for non-executive directors
- consider the patient experience
- receive the annual accounts
- appoint and remove the Foundation Trust's auditor
- hold the Board to account
- represent constituent members
- consider the Foundation Trust's forward plans and advise the Board of Directors on them

Governors are also expected to actively seek the views of the community they represent – this has typically been through members' events but the Trust is looking at other ways of involving the membership.

Structure of Council

The Council meets seven times a year and in order to assist in its work and meet the Councils statutory requirements, the Council has established four working groups. These are listed below with a brief overview of each group's responsibilities:

Membership recruitment and communications: To develop, implement and review the Trust's membership strategy as well as being accountable on behalf of the governors for ensuring that the elections are fair and true.

Strategy and audit: To make recommendations to the Council of Governors with respect to the appointment of the Trust's external auditor and to report to the Council of Governors with respect to the auditor's annual report, the Trust's forward plan and the Quality Accounts.

Non-executive director recruitment and remuneration: To carry out an annual appraisal of the chairman, review the remuneration of the non-executive directors on an annual basis, to be involved in the nomination process for all non-executive directors and to be involved in overseeing the arrangements of the Trust's annual members' meeting.

Patient experience: To advise the council in all aspects of the patient experience in the hospital, including quality of care, communication and administration, service development, development of the estate and public health issues.

At the time of writing this report, the governors were considering restructuring the working groups to strengthen the monitoring and scrutiny role of the Governing Council whilst still ensuring the statutory duties are met. The aim was also to strengthen the relationship with non-executive directors of the Trust which is recognised to be the primary means of ensuring the governors are holding the Board to account.

Governor terms of office

Public and staff governors

All public and staff governors are elected for a term of three years, with the exception of the first governors that were appointed to the Trust. In order to avoid an election process every three years that would see the replacement of 19 public governors, it was agreed by the Trust to initially stagger the terms of office for each governor in order to ensure business continuity and establishment of the Council.

This has resulted in a third of governors being appointed for a term of one year, another third for two years and the remaining third for three years. Every year only a third of governors stand for re-election.

Partner governors

Partner governors are nominated by their organisation and serve a term of office of three years. These governors can be replaced by their organisation during this time.

Governor election activity

All governors were appointed in June 2007, one third were given a term of one year, one third were given a term of two years, and the last third were given a term of three years.

During 2010/2011, the Council of Governors was made up as follows:

Elected representatives for Medway (nine):

- Vivien Bouttell (elected in June 2010)
- Nigel Cartlidge
- Renee Coussens
- Pamela Gibbon
- Angela Jenkins
- Margaret Ratcliffe
- Ann Richmond
- Sheila Shepherd
- Lee Tribe

Elected representatives for Swale (four):

- Ronald Clayton (elected in June 2010; resigned in September 2010)
- Sarah Drury (elected in December 2010)
- Christine Kite (elected in December 2010)
- Ruth Jenner
- John Mount

Elected representative for rest of England and Wales (one):

- Richard Tripp (elected in June 2010)

Elected staff representatives (five):

- Stephen Funnel (non-clinical – elected June 2010)
- Trish Marchant (management class – elected June 2010)
- Rosemary Toye (medical and dental class)
- Nancy Sayer (nursing and midwifery)
- John McLaughlin (allied health professions – elected in December 2010)

Nominated representatives from partner organisations (seven):

- Pippa Barber, NHS Medway (appointed September 2010; retired December 2010)
- Helen Buckingham, NHS Medway (retired September 2010)

- Adrian Crowther, Kent County Council
- Natalie Davies, NHS Medway (appointed December 2010)
- Councillor Jane Etheridge, Medway Council
- Tracey Manley, Chamber of Commerce (retired June 2010)
- Andrew Scott-Clark, NHS Eastern and Coastal Kent
- John Spence, League of Friends
- David Ward, Chamber of Commerce (appointed June 2010; retired January 2011)

Appointed / nominated	Name	Constituency	Term of office
Appointed 2007			
June 2007	Michael Burch	Medway	3 years
June 2007	Lee Tribe	Medway	3 years
June 2007	Victoria Allison	Swale	3 years
June 2007	Serena Gilbert	Rest of England and Wales	3 years
June 2007	Rosemary Toye	Staff: Medical and dental class	3 years
June 2007	Geraldine Mott	Staff: Management class (resigned 2009)	3 years
Appointed 2008			
June 2008	Ann Richmond	Medway	3 years
June 2008	Angela Jenkins	Medway	3 years
June 2008	Renee Coussens	Medway	3 years
June 2008	Margaret Ratcliffe	Medway	3 years
November 2008	Eric Ambrose	Staff: non-clinical (resigned 2010)	3 years
Appointed 2009			
June 2009	Nigel Cartlidge	Medway	3 years
June 2009	Ruth Jenner	Swale	3 years
June 2009	John Mount	Swale	3 years
June 2009	Sheila Shepherd	Medway (re-elected)	3 years
June 2009	Pam Gibbon	Medway (re-elected)	3 years
June 2009	Lena Wareham	Staff: Allied health professionals (resigned 2010)	3 years
June 2009	Nancy Sayer	Nursing and midwifery	3 years
Appointed 2010			
June 2010	Vivien Bouttell	Medway	3 years
June 2010	Ronald Clayton	Swale (resigned Sept 2010)	3 years
June 2010	Stephen Funnell	Staff: Non-clinical	3 years
June 2010	Trish Marchant	Staff: Management	3 years
June 2010	Rosemary Toye	Staff: Medical and dental (re-elected)	3 years
June 2010	Richard Tripp	Rest of England and Wales	3 years
June 2010	Lee Tribe	Medway (re-elected)	3 years
December 2010	Sarah Drury	Swale	3 years
December 2010	Christine Kite	Swale	3 years
December 2010	John McLaughlin	Staff: Allied health professionals	3 years
Nominated			
June 2007 June 2010	John Spence	League of Friends	3 years
June 2007 June 2010	Adrian Crowther	Kent County Council	3 years
June 2009	Cllr Jane Etheridge	Medway Council	3 years
December 2010	Natalie Davies	NHS Medway	3 years
June 2008	Andrew Scott-Clark	NHS Eastern and Coastal Kent	3 years
May 2010	Margaret Andrews	Universities	3 years
January 2011	Vacant	Chamber of Commerce	3 years

Attendance at Council of Governors meetings 1 April 2010/31 March 2011

Attendee	Attendance
Vernon Hull (Chairman)	6 out of 6
Victoria Allison	1 out of 1
Margaret Andrews	5 out of 5
Pippa Barber	0 out of 2
Vivien Bouttell	5 out of 5
Helen Buckingham	1 out of 3
Michael Burch	1 out of 1
Nigel Cartlidge	5 out of 6
Ronald Clayton	1 out of 1
Renee Coussens	6 out of 6
Adrian Crowther	6 out of 6
Natalie Davies	0 out of 1
Sarah Drury	1 out of 2
Councillor Jane Etheridge	3 out of 5
Stephen Funnell	4 out of 5
Pamela Gibbon	6 out of 6
Serena Gilbert	1 out of 1
Angela Jenkins	3 out of 6
Ruth Jenner	5 out of 6
Christine Kite	1 out of 2
Tracey Manley	0 out of 1
Trish Marchant	5 out of 5
John McLaughlin	0 out of 2
John Mount	6 out of 6
Margaret Ratcliffe	5 out of 6
Ann Richmond	6 out of 6
Nancy Sayer	6 out of 6
Andrew Scott Clarke	4 out of 6
Sheila Shepherd	5 out of 6
John Spence	4 out of 6
Lee Tribe	6 out of 6
Rosemary Toye	6 out of 6
Richard Tripp	5 out of 5
David Ward	2 out of 4

A register of governors' interests is held at the Trust's offices. Information regarding governors' interests and whether they have undertaken any material transactions with Medway NHS Foundation Trust can be obtained by contacting the governor and membership lead, Trust Offices, Medway NHS Foundation Trust, Windmill Road, Gillingham, Kent, ME7 5NY

Membership

Anyone aged 16 and over and who is not employed by the Trust can become a public member. Every member of staff automatically becomes a member unless they choose to opt out.

At 31 March 2011 we had 9,839 members and 3,855 staff members.

Membership strategy

The membership strategy outlines what the Trust's vision is in terms of recruiting, engaging and involving its members – the strategy provides a framework on how we aim to achieve this. The Trust wants to review how it can best serve its members and also how members can become involved with communicating to the Trust what the needs of the local community are.

Monitor, the Trust's independent regulating body, requires the membership base to be representative of the local community. This means the Trust needs to work hard at ensuring that its members reflect the socio economic breakdown of its population and is enabled to present a voice from the community.

Membership recruitment

During 2010/2011, the membership and communications working group planned several opportunities for recruiting new members.

The governors adopted a simple and cost effective method of face to face recruitment, using a team of governors who worked with the governor and membership lead. Methods included participation at local university freshers' and refreshers' fairs, a two week recruitment campaign in the Swale area, a talk at the local college as well as the recruitment of staff leavers every month. This has effectively produced over 1,500 new members.

The Trust aimed to have 10,500 members by 1 April 2011, and so far has recruited 9,839. Every effort is being made to ensure the Trust reaches its goal of 10,500 members as soon as possible. Governors are very keen to ensure we have members that can represent the hard to reach groups, including ethnic minorities and so the Trust is continuing to concentrate on targeting these areas. The recruitment of these groups are monitored by the membership recruitment and communications working group.

Engagement between members and governors

The governors are always looking for ways to engage with their members and a programme of nine members' events has been scheduled for 2011 and we will continue running a programme of at least eight events every year.

The members' quarterly newsletter is the Trust's biggest form of communication and allows the opportunity to include surveys or questionnaires to collect the views of the community on specific topics, such as transport to the hospital.

Monthly e-bulletins are also sent to members who have registered an email address with the membership office and provide an excellent link for communicating the upcoming events and latest news.

The Trust's new website was launched in January 2011 and continues to be developed to allow communication to flow from members to their governors. Presently the Trust provides a 'contact your governor' facility which sends the members' comments to the membership office to be forwarded to the relevant governor.

The Trust has launched a new intranet site. Governors will be able to access this new site giving them much more information.

Engagement between governors and members is an evolving and ongoing feature for the Trust and governors are continually looking at ways of improving ways of meeting members and ensuring that their views are taken into consideration.

Members' events have been held on specific subjects that have been requested by our members and are also an opportunity for members to meet their governors and raise any concerns or suggestions with them. The Trust has been successful in gaining press coverage for these members' events and the attendance has been steadily increasing. Four of the members' events are dedicated 'meet your governors' events and these have been held throughout the year.

The Trust held its second annual members meeting as a foundation trust in September 2010. This very successful event was organised jointly by the Trust and Council of Governors and was held at the St George's Centre, Chatham Maritime.

Membership base

The breakdown of our membership base per constituency is listed below.

Constituency	Total
Medway	6,523
Swale	1,734
Rest of England and Wales	1,582
Membership total	9,839

Statement setting out the steps that the members of the Board, in particular the non-executive directors, have taken to understand the views of the governors and members.

During the year the Trust has used a number of methods to ensure that directors understand and are aware of views expressed by governors and members.

The Council of Governors is chaired by the Trust chairman and its meetings are also attended by the chief executive who presents a report on performance and current issues. The chief executive is also available during the meeting to answer questions which provides the opportunity for governors to express their views and raise any other concerns. Other executive directors also attend Council of Governor meetings and working groups on a regular basis to provide updates as and when requested by the governors.

The non-executive directors regularly attend the Council of Governor meetings and are also invited to attend some of the working groups.

Governors are also invited to take part in various Trust groups and committees in order to communicate the views and concerns of their members, and to understand how the Board and sub-commitees work.

Regular departmental visits take place at least four times a month, providing an opportunity to inspect departments. One governor accompanies one executive director and one non-executive director on these visits.

Regular PEAT (patient environment assessment team) walkabouts take place and one governor accompanies the team to various areas within the Trust.

The Council of Governors has nominated a senior governor who meets with the senior independent director to discuss key issues which involve the non-executive directors and governors, such as the chairman's appraisal. The senior governor also has an open invitation to attend Board meetings, with a colleague governor, and reports back to governors on these meetings.

The Trust Board continues to look at developing a stronger relationship with its governors to understand better their views and the views of their members. The Trust is also looking at ways of forging stronger links between the governor working groups and the non-executive directors.

Members may contact governors through the membership office, which is situated in the postgraduate centre. They may contact the office by telephone **01634 825292**, in writing, by email to **members@medway.nhs.uk** or via our **website www.medway.nhs.uk**

Quality reporting

Annual quality report

The directors are required, under the Health Act 2009 and the National Health Service Act (Quality Accounts) Regulations 2010, to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports which incorporate the above legal requirements in the 'NHS Foundation Trust Annual Reporting Manual'.

The Quality Account is now coordinated by the director of nursing and the medical director and has input from people who lead on different issues for example, clinical audit and paediatric. This allows the directors to take an objective view of the data being submitted. Most of the data in the Quality Account will not be new and will have been subject to review throughout the year.

The Quality Account 2010/11 has been a tool to improve the quality of care and for the Trust to focus on nine priorities for improvement. However; it is intended that the Quality Account for 2011/12 will be a more useful document than the current one. This is because this has

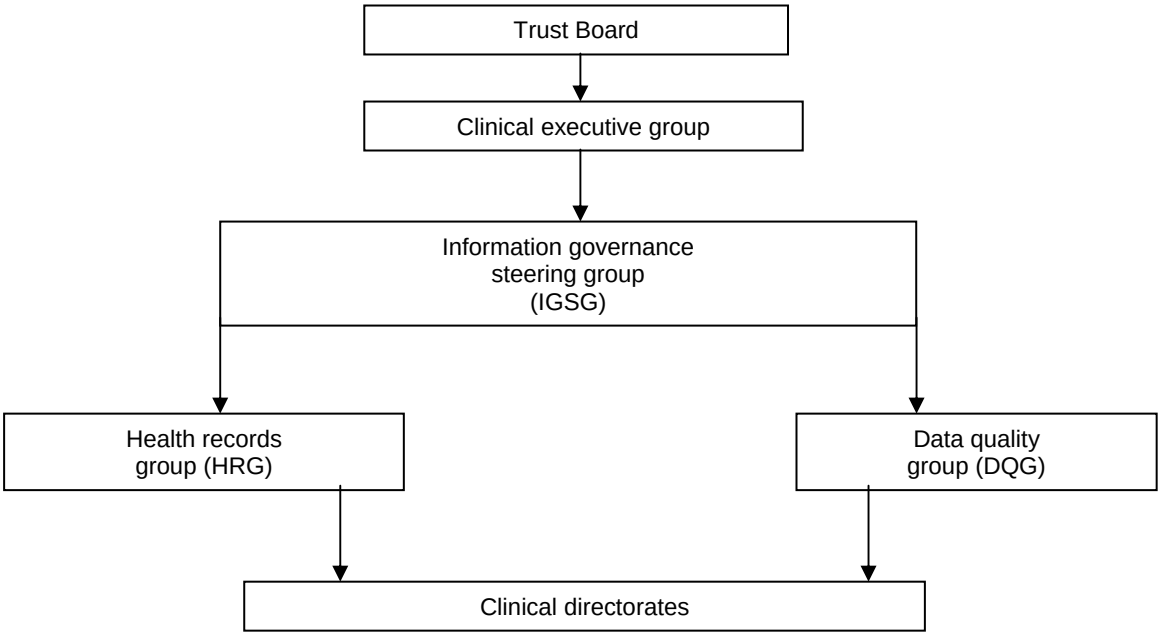
been an evolving process and the Trust is now ready to view the Quality Account as the central document not only for the priorities for improvement but also as a key element of the quality strategy.

The Quality Account for 2010/11 has been prepared. This has been coordinated by the director of nursing and the medical director. The guidance from the Department of Health and Monitor has been followed. Consultation on the priorities for improvement has taken place with governors, the Board, clinical directors and senior nurses. A draft version was presented to the members of the Quality Committee on 12 April. Comment on the content of the Quality Account has been requested from NHS Medway, Medway LINks and Medway Council's Overview and Scrutiny Committee.

Ensuring data quality at Medway NHS Foundation Trust

The following section describes the arrangements that the Medway NHS Foundation Trust has put in place to ensure data quality and provide assurances to the Trust Board and its sub-committees that the data used to report on performance and quality is robust.

The Board is responsible for seeking assurance that the data collected and used across the Trust is of the highest possible quality, and for ensuring that the Trust's management structures support the data quality agenda. The relationship between the Trust Board and its various committees are set out in the diagram below.



During 2010/11, the Trust developed a data quality policy which formally sets out responsibilities for data quality throughout the Trust. The executive director with lead responsibility for data quality is the director of operations/deputy chief executive, with operational support provided by the associate director of performance and business support.

The Integrated Audit Committee (IAC) is the Board sub-committee with particular responsibility for overseeing the monitoring and, where necessary, seeking improvements of data quality.

The information governance steering group (IGSG) is responsible for overseeing the establishment and work of the data quality group (DQG) and the existing health records group (HRG). Both the DQG and the HRG will make regular reports to the IGSG.

The DQG has a work programme of activities, audits and training reviews intended to monitor and promote data quality and, where necessary improve data quality across the Trust. The results of the work of the DQG will be reported to the IGSG, IAC and Board as a matter of course and to relevant other bodies (e.g. the clinical executive group, Patient Safety Committee, health records group) where appropriate. Particular emphasis will be paid to data quality systems and controls which support the delivery and monitoring of the Trust's corporate objectives, including the matters identified in the Quality Accounts.

At an operational level the DQG is responsible for implementing appropriate measures necessary to improve data quality. Its membership is made up of information staff, health records, clinical coding, PAS training and management, together with those staff from all directorates which have a responsibility for data recording.

The data quality group meets bi-monthly and during 2010/11 had an agreed work plan which includes a comprehensive review of both clinical coding and data quality used to assess the performance of the Trust.

Comprehensive coding audits are carried out at bi-monthly intervals. Audits are undertaken using the latest audit methodology as recommended by Connecting for Health (CfH). All internal audits are carried out by the clinical coding service manager who is an accredited clinical coder, CfH registered clinical coding auditor and experienced clinical coding trainer.

In addition, the Trust is required to carry out a coding audit to satisfy the Information

Governance Toolkit requirements (IG505). This audit was carried out in June 2010 and concentrated on the quality of coding for deceased patients. The results of these audits were presented to the Patient Safety Committee in October 2010 as follows:

- during 2010, the Trust was subject to external reviews of data by the Audit Commission as part of their national PbR Data Assurance Framework. A review of outpatient data was completed in February 2010, followed by a review of admitted patient clinical coding in June 2010. Both reports and subsequent action plans were reported to the IAC during 2010/11. Both reports highlighted areas for improvement but the Audit Commission's overall assessment was that the Trust's arrangements provided sufficient assurance so that a follow up review of data would not be required in either area.
- for data quality, internal audit (IA) undertakes a series of reviews to assure the Trust that the system of data collection and methodologies used for calculating performance is robust. However, the amount of time and resource that they offer is limited by other priorities in the annual audit plan.
- therefore, alongside the more formal reviews carried out by IA, a process of 'peer review' has been introduced to provide assurance that data is robust. The work of IA and the peer reviews will be complimentary as IA will carry out a full audit of the data whilst the peer review process will be a 'lighter touch' and will include spot checks of data. If any problems are found as a result of the review then these will be escalated via a process of 'data alerts' to the deputy chief executive/director of operations.
- peer reviews are carried out by selected Trust staff who have a background in data accreditation, information governance or information management. A work plan for the reviewers has been drawn up which prioritises key targets or those which will attract a financial penalty if not achieved during the year. The plan has been shared with internal audit.
- reports on the findings of the reviews are made to the data quality group and to the Integrated Audit Committee. Where appropriate, reports are also made to the Quality Committee.

CHKS data quality dashboard

The Trust accesses a monthly data quality dashboard from its CHKS benchmarking system. This compares the Trust performance with a wide peer group. The latest results show that the Trust is performing to a higher level than our peers in most areas.

	YTD (April to December 2010)		
Data quality indicator	**Trust volume**	**Trust rate**	**Peer rate**
Data quality index	59,784	93.3	90.7
Data quality index (HRG v4 based)	59,784	93.3	90.5
Blank primary diagnosis	337	0.56%	2.02%
Unacceptable primary diagnosis	222	0.37%	0.13%
Diagnosis conflicts with age or sex	52	0.09%	0.16%
Diagnosis non-specific	9,179	15.44%	14.47%
Procedure non-specific	1,309	2.20%	2.36%
Sign and symptom as a primary diagnosis	6,701	11.27%	13.67%
Admitting diagnosis emergency for elective admission	344	1.82%	1.21%
Volume of coded FCEs with palliative care code	439	0.74%	0.57%
Volume of deaths with palliative care code	198	19.94%	15.28%
Date conflicts	4	0.01%	0.14%
HRG U groups	27	0.05%	0.04%
HRG U groups (HRG v4)	36	0.06%	0.33%
Average diagnosis per coded episode		3.9	3.7

Source- CHKS

Secondary uses service (SUS data)

SUS data is the single source of comprehensive data in the NHS used to enable a range of reporting and analysis, including benchmarking. It is the standard repository for activity for performance monitoring, reconciliation and payments and therefore its accuracy is essential. SUS data quality is discussed at IGSG meetings where a SUS data quality dashboard has been developed to indicate any areas of concern. The areas reviewed are admitted patients (14 indicators), outpatients (17 indicators) and A&E (14 indicators). Against these 45 indicators, the Trust reported seven to be ‘red’ (of which three were related to the same ‘site

code' issue), two 'amber' and 36 'green' at the end of December 2010. The RAG rating relates to whether the Trust is above the national average or not. Where problems have been identified, an improvement plan has been developed and updates on progress are made to both the IGSG and the data quality group.

Performance standards (Monitor targets are given in red)

Cancer waiting times			
Performance indicator	Target	Score	RAG
All cancers: urgent GP referrals seen within two weeks	93%	94.4%	G
Symptomatic breast: GP referrals seen within two weeks	93%	95.7%	
All cancers: one month diagnosis to first definitive treatment	96%	98.3%	G
All cancers: one month decision to treat to start of treatment for subsequent treatment – surgery	94%	97.0%	G
All cancers: one month decision to treat to start of treatment for subsequent treatment – anti-cancer drug	98%	100%	G
All cancers: two month referral to treatment – standard	85%	93.0%	G
All cancers: two month referral to treatment – screening	90%	98.6%	G

Cancelled operations			
Performance indicator	Target	Score	RAG
Cancelled on day of surgery	<0.8%	0.88%	A
% cancellations not re-admitted within 28 days	<5%	0.8%	G

Delayed transfers of care			
Performance indicator	Target	Score	RAG
Delayed transfers of care	<3.5%	3.8%	A

Number of inpatients waiting longer than the standard			
Performance indicator	Target	Score	RAG
Inpatients waiting >6 months (at each month end)	0	1	G

Number of outpatients waiting longer than the standard			
Performance indicator	Target	Score	RAG
Outpatients waiting >13 weeks (GP referrals only)	0	7	G

Total time in A&E: four hours or less			
Performance indicator	Target	Score	RAG
Total time in A&E 4 hours or less	95%	97.64%	G
Waiting times for RACPCs			

Performance indicator	Target	Score	RAG
Waiting time for RACPCs	98%	100%	G

Access to GUM clinics			
Performance indicator	Target	Score	RAG
Access to GUM clinics	98%	100%	G

MRSA bacteraemia			
Performance indicator	Target	Score	RAG
MRSA bacteraemia	<4	0	G

Clostridium difficile			
Performance indicator	Target	Score	RAG
MRSA bacteraemia	<89	49	G

18-week referral to treatment			
Performance indicator	Target	Score	RAG
18-Week Wait: Admitted patients	90%	91.1%	G
18-Week Wait: Non-admitted patients	95%	98.7%	G
18-Week Wait: Direct access audiology	95%	100%	G

Code of governance compliance

The Trust's Board of Directors supports and agrees with the principles set out in the 'NHS Foundation Trust Code of Governance', published by Monitor in 2006.

The way in which the Board applies the principles and provisions is described within the various sections of the report and the directors consider that, for the 2010/2011 year, the Trust has been compliant with the code with the exception of the following:

D.2 – Performance evaluation

The Trust Board has not carried out a formal and rigorous annual evaluation of its performance in the last financial year; this is being addressed. An away day was arranged in May 2010 which focused on performance evaluation and ensuring that systems and processes are put in place to address this in the future.

Statement on internal control

1. Scope of responsibility

1.1. As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's ('the Trust') 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 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'.

2. The purpose of the system of internal control

2.1. 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 Medway 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 Medway NHS Foundation Trust for the year ended 31 March 2011 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

3.1. Responsibility for leading the management of risk throughout the Trust has been delegated to the director of finance (for financial risk), to the medical director (for clinical risks) and the director of governance and risk (for corporate risks) at Board level.

3.2. The Integrated Audit Committee oversees the performance of the risk management system via internal and external audit who report to this committee.

3.3 There is a corporate risk management strategy which was endorsed by the Board in October 2009 and reviewed in August 2010.

3.4 The risk management strategy covers all aspects of the Trust's business including operational, clinical, reputational and environmental risks. Policies and procedures in relation to risk management are reviewed and approved by the Board via the Quality Committee (previously called Quality and Safety Committee).

3.5 The Trust has an established process for the reporting and investigation of all serious untoward incidents, adverse occurrences and near misses. It actively encourages its staff to report any concerns which identify risks. The Quality Committee, which meets monthly, receives a comprehensive update on all serious untoward incidents at every other meeting and reports to the Board on a bi-monthly basis.

3.6 The Trust has comprehensive arrangements in place with stakeholders and partnership organisations. These cover both operational and strategic issues such as service planning and commissioning, performance management, research, education and clinical governance.

3.7 All staff receive an introduction to aspects of risk management on Trust induction which covers the reporting of, and learning from, untoward incidents. A more practice based training on a one-to-one level is provided by line managers. Fire, information governance, moving and handling and health and safety, adult protection and child protection, which are considered as essential training, are covered at induction and then on a regular basis thereafter as appropriate to the role. An overview of managing clinical equipment is also provided which is supported by a structured clinical equipment training programme annually. In addition to all of these, there are manager awareness sessions which set out the responsibilities of managers and demonstrate how to carry out risk assessments. The head of governance and risk provides Board level risk awareness training.

4. The risk and control framework

4.1 The Trust's comprehensive risk management strategy is available to all staff on the Trust's intranet site. The strategy describes the Trust's overall processes for managing risk, corporate and directorate responsibilities for risk, the risk management process and the Trust's risk identification, evaluation and control

system. The latter includes the risk matrix used to evaluate risks in the Trust's risk registers.

4.2 Risks are identified from a number of sources including directorate meetings, performance reports, serious untoward incidents, claims/litigation, and reports from external organisations, internal management reviews and complaints.

4.3 The Trust continues to populate a corporate risk register, and all the 'red rated', highest scoring major risks are discussed at the clinical and executive group. This group receives and discusses the corporate risk register from the head of quality and risk at every meeting before making recommendations to the monthly Board meeting. Two directorate risk registers are also presented and challenged by the clinical and executive group at each monthly meeting.

4.4 Risks are rated according to their severity using a risk rating matrix based on a combination of the probability score of risk occurrence and the impact score, by use of a formula that provides an overall score for each risk, which can then be colour coded to reflect the corporate risks to the organisation.

4.5 During the past year, the Board has discussed and challenged the Board Assurance Framework on a regular basis and it has been continually updated and improved and now fully reflects the strategy and key corporate objectives. It identifies the principal risks to the achievement of the objectives, the key controls in place to manage these risks and sources of internal and external assurances about the effectiveness of these controls, the cost of implementing these controls, the responsible director and asks whether the item appears on the corporate risk register. The assurance framework also details any gaps in control and assurance and identifies the actions being taken to address them.

4.6 The Trust maintained 'level 1' compliance with 'NHS Litigation Authority Risk Management Standards for Acute Trusts' following its last assessment in November 2009, with a much higher score than previously, which now covers the Risk Pooling Scheme for Trusts (RPST). The Trust also successfully achieved 'level 2' maternity Clinical Negligence Scheme for Trusts (CNST) in September 2010.

4.7 The Trust recognises the importance of having robust systems in place to safeguard

personal and other sensitive information. The Trust employs an information governance manager who is responsible for completing and submitting the information governance toolkit. In 2010/2011 the Trust achieved 69 percent, making it the best performing acute trust in Kent. The director of governance and risk has been identified as the senior information risk owner (SIRO) to fulfil the requirements to have an executive director responsible for managing information governance and associated risks at Board level.

4.8 The Trust has an information governance steering group which oversees and monitors this area; information governance risks are included in the corporate risk register and reported to the Board and sub-committees as required. Minutes of the information governance steering group are provided on a regular basis to the clinical and executive group.

4.9 Risks to data security are being managed by providing annual information governance (IG) training and regular global emails to remind staff of the dangers of not securing information. Policies are also in place outlining appropriate use of email, internet and equipment. All known incidents are logged and reported to the IG steering group and spot checks are carried out and advice given where concerns are noted. A quarterly briefing is provided to the Board outlining recent incidents, work undertaken by the IG steering group and progress against the IG Toolkit.

4.10 Attainment of the standards set out in the Information Governance Toolkit issued by 'Connecting for Health' is monitored by the information governance steering group. The Board approved the 2010/11 Toolkit declaration at its March meeting and no departure from those standards is anticipated. The Trust will need to focus on achievement of the required level of information governance training for staff, but it is nevertheless expected that this target will be reached.

4.11 The Trust has established committees for patient safety and patient experience, which report into the Quality Committee, a sub-committee of the Board. The Trust has also appointed patient safety leads in each of its clinical directorates. As part of this reporting system, the Quality Committee receives a report on the Trust's performance against its quality indicators. It also receives a report from the chairmen of the Patient Safety and Patient Experience Committees on their achievements against these indicators.

4.12 The head of governance and risk receives a monthly report from the directorate governance leads (who are senior nurses or doctors), which consists of a 'Red-Amber-Yellow-Green' rating against each of the CQC 'Essential Standards of Quality' and also receives a signed compliance declaration. It is an integral part of the Trust's registration with the CQC that the Trust must demonstrate compliance with these essential standards. On a quarterly basis, this information is reviewed and signed off by the governance lead and the directorate's management team (clinical director, head of nursing and general manager). A governance panel, consisting of the executive director leads for each of the standards, supported by the head of governance and risk meets on a quarterly basis and challenges each directorate team on the evidence supporting their declarations.

4.13 The Trust published a Corporate Equality Impact Assessment (EIA) programme for 2010/2011. This annual programme identifies priority equality impact assessments for the year and is designed to improve both the quality and scope of impact assessments undertaken, particularly in service delivery areas.

4.14 Impact assessments from the programme are quality assured by the equality impact assessment sub-group which reports into the equality and fairness steering group (E&FSG). Quarterly and annual EIA progress reports are monitored by the E&FSG, which is the overarching committee that ensures the Trust meets its legal duties and healthcare regulations. The main aim of the group is to make a positive contribution to the equality and diversity agenda. This group reports into the Trust's clinical and executive group, a sub-committee of the Board.

4.15 The E&FSG scrutinises quarterly and annual workforce and patient diversity monitoring reports. Minutes of E&FSG meetings, together with monitoring reports, the corporate EIA programme and completed impact assessments are published on the Trust website.

4.16 There is a paragraph provided in every Board and committee report which ensures the author considers, and comments on, whether the proposal will have any impact on equality.

4.17 The Trust has also introduced a 'being open' policy which ensures that patients, carers and visitors are involved in discussions following an incident.

4.18 The Trust involves the public as stakeholders in managing risks which impact on them: The Trust has a governors' patient experience working group who highlight risks identified to them by members and receive feedback on any risks they have identified; governors and non-executive directors participate in departmental visits throughout the hospital – part of this role is to ensure that identified risks are being managed and to report any unidentified risks. The Trust has also introduced a comments system in outpatients and maternity to give patients the opportunity to provide suggestions on how the Trust can improve. The Trust's patient experience manager attends LINks' patient experience working group for Medway and Swale and listens to stakeholder feedback and response to questions. The Trust's complaints system has also identified areas and actions have been taken as a result of these.

4.19 The Foundation Trust has undertaken risk assessments and carbon delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on the UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the 'Adaptation Reporting Requirements' are complied with.

5 Disclosure on CQC 'Essential Standards of Quality and Safety'

5.1 During the previous year, CQC considered the Trust's application's to be a licensed registered provider of acute healthcare services and applied four conditions to the Trust's registration on 1 April 2010. These were:

- outcome 2 – consent to care and treatment (this related to insufficient numbers of staff trained in the Mental Capacity Act)
- outcome 7 – safeguarding people who use services from abuse (there were insufficient numbers of staff trained in safeguarding, both for adults and children)
- outcome 16 – assessing and monitoring the quality of service provision (two conditions regarding governance covering: firstly, the system to monitor outcomes of audits and reporting to the Board were not well established; and second, the Trust did not have a robust system for reporting, investigating and disseminating learning from incidents).

5.2 During this year, the Trust put in place robust action plans to meet these four

conditions. All four of these conditions were lifted in November 2010.

5.3. The CQC carried out a planned compliance review of all four of the Trust's registered locations in February 2011. The CQC has reported that three of its locations (Medway Maritime Hospital, Woodlands Special Needs Nursery and the Trust's dermatology clinic at the Trust's dermatology clinic at Borough Green Medical Centre) are compliant with the CQC 'Essential Standards of Quality and Safety'. With regard to the fourth location (Preston Skreens), the CQC had two moderate concerns that two standards were not being complied with and identified compliance actions.

5.4. As a result of this one location (Preston Skreens), the Foundation Trust is not fully compliant with the CQC 'Essential Standards of Quality and Safety'.

5.5 Continuous compliance with the CQC 'Essential Standards of Quality and Safety' is monitored by the governance panel on a quarterly basis. Areas of non-compliance are identified by the directorates and action plans to bring practice into compliance are produced. Implementation of those action plans is also monitored by the panel. Implementation of action plans produced for the CQC following the February 2011 compliance review will be monitored by the executive team. The implementation of the actions will be overseen by the director of governance and risk. This approach was agreed by the chief executive, director of governance and risk and the directorate management team with an aim to completing all actions by 30 April 2011. This has taken place and will be verified by audits at one and three month intervals.

5.6 It is not anticipated that there will be any barriers to the prompt removal of the moderate and minor concerns imposed on the Trust's CQC registration following the compliance review.

6 Equality, diversity and human rights

6.1 Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with. Under current legislation, the Trust is required to review its disability, race and gender equality schemes every three years; the Trust's previous Equality Scheme was approved in March 2007. This was fully revised this year and the Single Equality Scheme for 2011 – 2014 sets out the Trust's commitment to taking equality and human rights into account in everything

we do. The scheme supports the Trust's strategic objectives, legislative responsibility and requirements of its regulators. It also delivers a coherent plan for embedding equality and human rights into the work of the Trust, ensuring that we have in place the systems needed to deliver on equality and human rights, to monitor progress and report on the Trust's outcomes and achievements. This strategy is available on the Trust's website.

7 NHS pension scheme

7.1 As an employer with staff entitled to membership of the NHS pension scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

8 Review of economy, efficiency and effectiveness of the use of resources

8.1 The objectives of maximising efficiency, effectiveness and economy within the Trust continues to be achieved by employing internally a range of accountability and control mechanisms whilst also obtaining independent external assurances.

8.2 One of the principal aims of the whole system of internal control and governance is to ensure that the Trust optimises the use of all resources. In this respect the main operational elements of the system are the Board Assurance Framework, the Integrated Audit Committee and the reporting and assurance work of both internal and external audit functions, the Performance and Investment Committee, the comprehensive system of budgetary control, the framework of which has been strengthened at the request of the Performance and Investment Committee for 2011/2012.

8.3 The Integrated Audit Committee is chaired by a non-executive director and the committee reports directly to the Board. Independent assurance is provided by internal and external audit, and counter fraud specialists who support and provide regular reports. The Integrated Audit Committee also receives other external reports and investigations undertaken during the year. The Integrated Audit Committee

agrees and monitors the work undertaken by the internal and external auditors, counter fraud specialist and clinical audit and sets aside time with the internal and external auditors and the counter fraud specialist in private so that any confidential items can be discussed if necessary.

8.4 A non-executive director also chairs the Performance and Investment Committee which reports comprehensively to the Board upon resource utilisation, financial performance and risks and service development initiatives.

9 Annual quality report

9.1 The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports which incorporate the above legal requirements in the 'NHS Foundation Trust Annual Reporting Manual'.

9.2 During 2010/2011 there were a number of changes to the Trust's approach to quality which have given the Trust a clearer way forward for further development over the next twelve months. The changes include:

- using the three elements of quality: Patient safety, patient experience and clinical effectiveness, the Trust has ensured that these are seen as inter-dependent and not as three separate entities.
- the director of nursing and medical director now have responsibility for Quality Accounts and have regular meetings to discuss action plans, etc, about quality issues and continually monitor the situation together. This has improved the leadership and governance of quality across the Trust.
- a quality performance indicator dashboard has been produced so that quality measures are seen together rather than dispersed in the operational performance dashboard.

9.3 The Quality Account is now coordinated by the director of nursing and medical director and has input from people who lead on different issues, for example, clinical audit and paediatrics. This allows the directors to take an objective view of the data being submitted. Most of the data in the Quality Account will not be new and will have

been subject to review throughout the year.

9.4 The Quality Account 2010/2011 has been a tool to improve the quality of care and for the Trust to focus on nine priorities for improvement. However the Quality Account for 2011/2012 will be a more comprehensive document than the previous one and will focus minds on identifying and promoting quality issues. This has been an evolving process and the Trust is now ready to view the Quality Account as the central document for the priorities for improvement in the quality of the Trust's services.

9.5 Comments and advice on the Quality Accounts have been sought from clinicians, the Board, governors, members of the public, NHS Medway, Medway LINks and Medway Council's Overview and Scrutiny Committee. These processes have resulted in the Quality Account providing a balanced view of quality performance.

10.0 Ensuring data quality at Medway NHS Foundation Trust

10.1 During 2010/11, the Trust developed a data quality policy which formally set out responsibilities for data quality throughout the Trust. The executive director with lead responsibility for data quality is the director of operations/deputy chief executive, with operational support provided by the associate director of performance and business support, and a data quality group was established in September 2010.

10.2 The data quality group meets on a bi-monthly basis and has a work programme which includes a comprehensive review of both clinical coding and data quality used to assess the performance of the Trust as well as training reviews intended to monitor and promote data quality and, where necessary improve data quality across the Trust. The work of the data quality group is reported to the information governance steering group, Integrated Audit Committee and Board and to relevant other bodies, e.g. the clinical executive group, Patient Safety Committee, health records group where appropriate. Particular emphasis will be paid to data quality systems and controls which support the delivery and monitoring of the Trust's corporate objectives, including the matters identified in the Quality Committee.

10.3 The Integrated Audit Committee is the Board sub-committee and has a broad remit to gain assurance across all areas of the Trust and within that has responsibility for gaining assurance in respect of data quality. Data quality is an area requiring

continual improvement to ensure intelligent information is available to support the ever changing business of a modern hospital.

10.4 The information governance steering group is responsible for overseeing the establishment and work of the data quality group and the existing health records group. Both the data quality group and the health records group will make regular reports to the information governance steering group.

10.5 During 2010, the Trust was subject to external reviews of data by the Audit Commission as part of its 'Payment by Results (PbR) Data Assurance Framework'. A review of outpatient data was completed in February 2010, followed by a review of admitted patient clinical coding in June 2010. Both reports and subsequent action plans were reported to the Integrated Audit Committee during 2010/11.

10.6 Results of the Audit Commission's PbR Data Assurance Framework Audit published in June 2010 were disappointing as the Trust's performance was assessed as 'weak' on the areas that had been selected for review by the Audit Commission. Overall the Trusts HRG error rate was 10.7 percent. This was largely due to a local policy being followed within the coding department which led to gynaecological procedures being coded as diagnostic instead of therapeutic. Action plans were implemented as a result and the Audit Commission reported good progress in implementing these and had sufficient assurance in the Trust's arrangements to report that there would be no return review in 2011/12.

10.7 Internal coding audits are now carried out at bi-monthly intervals. Audits are undertaken using the latest audit methodology as recommended by 'Connecting for Health'. All internal audits are carried out by the clinical coding service manager who is an accredited clinical coder, registered clinical coding auditor and experienced clinical coding trainer.

10.8 Alongside the more formal reviews carried out by internal audit, a process of 'peer review' has been introduced to provide assurance that data is robust. The work of internal audit and the peer reviews will be complimentary as internal audit will carry out a full audit of the data whilst the peer review process will be a 'lighter touch' and will include spot checks of data. If any problems are found as a result of the review then these will be escalated via a process of 'data alerts' to the deputy chief

executive/director of operations. At the time of writing, no major issues have been unearthed regarding the quality of data used to report performance.

10.9 The Trust accesses a monthly data quality dashboard from its CHKS benchmarking system. This compares the Trust performance with a wide peer group. The latest results show that the Trust is performing to a higher level than its peers.

11.0 Review of effectiveness

11.1 As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Account attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their governance letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Integrated Audit Committee, the Quality Committee, the clinical and executive group and plans to address weaknesses and ensure continuous improvement in the system are in place.

11.2 During the year, the Trust appointed a full-time director of governance and risk who is responsible for governance and compliance matters and this has improved the Trust's overall performance in all areas of compliance. The Trust has also radically redesigned the risk register in consultation with the internal auditors and has strengthened the monitoring and scrutiny arrangements of these at executive director and Board level.

11.3 My review is also informed by the following mechanisms:

- review and challenge from non-executive directors within committees and at the Board and the subsequent improvements in the risk management process and Board Assurance Framework
- the challenge of the corporate risk register and individual directorate risk registers at the monthly clinical and executive group which consists of all

clinical directors and the executive directors

- review and challenge at the governance panel on the CQC 'Essential Standards of Quality and Safety'
- external review bodies, e.g. CQC and Audit Commission
- discussions with Monitor
- the clinical audit plan, which is regularly reviewed at the Integrated Audit Committee and national audits which are presented to the Quality Committee for discussion
- the Board (and subsequently the Quality Committee's) quarterly review of the Quality Accounts, which from 2011/2012 will be presented monthly to the Quality Committee
- Medway Council's and Kent County Council's Overview and Scrutiny Committees
- staff and patient surveys (both external and internal)
- liaison with key stakeholders, including PCTs, Council of Governors, partner trusts and representatives from patient groups and members
- complaints and claims reports
- internal and external audit reports
- NHS Litigation Authority and CNST assessments.

11.4 As outlined in the Trust's risk management strategy, each directorate has a governance lead responsible for coordinating risk management processes within the directorate, including management of the directorate risk register and maintaining the directorate's prioritised risk management plan. The governance lead reports to directorate meetings, which are attended by the head of governance and risk who reports to the clinical and executive group.

11.5 The review and maintenance of the effectiveness of the system of internal control is undertaken as follows:

- annual review of the risk management strategy by the Board
- ongoing development and review of the corporate risk register by the Board via the clinical and executive group
- ongoing challenge and review of the Board Assurance Framework by the Board
- all managers have the responsibility for developing and implementing the risk management strategy within the line management of individual directorates

- the Trust's internal auditors, South Coast Audit, verify that a system of risk management internal controls is in place.

11.6 Data protection incidents have continued to occur and 147 incidents have been reported within the Trust during 2010/2011. However, only one of these was recorded as a serious untoward incident and was reported to the Strategic Health Authority. This incident has now been closed. Actions taken to address this issue included: Health records training to be introduced for all local inductions for secretarial staff as well as regular team updates, a clear flow chart of escalation of issue to be produced for secretarial teams, managers to carry out spot checks to ensure adherence to policies and that health records management team to ensure that regular checks are in place across health records regarding temporary or missing files.

11.7 The Trust was notified by Monitor on 27 April 2011 that as a result of a negative variance from forecast surplus for the year ending 31 March 2011 and the previous year surplus also not being achieved, it considered the Board level scrutiny and assurance processes concerning financial planning and performance at the Trust had not been effective and that there was insufficient assurance that these are now fully effective. As a result of this, Monitor was not assured that the Trust had a credible plan to return to a financial risk rating of three on a sustainable basis or that the Trust has the level of Board reporting and scrutiny in place to ensure that its plan is delivered. As a result of this, Monitor has decided that the Trust is in significant breach of two terms of its authorisation, namely – the general duty to exercise its functions effectively, efficiently and economically; and its governance duty. This means that the Trust will be red rated for governance risk until Monitor is assured that the Trust is returning to full and sustainable compliance with its authorisation.

12.0 Conclusion

The Trust has put plans in place to address the issues identified by Monitor and has commissioned external advisors to provide further assurance over the 2011/2012 financial plan and review financial governance. This work has not been completed at the time of this report; however, any recommendations will be implemented. The Trust will be reporting progress to Monitor on a monthly basis and the Board will be taking overall responsibility for monitoring progress throughout the forthcoming year.

Signed: M Devlin, Chief Executive Date: 6th June 2011

Annual accounts 2010/11

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF MEDWAY NHS FOUNDATION TRUST

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed the Medway 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 Medway NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

• observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
• make judgements and estimates on a reasonable basis;
• state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; 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/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Signed: M Devlin, Chief Executive Date: 6th June 2011

Independent Auditors' report to the Board of Governors of Medway NHS Foundation Trust

We have audited the financial statements of Medway NHS Foundation Trust for the year ended 31 March 2011 under the National Health Service Act 2006 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. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

We have also audited the information in the Remuneration Report that is described as having been audited.

This report is made solely to the Board of Governors of Medway NHS Foundation Trust 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 Board of Governors those matters we are required to state to it in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Foundation Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of Medway NHS Foundation Trust's affairs as at 31 March 2011 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts, and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the National Health Act 2006; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We have nothing to report in respect of the following matters where the National Health Service Act 2006 and Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- proper practices have not been observed in the compilation of the financial statements; or
- the Statement on Internal Control does not reflect compliance with Monitor's requirements.

Qualified certificate

The Accountable Officer has a general duty under paragraph 63 of Schedule 5 of the National Service Act 2006 to exercise the functions of the Foundation Trust effectively, efficiently and economically. Paragraph 1 of Schedule 10 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts requires that we satisfy ourselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where adequate arrangements have not been made.

On 27 April 2011 Monitor issued a notice to the Foundation Trust to report that it considers that Board level scrutiny and assurance processes concerning financial planning and performance (recovery) at the Foundation Trust have historically not been effective, that there is insufficient assurance that these are now fully effective , that Monitor cannot be assured that the Foundation Trust has a credible plan to return to an Financial Risk Rating Level 3 on a sustainable basis, or has the level of Board reporting and scrutiny in place to ensure that its plan is delivered. As a result, Monitor informed the Foundation Trust that it is in significant breach of two Terms of its Authorisation, namely: the general duty to exercise its functions effectively, efficiently and economically (Condition 2) and its governance duty (Condition 5).

As a result of the matters discussed in the notice issued by Monitor, we are not satisfied that Medway NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2011.

Certificate

We certify that we have completed the audit of the accounts of Medway NHS Foundation Trust 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 issued by Monitor.

Leigh Lloyd-Thomas
for and on behalf of PKF (UK) LLP
London, UK

6 June 2011

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2011

	NOTE	2010/11	2009/10
		£000	£000
Revenue			
Revenue from patient care activites	**3**	**194,791**	186,083
Other operating revenue	**4**	**23,391**	24,794
Operating expenses	**5**	**(216,825)**	(206,437)
Operating surplus		**1,357**	4,440
Finance costs			
Finance income	**12**	**41**	60
Finance expenses - financial liabilities	**13**	**(77)**	(64)
Finance expenses - unwinding of discount on provisions	**25**	**(18)**	(15)
PDC Dividends payable		**(4,821)**	(5,334)
Net finance costs		**(4,875)**	(5,353)
Operating deficit prior to impairment		**(3,518)**	(913)
Impairment losses property, plant and equipment	**4/5**	**0**	(7,584)
Deficit for the year		**(3,518)**	(8,497)
Other comprehensive income			
Revaluation gains and (impairment losses) property, plant and equipment		**1,043**	(17,614)
Increase in the donated asset reserve due to receipt of donated assets		**348**	634
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets		**(243)**	(688)
Total comprehensive income for the year		**(2,370)**	(26,165)

The notes on pages 88 to 118 form part of these accounts.

All operating activities are from continuing operations.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2011

	NOTE	31 March 2011 £000	31 March 2010 £000
Non Current Assets			
Property, plant and equipment	14.1	**145,458**	145,036
Total non current assets		**145,458**	145,036
Current Assets			
Inventories	15.1	**4,785**	5,046
Trade and other receivables	16	**13,415**	16,416
Other current assets	19	**122**	57
Cash and cash equivalents	26	**3,345**	4,622
Total current assets		**21,667**	26,141
Current liabilities			
Trade and other payables	20	**(21,169)**	(24,937)
Borrowings	22	**(2,444)**	(406)
Provisions	25	**(169)**	(160)
Other liabilities	21	**(124)**	(198)
Total current liabilities		**(23,906)**	(25,701)
Total assets less current liabilities		**143,219**	145,476
Non current liabilities			
Borrowings	22	**(911)**	(805)
Provisions	25	**(831)**	(884)
Other liabilities	21	**(162)**	(102)
Total non current liabilities		**(1,904)**	(1,791)
Total assets employed		**141,315**	143,685
Financed by:			
Taxpayers' equity			
Public dividend capital		**109,104**	109,104
Revaluation reserve		**30,986**	30,841
Donated asset reserve		**2,089**	1,957
Income and expenditure reserve		**(864)**	1,783
Total taxpayers' equity		**141,315**	143,685

The financial statements were approved and authorised for issue by the Board on 31st May 2011 and signed on its behalf by the Chief Executive and Director of Finance.

Signed: M Devlin, Chief Executive Date: 6th June 2011

Signed: S Orpin, Director of Finance Date: 6th June 2011

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public Dividend Capital £000	Revaluation Reserve £000	Donated Asset Reserve £000	Income and Expenditure Reserve £000	**Total £000**
At 1 April 2010	109,104	30,841	1,957	1,783	**143,685**
Deficit for the year	-	-	-	(3,518)	**(3,518)**
Revaluation gains and impairment losses property, plant and equipment	-	1,015	28	-	**1,043**
Increase in the donated asset reserve due to receipt of donated assets	-	-	348	-	**348**
Reduction in the donated asset reserve due to depreciation, revaluation, and/or disposal of donated assets	-	-	(244)	-	**(244)**
Other recognised gains	-	-	-	1	**1**
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	-	(870)	-	870	**0**
At 31 March 2011	**109,104**	**30,986**	**2,089**	**(864)**	**141,315**
At 1 April 2009	109,104	49,525	1,903	9,318	**169,850**
Deficit for the year	-	-	-	(8,497)	**(8,497)**
Revaluation losses and impairment losses property, plant and equipment	-	(17,722)	108	-	**(17,614)**
Increase in the donated asset reserve due to receipt of donated assets	-	-	634	-	**634**
Reduction in the donated asset reserve due to depreciation, revaluation, and/or disposal of donated assets	-	-	(688)	-	**(688)**
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	-	(962)	-	962	**0**
At 31 March 2010	**109,104**	**30,841**	**1,957**	**1,783**	**143,685**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2011

	NOTE	2010/11 £000	2009/10 £000
Cash flows from operating activities			
Operating surplus from continuing operations		**1,357**	4,440
Non-cash income and expense			
Depreciation and amortisation		**8,085**	8,640
Transfer from the donated asset reserve		**(244)**	(688)
(Increase) / decrease in Trade and other Receivables		**2,554**	(3,229)
(Increase) in other assets		**(65)**	0
(Increase) / decrease in Inventories		**261**	(828)
Increase / (decrease) in Trade and other Payables		**(3,784)**	8,713
Increase in other liabilities		**70**	0
Increase / (decrease) in Provisions		**(62)**	216
Other movements in operating cashflows		**(64)**	(156)
Net cash generated from operations		**8,108**	17,108
Cash flows from investing activities			
Interest received		**41**	60
Payments to acquire Property, Plant and Equipment		**(6,725)**	(12,568)
Receipts from sales of Property, Plant and Equipment		**1**	18
Net cash used in investing activities		**(6,683)**	(12,490)
Cash flows from financing activities			
Loans received	**22**	**67**	21
Loans repaid	**22**	**(4)**	0
Capital element of finance lease rental payments		**(498)**	(357)
Interest paid		**(13)**	0
Interest element of finance leases		**(64)**	(64)
PDC Dividend paid		**(4,358)**	(5,781)
Cash flows from other financing activities		**168**	444
Net cash used in financial activities		**(4,702)**	(5,737)
Increase / (decrease) in cash and cash equivalents		**(3,277)**	(1,119)
Cash and Cash equivalents at 1 April		**4,622**	5,741
Cash and Cash equivalents at 31 March	**26**	**1,345**	4,622

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 NHS Foundation Trust Annual Reporting Manual 2010/11 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment at their value to the business and the other financial asset relating EU Emissions Trading Scheme at market value.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is from commissioners in respect of healthcare services provided under local agreements (NHS Contracts). Income is recognised in the period in which services are provided. For patients whose treatment straddles the year end income is apportioned across the financial years on the basis of length of stay, insofar as it is in accordance with the terms of the contract. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

The basis for the calculation of the partially completed spells provision was those patients who were occupying a Trust bed on 31st March 2011 but were not discharged until the new financial year. Average prices by speciality and by point of delivery were then applied to these spells with adjustments made to ensure that income due was appropriately distributed between the 2010/11 and 2011/12 financial years, based on the distribution of length of stay.

1.3 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.4 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

- 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;
- it is expected to be used for more than one financial year;

- the cost of the item can be measured reliably; and
- individually have a cost of at least £5,000; or
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Staff costs have also been capitalised within specific projects where amounts are considered capital in nature.
The finance costs of bringing fixed assets into use are not capitalised.
Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes 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 end of the reporting period. Fair values are determined as follows;
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. This basis of valuation was adopted by the Trust on 31st March 2010.

All land and buildings are restated to current value using professional valuations in accordance with IAS16 every five years. A three yearly interim valuation is also carried out. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last asset valuations were undertaken in 2011 as at the valuation date of 31 March 2011, and have been valued on a modern equivalent asset basis.

Properties in the course of construction for services or administration purposes are carried at cost, less any impairment loss. Costs 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 the 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. For assets over £100,000 or that have a life over 15 years, these will be revalued to fair value if materially different from carrying value.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

Depreciation

Items of Property, Plant and Equipment are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated economic lives. Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.
Buildings, installations and fittings and depreciated on their current value over the estimated remaining life of the asset as assessed by the Trust's professional valuers. Assets held under a finance lease are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life of the asset using the following lives:

Medical equipment and engineering plant and equipment	5 to 15
Furniture	10
Mainframe information technology installations	8
Soft furnishings	7
Office and information technology equipment	5
Set-up costs in new buildings	10
Vehicles	7

Information Technology assets also include the Picture Archiving and Communications Systems (PACS) deployment costs, which is depreciated over a 10 year life.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.
Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.
Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of „other comprehensive income.

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal

to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of „other impairments are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met;

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
    - management are committed to a plan to sell the asset;
    - an active programme has begun to find a buyer and complete the sale;
    - the asset is being actively marketed at a reasonable price;
    - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.5 Donated Assets

Donated non-current assets are capitalised at their current value on receipt and this value is credited to the Donated Asset Reserve. They are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the Donated Asset Reserve and, each year, an amount equal to the depreciation charge on the asset is released from the Donated Asset Reserve to the Statement of Comprehensive Income. Similarly, any impairment on donated assets charged to the Statement of Comprehensive Income is matched by a transfer from the Donated Asset Reserve. On sale of donated assets, the net book value of the donated asset is transferred from the Donated Asset Reserve to the Income and Expenditure Reserve.

1.6 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 are accounted for as Government grants as are grants from the Big Lottery Fund. Where the

Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset on a basis consistent with the depreciation charge for that asset.

1.7 Inventories

Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Inventories comprise goods in intermediate stages of production.

1.8 Provisions and Contingencies

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed in the notes to the accounts, but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

Contingencies

Contingent liabilities are not recognised, but are disclosed in note 28, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.9 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not

taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

Past and present employees are covered by the provision of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.pensions.nhsbsa.nhs.uk. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the Scheme is accounted for as a defined contribution scheme.
Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.10 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. Interest earned on bank accounts and interest charged on overdrafts are recorded as, respectively, 'Interest receivable' and 'Interest Payable' in the periods to which they relate. Bank charges are recorded as operating expenses in the periods to which they relate.

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. Deposits held in seven day notice accounts are treated as cash equivalents. The Trust does not hold any investments with maturity dates exceeding one year from the date of purchase.

1.11 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.12 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchases, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as 'Fair Value through Income and Expenditure', ‘Loans and receivables’ or ‘available for sale financial assets’. The Trust currently has not classified any financial assets as ‘Fair Value through Income and Expenditure’ or ‘available for sale financial assets’.

Financial liabilities are classified as ‘Fair Value through Income and Expenditure’ or ‘Other Financial liabilities’. The Trust currently has not classified any financial liabilities as ‘Fair Value through Income and Expenditure’.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other Financial liabilities

All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as non-current liabilities.

The Trust’s financial liabilities comprise: NHS and non-NHS payables, other payables, accrued expenditure, and borrowings and finance lease obligations.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any loans and receivables are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future 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 through the use of an allowance account/bad debt provision.

1.13 Foreign Exchange

The functional and presentational currency of the Trust is sterling. Transactions that are 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.

1.14 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of the HM Treasury Financial Reporting Manual.

1.15 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant period rate of interest of the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.16 Public Dividend Capital (PDC) and PDC Dividend

Public dividend capital is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the Trust, is paid over as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) cash held with the Government Banking Service (GBS) excluding cash balances held in GBS that relate to a short term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the „pre-audit version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.17 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 in the Statement of Comprehensive Income on an accruals basis, including losses which would have been made good through insurance cover had Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However, the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

1.18 EU Emissions Trading Scheme

EU Emission Trading Scheme allowances are accounted for as government granted other current assets, valued at fair value. As the Trust makes emissions a provision is recognised, with an offsetting transfer from the government grant reserve. The provision is settled on surrender of the allowances. The other financial asset, provision and government grant reserve is valued at fair value at the Statement of Financial Position date.

1.19 Charitable Funds

The Trust is the corporate Trustee of Medway NHS Foundation Trust Charitable Fund – Registered Charity number 1051748. Under the control criteria in IAS 27 this could require consolidation. However, Monitor has obtained a dispensation from HM Treasury to the application of IAS 27 by NHS foundation Trusts in relation to NHS charitable funds for period ending 31 March 2011.

1.20 Accounting standards and amendments issued but not yet adopted

The following standards and interpretations issued by the IASB which have not yet been adopted. None of them are expected to impact upon the Trust's financial statements.

IAS 24 (Revised) 'Related Party Disclosures'
Annual Improvements 2010
IFRIC 14 amendment
IFRIC 19 'Extinguishing financial liabilities with Equity Instruments'

2 Operating segments

The Trust reports to the Board on a monthly basis the performance on a directorate level. In considering segments with a total income of 10% or more the Trust has identified three reportable segments. The main source of income for the Trust is from commissioners in respect of healthcare services from PCT's who are under common control and classified as a single customer. Net assets are not reported to the Board so therefore have been excluded for the purposes of this note.

The level of income received from PCTs shown above amounted to £193,251,000. The Trust report to the Board by directorate down to an Operating Contribution. All further costs and income are shown on a corporate level so have been excluded in the above analysis. From 2010/11 income relating to the Market Forces Factor (MFF) has been devolved out to individual Directorates and has been removed from central income.

Operating segments 2010/11

	A&E and Adult Medicine 2010/11 £000	Children and Women's Services 2010/11 £000	Surgery and Anaesthetics 2010/11 £000	Central 2010/11 £000	Total 2010/11 £000
Income	**75,773**	**45,510**	**71,228**	**10,100**	**202,611**
Expenditure	**(59,075)**	**(40,141)**	**(66,529)**	**(19,234)**	**(184,979)**
Contribution	**16,698**	**5,369**	**4,699**	**(9,134)**	**17,632**

Reconciliation to accounts

	Directorates	Under 10%		Total
Income	202,611	15,571		218,182
Expenditure	(184,979)	(23,761)		(208,740)
Contribution	17,632	(8,190)		9,442
			Depreciation	**(8,085)**
			Finance expenses	**(95)**
			Finance income	**41**
			PDC dividend	**(4,821)**
			Operating deficit	**(3,518)**

Operating segments 2009/10

	A&E and Adult Medicine 2009/10 £000	Children and Women's Services 2009/10 £000	Surgery and Anaesthetics 2009/10 £000	Central 2009/10 £000	Total 2009/10 £000
Income	**63,696**	**42,648**	**62,616**	**23,768**	**192,728**
Expenditure	**(53,086)**	**(37,260)**	**(62,553)**	**(14,838)**	**(167,737)**
Contribution	**10,610**	**5,388**	**63**	**8,930**	**24,991**

Reconciliation to accounts

	Directorates	Under 10%		Total
Income	192,728	18,149		210,877
Expenditure	(167,737)	(30,060)		(197,797)
Contribution	24,991	(11,911)		13,080
			Depreciation	**(8,640)**
			Finance expenses	**(79)**
			Finance income	**60**
			PDC dividend	**(5,334)**
			Operating deficit	**(913)**

3. Income from Activities

3.1 Income from Activities (by classification)

	2010/11 £000	2009/10 £000
Elective income	**38,149**	**32,456**
Non elective income	**70,701**	**70,368**
Outpatient income	**41,107**	**37,047**
A & E income	**6,986**	**6,393**
Other NHS clinical income	**36,455**	**36,236**
Private patient income	**318**	**214**
Other non-protected clinical income - Injury cost recovery (including Road Traffic Act Income)	**1,133**	**3,369**
	194,849	186,083

3.2 Income from Activities (by type)

	2010/11	2009/10
	£000	£000
Primary Care Trusts	**193,251**	184,932
NHS Foundation Trusts	**58**	0
NHS Trusts	**31**	0
Department of Health	**0**	50
Non NHS:		
- Private patients	**164**	121
- Overseas patients (non-reciprocal)	**154**	93
- Injury cost recovery (including Road Traffic Act Income)	**1,133**	887
	194,791	186,083

Injury Cost Recovery income is subject to a provision for doubtful debts of 9.6% (7.8% 2009/10) to reflect expected rates of collection.

Private patient income

The Trust's private patient activity is restricted by the private patient cap, as set out in the Trust's terms of authorisation as a foundation Trust, based on its 2002/03 income, and for the Trust is 0.2% of total patient income. Income from private patient activity for 2010/11 totalled £318k (£214k 2009/10), which equates to 0.16% of total patient related income, which is within the cap. Included in this figure are overseas patients where there is no reciprocal agreement.

	2010/11	2009/10	2002/03 Base year
	£000	£000	£000
Private Patient Income	**318**	214	187
Total patient related income	**193,340**	186,083	103,467
Proportion (as a percentage)	**0.16%**	0.12%	0.18%

4 Other Operating Income

	2010/11	2009/10
	£000	£000
Research and development	**445**	396
Education and training	**5,964**	6,210
Charitable and other contributions to expenditure	**164**	190
Transfers from the donated asset reserve	**243**	688
Non-patient care services to other bodies	**8,567**	8,488
Reversal of Impairment	**536**	0
Other income	**8,008**	8,822
	23,927	24,794

The impairment loss in 2010/11 of £536,000 (2009/10 £7,584,557) and Impairment Reversal of £536,000 (2009/10 £0) has been shown as an exceptional item in the Statement of Comprehensive Income as this is outside the normal course of business.

Other Income includes

	2010/11	2009/10
	£000	£000
Car parking	**1,311**	1,252
Staff accommodation	**378**	236
Creche	**353**	366
Catering	**645**	623
	2,687	2,477

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

5 Operating Expenses

Operating expenses comprise

	2010/11	2009/10
	£000	£000
Services from other NHS Trusts	**4,030**	3,446
Services from PCTs	**2,399**	1,240
Services from non NHS bodies	**922**	1,287
Services from Foundation Trusts	**639**	588
Non executive Directors' costs	**133**	129
Executive Directors' costs	**719**	766
Staff costs	**146,059**	141,002
Supplies and services - clinical	**32,778**	28,649
Supplies and services - general	**2,541**	2,642
Consultancy services	**859**	409
Establishment	**2,077**	2,327
Transport	**96**	338
Premises	**6,780**	6,907
Increase in bad debt provision	**82**	15
Depreciation	**8,085**	8,640
Fixed asset impairments and reversals	**536**	7,584
Statutory audit fee	**68**	59
Loss on disposal of property, plant and equipment	**19**	0
Clinical negligence	**4,969**	4,657
Other	**3,570**	3,336
	217,361	214,021

Audit Fees of £68,000 (2009/10 £59,000) comprise exclusively statutory audit fees and no other assurance services or other services have been provided.

The impairment loss in 2010/11 of £536,000 (2009/10 £7,584,557) and Impairment Reversal of £536,000 (2009/10 £0) has been shown as an exceptional item in the Statement of Comprehensive Income as this is outside the normal course of business.

6 Operating Leases

As lessee

Payments recognised as an expense

	2010/11 £000	2009/10 £000
Minimum lease payments	337	316
	337	316

Total future minimum lease payments

	31 March 2011 £000	31 March 2010 £000
Payable:		
Not later than one year	**359**	323
Between one and five years	**824**	806
After five years	**0**	0
Total	**1,183**	1,129

In general, operating leases are for various pieces of equipment and are for a five year period. Generally all equipment leases are taken out under the 'NHS Conditions of Contract for the Lease of Goods.' None of these equipment leases are deemed to be significant or described as specialised in nature, with the largest being £76,050 in annual payments. The Trust has also entered into an operating lease for the use of a building which is for a fifteen year period, but with a break clause at years five and ten, provided that six months' prior written notice has been given.

7 The late payment of commercial debts (interest) Act 1998

The late payment of commercial debts (interest) Act 1998

	2010/11 £000	2009/10 £000
Amounts included within other interest payable arising from claims made under this legislation	**1**	1
Compensation paid to cover debt recovery costs under this legislation	**2**	1

8 Employee expenses and numbers

8.1 Employee expenses

	2010/11			2009/10		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**124,306**	110,229	14,077	120,231	106,845	13,386
Social Security Costs	**9,615**	9,141	474	9,230	8,773	457
Employer contributions to NHS Pension Scheme	**12,857**	12,520	337	12,307	11,935	372
	146,778	**131,890**	**14,888**	141,768	127,553	14,215

This analysis excludes non executive director costs of £133,000 (2009/10 £129,000)

8.2 Directors' Remuneration and Other Benefits

	2010/11	2009/10
	£000	£000
Directors Remuneration	**696**	724
Social Security Costs	**76**	76
Employer contributions to NHS Pension scheme	**80**	95
Total Remuneration	**852**	895

6 directors (2009/10 6) are accruing pension benefits uner the NHS Pension Scheme (Defined benefits)

8.3 Average number of persons employed

	2010/11			2009/10		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**438**	409	29	426	400	26
Administration and estates	**1,134**	1,076	58	1,169	1,092	77
Healthcare assistants and other support staff	**528**	528	0	469	469	0
Nursing, midwifery and health visiting staff	**1,240**	1,016	224	1,221	997	224
Nursing, midwifery and health visiting learners	**67**	22	45	63	25	38
Scientific, therapeutic and technical staff	**281**	266	15	299	271	28
Total	**3,688**	**3,317**	**371**	3,647	3,254	393

9 Pension costs

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

The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is

accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011 is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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

c) Scheme provisions
In 2010/11 the NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

Annual Pensions
The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are

practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

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

Pensions Indexation
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

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

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

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

Transfer between Funds
Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits
Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Compensation for Early Retirement
Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer’s cost.

10 Retirements due to ill-health

During 2010/11 there were 4 (2009/10, 4) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £313,346 (2009/10, £306,886). The cost of these ill-health retirements will be borne by the NHS Business Services Authority -Pensions Division.

11 Salary and pension entitlements of senior managers
a) Remuneration

Name and title	2010/11 Salary (bands of £5000) £000	2010/11 Other Remuneration (bands of £5000) £000	2010/11 Benefits in kind Rounded to the nearest £100	2009/10 Salary (bands of £5000) £000	2009/10 Other Remuneration (bands of £5000) £000	2009/10 Benefits in kind Rounded to the nearest £100
Mr Vernon Hull, Chairman	40-45	-	-	40-45	-	-
Mr G Clayden, Non-executive Director	10-15	-	-	10-15	-	-
Mrs A Penman, Non-executive Director	10-15	-	-	10-15	-	-
Mr A Horwood, Non-executive Director	10-15	-	-	10-15	-	-
Mr C Wilby, Non-executive Director	10-15	-	-	10-15	-	-
Mr C Ofili, Non-executive Director	10-15	-	-	10-15	-	-
Mr J Sands, Non-executive Director	10-15	-	-	5-10	-	-
Mr M Jamieson, Non-executive Director	0-5	-	-	-	-	-
Mr M Devlin, Chief Executive	150-155	-	-	-	-	-
Mr P Johnson, Director of Operations and Deputy CEO	125-130	-	-	-	-	-
Mr J Moon, Director of Finance	110-115	-	-	110-115	-	-
Dr G Smith-Laing, Medical Director	25-30	170-175	-	10-15	65-70	-
Mrs J McKenna, Director of Nursing	100-105	-	-	100-105	-	-
Miss C Lee, Director of Human Resources	5-10	-	-	90-95	-	-
Mrs J Sutherland, Interim Director of Operations	5-10	-	-	90-95	-	-

Notes

For the purposes of the remuneration report, Senior Managers are defined as those with voting rights at a Trust Board meeting.
Mr M Devlin commenced on 1 April 2010
Mr P Coles left on 6 April 2010 and ceased to as Interim Chief Executive on 31 March 2010
Mr P Johnson commenced on 26 April 2010 as Interim Director of Operations and on 30 June 2010 was appointed Director of Operations and Deputy Chief Executive Officer
Mrs J Sutherland resigned on 25 April 2010
Mrs A Penman retired on 31 December 2010
Mr M Jamieson commenced on 22 December 2010
Miss C Lee salary excludes maternity pay and relates to the period 1 April 2010 to 4 May 2010 and 29 March to 31 March 2011
Mr A Brown provided services as an Interim Director of Human Resources between 1 June 2010 and 31 March 2011 while employed by Dartford and Gravesham NHS Trust. Salary costs of £59,381 for this period (including pension and employers' costs) were recharged to the Trust by Dartford and Gravesham NHS Trust.

b) Pension benefits

Name and title	Real increase in pension and related lump sum at age 60 (bands of £2500) £000	Total accrued pension and related lump sum at age 60 at 31 March 2011 (bands of £2500) £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Real Increase in Cash Equivalent Transfer £000
Mr M Devlin, Chief Executive	57.5-60	165-167.5	558	-	125
Mr P Johnson, Director of Operations and Deputy CEO	0-2.5	5-7.5	63	-	16
Mr J Moon, Director of Finance	0-2.5	105-107.5	504	525	-48
Miss C Lee, Director of Human Resources	0-2.5	30-32.5	64	77	-17
Mrs J McKenna, Director of Nursing	(0)-(2.5)	115-117.5	452	492	-65
Dr G Smith-Laing, Medical Director	30-32.5	315-317.5	Note a	Note a	Note a

a) Dr G Smith-Laing has reached the age of 60 and hence a CETV figure is not provided by the Pensions Agency.
b) The information in the above table has been provided by the NHS Pensions Agency.
c) In the budget in June 2010 it was announced that the uprating (annual increase) of public sector pensions would change from the Retail Prices Index (RPI) to the Consumer Prices Index (CPI) with the change expected from April 2011. As a result the Government Actuaries Department undertook a review of all transfer factors. The new CETV factors have been used in the above calculations and are lower than the previous factors used. Therefore the value of CETV's for some members have fallen since 31 March 2010.

12 Finance income

	2010/11 £000	2009/10 £000
Interest on loans and receivables	**41**	60
	41	60

13 Finance costs – interest expense

	2010/11 £000	2009/10 £000
Finance leases	**64**	64
Working Capital Facility	**11**	0
Other	**2**	0
	77	64

14. Property, plant and equipment

14.1 Property, plant and equipment 2010/11

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and POA	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2010	20,435	99,740	6,105	4,550	35,588	475	8,330	10,074	185,297
Additions - purchased	0	0	0	5,819	1,097	0	219	0	7,135
Additions - donated	0	0	0	0	348	0	0	0	348
Impairments	0	(526)	(100)	0	0	0	0	0	(626)
Reclassifications	0	8,317	102	(8,799)	135	0	193	52	0
Revaluation	0	(2,250)	(26)	0	0	0	0	0	(2,276)
Disposals	0	0	0	0	(168)	0	(38)	0	(206)
Cost or Valuation at 31 March 2011	**20,435**	**105,281**	**6,081**	**1,570**	**37,000**	**475**	**8,704**	**10,126**	**189,672**
Depreciation at 1 April 2010	0	53	11	0	26,622	469	4,551	8,555	40,261
Provided during the year	0	3,766	280	0	2,772	3	957	307	8,085
Impairments	0	0	0	0	0	0	0	0	0
Revaluation	0	(3,689)	(257)	0	0	0	0	0	(3,946)
Disposals	0	0	0	0	(148)	0	(38)	0	(186)
Depreciation at 31 March 2011	**0**	**130**	**34**	**0**	**29,246**	**472**	**5,470**	**8,862**	**44,214**
Net book value									
- Owned at 1 April 2010	20,435	98,563	6,094	4,550	7,016	6	3,763	1,486	141,913
- Finance lease at 1 April 2010	0	0	0	0	1,166	0	0	0	1,166
- Donated at 1 April 2010	0	1,124	0	0	784	0	16	33	1,957
- Total at 1 April 2010	**20,435**	**99,687**	**6,094**	**4,550**	**8,966**	**6**	**3,779**	**1,519**	**145,036**
- Owned at 31 March 2011	20,435	104,041	6,047	1,570	5,493	3	3,227	1,237	142,053
- Finance lease at 31 March 2011	0	0	0	0	1,316	0	0	0	1,316
- Donated at 31 March 2011	0	1,110	0	0	945	0	7	27	2,089
- Total at 31 March 2011	**20,435**	**105,151**	**6,047**	**1,570**	**7,754**	**3**	**3,234**	**1,264**	**145,458**

14.2 Analysis of property, plant and equipment 31 March 2011

Net book value									
Protected assets at 31 March 2011	20,160	104,891	0	0	0	0	0	0	125,051
Unprotected assets at 31 March 2011	275	260	6,047	1,570	7,754	3	3,234	1,264	20,407
	20,435	**105,151**	**6,047**	**1,570**	**7,754**	**3**	**3,234**	**1,264**	**145,458**

14.3 Property, plant and equipment 2009/10

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and POA	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	21,485	120,441	6,259	6,056	34,637	475	7,918	9,566	206,837
Additions - purchased	0	9	56	11,493	401	0	69	101	12,129
Additions - donated	0	0	0	121	512	0	1	0	634
Impairments	(1,040)	(23,175)	(170)	0	0	0	0	0	(24,385)
Reclassifications	0	11,797	220	(13,120)	341	0	355	407	0
Revaluation	(10)	(9,321)	(260)	0	0	0	0	0	(9,591)
Disposals	0	(11)	0	0	(303)	0	(13)	0	(327)
Cost or Valuation at 31 March 2010	**20,435**	**99,740**	**6,105**	**4,550**	**35,588**	**475**	**8,330**	**10,074**	**185,297**
Depreciation at 1 April 2009	0	4,023	213	0	24,213	462	3,610	8,186	40,707
Provided during the year	0	4,391	225	0	2,696	7	952	369	8,640
Impairments	10	7,574	0	0	0	0	0	0	7,584
Revaluation	(10)	(15,924)	(427)	0	0	0	0	0	(16,361)
Disposals	0	(11)	0	0	(287)	0	(11)	0	(309)
Depreciation at 31 March 2010	**0**	**53**	**11**	**0**	**26,622**	**469**	**4,551**	**8,555**	**40,261**
Net book value									
- Owned at 31 March 2010	20,435	98,563	6,094	4,550	7,016	6	3,763	1,486	141,913
- Finance lease at 31 March 2010	0	0	0	0	1,166	0	0	0	1,166
- Donated at 31 March 2010	0	1,124	0	0	784	0	16	33	1,957
- Total at 31 March 2010	**20,435**	**99,687**	**6,094**	**4,550**	**8,966**	**6**	**3,779**	**1,519**	**145,036**

14.4 Analysis of property, plant and equipment 31 March 2010

Net book value									
Protected assets at 31 March 2010	20,160	99,487	0	0	0	0	0	0	119,647
Unprotected assets at 31 March 2010	275	200	6,094	4,550	8,966	6	3,779	1,519	25,389
	20,435	**99,687**	**6,094**	**4,550**	**8,966**	**6**	**3,779**	**1,519**	**145,036**

14.5 Property, plant and equipment (contd)

Of the totals at 31 March 2011, none related to land valued at open market value, none related to buildings valued at open market value and none related to dwellings valued at open market value.

During the year assets have been donated by the following organisations;

Medway NHS Foundation Trust Charitable Fund	£115,540
Medway League of Friends	£232,920

14.6 Economic Lives

Information on the economic life of property, plant and equipment is included in the accounting policies.

15.1 Inventories

	31 March 2011 £000	31 March 2010 £000
Materials	**4,785**	5,046
TOTAL	**4,785**	5,046

15.2 Inventories recognised in expenses

	2010/11 £000	2009/10 £000
Inventories recognised as an expense in the period	**31,890**	26,865
	31,890	26,865

16 Trade receivables and other receivables

	31 March 2011 £000	31 March 2010 £000
Current:		
NHS receivables	8,240	10,970
Provision for impaired receivables	(281)	(207)
Prepayments, accrued income and deferred expenditure	1,609	1,605
PDC dividend receivable	0	447
Other receivables	3,847	3,601
TOTAL	**13,415**	16,416

The majority of trade is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

17 Provision for impairment of receivables

	31 March 2011 £000	31 March 2010 £000
Balance at 1 April	**207**	194
Increase in provision	**82**	15
Amount utilised	(8)	(2)
Balance at 31 March	**281**	207

This principally relates to a provision for doubtful debts of 9.6% for Road Traffic Act income.

18 Analysis of receivables past due impaired and non-impaired

	31 March 2011 £000	31 March 2010 £000
Ageing of past due impaired receivables		
Up to three months	0	0
In three to six months	0	0
Over six months	281	207
	281	207
Ageing of past due non-impaired receivables		
Up to three months	1,288	3,981
In three to six months	454	709
Over six months	1,410	1,064
	3,152	5,754

19 Other Current Assets

19.1 Other Current Assets

	31 March 2011 £000	31 March 2010 £000
EU Emissions Trading Scheme	**122**	57
TOTAL	**122**	57

20 Trade and other payables

	31 March 2011 £000	31 March 2010 £000
Current		
NHS payables	**8,722**	8,023
Non - NHS trade payables - revenue	**5,321**	6,469
Non - NHS trade payables - capital	**1,774**	2,576
Social security costs	**1,374**	1,349
Other payables	**1,902**	1,930
PDC Payable	**16**	0
Accruals	**2,060**	4,590
TOTAL	**21,169**	24,937

NHS payables include;

- £1,606,784 outstanding pensions contributions at 31 March 2011 (31 March 2010 £1,570,634).

21 Other liabilities

Other Liabilities

	31 March 2011 £000	31 March 2010 £000
Current		
Deferred Income	**24**	1
Deferred Government Grant	**100**	197
TOTAL	**124**	198
Non Current		
Deferred Government Grant	**162**	102
TOTAL	**162**	102

22 Borrowings

	31 March 2011 £000	31 March 2010 £000
Current		
Other loans	**29**	3
Obligations under finance leases	**415**	403
Working capital	**2,000**	0
	2,444	406
Non Current		
Other loans	**55**	18
Obligations under finance leases	**856**	787
	911	805

23 Prudential Borrowing Limit (PBL)

The Trust is required to comply and remain within a prudential borrowing limit ("PBL") made up of two elements:

- the maximum cumulative amount of long term borrowing. This is set by reference to the four ratios 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.
- the amount of any working capital facility approved by Monitor.

Further information on the Trust's Prudential Borrowing Code & Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

The Trust had a prudential borrowing limit of £38.4 million at 31 March 2011. The Trust has actually borrowed £1,354,903 (£1,211,521 31 March 2010). This borrowing relates primarily to finance leases and £83,884 in respect to non-interest bearing loans.

The Trust has a £15.9 million approved working capital facility. At the end of the financial year a balance of £2 million was drawn down against the working capital facility.

The financial ratios for the period are shown below with the actual level of achievement for the period.

Financial Ratio	**Actual Ratio March 2011**	**Approved PBL Ratio March 2011**	**Actual Ratio March 2010**	**Approved PBL Ratio March 2010**
Minimum Dividend Cover	1.9x	>1x	2.4x	>1x
Minimum Interest Cover	121x	>3x	204x	>3x
Minimum Debt Service Cover	18x	>2x	32x	>2x
Maximum Debt Service to Revenue	<1%	<2.5%	<1%	<2.5%

24 Finance lease obligations

Amounts payable under finance leases	**Minimum Lease Payments**		**Present value of minimum lease payments**	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
Within one year	**519**	403	**519**	403
Between one and five years	**880**	897	**752**	787
After five years	**0**	0	**0**	0
Less future finance charges	**(128)**	(110)	**0**	0
Present value of minimum lease payments	**1,271**	1,190	**1,271**	1,190
Included in:				
Current borrowings			**519**	403
Non-current borrowings			**752**	787
			1,271	1,190

25 Provisions for liabilities and charges

	Current		Non-Current	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
Pensions relating to staff	**27**	29	717	770
Legal claims	**107**	116	0	0
EU Emissions Trading Scheme	**35**	15	0	0
Dilapidation	**0**	0	114	114
TOTAL	**169**	160	**831**	884

	Pensions relating to staff	Legal claims	European Union Emissions Trading Scheme	Dilapidation provision	**Total**
	£000	£000	£000	£000	**£000**
At 1 April 2010	799	116	15	114	**1,044**
Change in the discount rate	(40)	0	0	0	**(40)**
Arising during the year	34	102	125	0	**261**
Utilised during the year	(67)	(68)	(105)	0	**(240)**
Reversed unused	0	(43)	0	0	**(43)**
Unwinding of discount	18	0	0	0	**18**
	744	107	35	114	**1,000**
Expected timing of cashflows:					
Within one year	27	107	35	0	**169**
Between one and five years	127	0	0	0	**127**
After five years	590	0	0	114	**704**
	744	107	35	114	**1,000**

The provision for pensions relating to other staff reflects the liabilities due to early retirements prior to 6 March 1995. The legal claims provision reflects liabilities arising from Public and Employee Liability claims.

The provision relating to the European Union Emissions Trading Scheme reflects the liability to surrender part of the 2011 calendar year allowance arising from emissions since 1st January 2011.

The dilapidation provision relates to the cost to bring the leased property at Stirling Park back to its original condition.

£18,309,213 is included in the provisions of the NHS Litigation Authority at 31 March 2011 in respect of clinical negligence liabilities of the Trust (31 March 2010 £15,276,848).

26 Cash and cash equivalents

	At 1 April 2010	Cash changes 2009/10	**At 31 March 2011**
	£000	£000	**£000**
Government Banking Service cash at bank	4,443	(1,154)	**3,289**
Commercial cash at bank and in hand	179	(123)	**56**
Working Capital Facility	0	(2,000)	**(2,000)**
Cash and cash equivalents as in Statement of Financial Position and Statement of Cash Flows	4,622	(3,277)	**1,345**

27 Capital Commitments

Commitments under capital expenditure contracts at 31 March 2011 were £43,859 (31 March 2010 £2,812,792), this relates to the completion of Generators and MRI enabling works.

28 Contingencies

The contingent liabilities relating to the Trust as at 31 March 2011 were £69,030 (£64,733 as at 31 March 2010) relating to NHS Litigation Authority Legal Claims.

The Trust has continued to pursue, through mediation, the performance and resolution of defects/snags arising from a previous contract for the redevelopment of Medway Hospital.

29 Related Party Transactions

The Medway NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.

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 Trust.

The Department of Health is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

Strategic Health Authorities
Primary Care Trusts
NHS Trusts and NHS Foundation Trusts
NHS Arms Length Bodies

The main entities with which the Trust had material transactions are within the Kent and Medway Health Economy, or are Arms Length Bodies and are:

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to related Party £000	Amounts due from Related Party £000
Strategic Health Authorities				
South East Coast Strategic Health Authority	106	5,704	104	30
Primary Care Trusts				
Eastern and Coastal Kent Primary Care Trust	0	47,545	0	1,339
Medway Primary Care Trust	1,799	131,863	1,012	2,241
West Kent Primary Care Trust	133	14,087	24	1,765
NHS trusts				
Dartford and Gravesham NHS Trust	1,453	356	171	51
Kent and Medway NHS and Social Care NHS Trust	348	1,831	107	370
Maidstone and Tundbridge Wells NHS Trust	3,028	1,333	1,047	224
South East Coast Ambulance NHS Trust	8	199	0	0
NHS Foundation trusts				
East Kent Hospitals NHS Foundation Trust	113	1,837	103	252
NHS Arms Length Bodies				
NHS Business Services Authority	1,433	0	1,198	0
NHS Litigation Authority	5,295	0	1	0
NHS Purchasing and Supply Agency	5,812	0	1,866	0
NHS Pensions Agency	19,227	0	1,623	0
Other Government Departments				
HM Revenue and Customs	36,475	0	3,086	60
The Trust has also received income from charitable funds where the Trust is the corporate Trustee				
Medway NHS Foundation Trust Charitable Fund	0	164	8	25

30 Financial Instruments

Financial reporting standard IFRS 7 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. The 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.

The Trust invests surplus cash based on forecasted cash flows with Commercial Banks in line with the Treasury Policy. Institutions are selected based on their Moody's rating, which determines the maximum amount to be invested. Moody's Investors Services Ltd is an international rating agency who provides a rating system to help investors determine the risk associated with investing in a specific company, investing instrument, or market. The Trust has continued to implement stricter guidance during the year restricting the amount with any one institution to 25% of the Trust's cash holdings.

Interest-Rate Risk

91% of the Trust's financial liabilities carry nil or fixed rates of interest. The only element of the Trust's financial liabilities that is subject to a variable rate is the working capital facility, utilised for short term cashflow requirements. 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.

Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

Credit Risk

The Trust operates primarily within the NHS market and receives the majority of its income from other NHS organisations. There is therefore little risk that one party will fail to discharge its obligations with the other. Disputes can arise, however, around how the amounts owed are calculated, particularly due to the complex nature of the Payments 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.

Liquidity Risk

The Trust's net operating costs are incurred under contracts with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust received such contract income in accordance with Payments by Results (PBR), which is intended to match the income received in year to the activity delivered in that year by reference to the National Tariff procedure cost. The Trust receives cash each month based on an annually agreed level of contract activity and there are monthly payments made to adjust for the actual income due under PBR. The Trust has continued to put in place a £15,900,000 working capital facility with its current Bankers, which has been utilised during the year, and of which £2,000,000 was outstanding at the 31st March 2011.

The Trust presently finances its capital expenditure from internally generated funds or funds made available from Government, in the form of additional Public Dividend Capital, under an agreed limit. In addition, the Trust can borrow from the Foundation Trust Financing Facility and commercially to finance capital schemes. Financing is drawn down to match the capital spend profile of the scheme concerned and the Trust is not, therefore, exposed to significant liquidity risks in this area.

Financial assets by category

The Trust does not hold any financial assets or liabilities that are held at fair value through Income and Expenditure. All financial assets are shown within loans and receivables and financial liabilities are shown as other.

	Loans and receivables	Book Value	Fair Value
At 31 March 2011			
Receivables	11,945	11,945	11,945
Cash and cash equivalents	3,345	3,345	3,345
	15,290	**15,290**	**15,290**
At 31 March 2010			
Receivables	14,532	14,532	14,532
Cash and cash equivalents	4,622	4,622	4,622
	19,154	**19,154**	**19,154**

Financial liabilities by category

	Other	Book Value	Fair Value
At 31 March 2011			
Payables	18,067	18,067	18,067
Other borrowings	2,084	2,084	2,084
Finance leases	1,271	1,271	1,271
	21,422	**21,422**	**21,422**
At 31 March 2010			
Payables	21,963	21,963	21,963
Other borrowings	21	21	21
Finance leases	1,190	1,190	1,190
	23,174	**23,174**	**23,174**

31 Third Party Assets

The Trust held £2,253 cash at bank and in hand at 31 March 2011 (£1,803 - at 31 March 2010) which relates to monies held on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

32 Intra-Government and Other Balances

	Debtors: amounts falling due within one year	**Debtors: amounts falling due after more than one year**	**Creditors: amounts falling due within one year**	**Creditors: amounts falling due after more than one year**
	£000	**£000**	**£000**	**£000**
Balances with other Central Government Bodies	60	0	3,091	0
Balances with NHS Trusts and Foundation Trusts	8,240	0	8,722	0
Balances with bodies external to government	1,609	0	2,060	0
At 31 March 2011	**9,909**	**0**	**13,873**	**0**

33 Losses and Special Payments

There were 294 cases of losses and special payments (2009/10: 210 cases) totalling £114,691 (2009/10: £93,893) paid during 2010/11.
There were 0 cases where the net payment exceeded £250,000 (2009/10: 0 cases).

Losses and special payments are transactions 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, and special notation in the accounts to draw them to the attention of Parliament. They are divided into different categories, which govern the way each individual case is handled.

Clinical negligence cases are managed by the National Health Service Litigation Authority and transactions relating to such cases are held in their accounts. The Trust pays a premium for their services and excesses on some cases. Therefore, these cases have not been accounted for in the Trust's accounts.

MEDWAY NHS FOUNDATION TRUST – QUALITY ACCOUNT 2010-11

Part 1

Chief Executive Officer's statement on Quality

Welcome to the Medway NHS Foundation Trust's second Quality Account. This report aims to demonstrate to the public and our partners that the quality of the services we provide is at the heart of everything we do. It will highlight the many achievements, in terms of patient safety and patient experience, through the year and also the areas which we will focus on to improve over the next year.

Throughout 2010-11, the Trust Board has committed itself to improving patient safety, patient experience and the clinical effectiveness of treatments. Every Board meeting now starts with a patient story which brings to life the strategies agreed and those that are monitored at Board level. The Board has reviewed its patient safety visit programme, which now also encompasses the feedback on patient and staff experience. This enables directors to visit wards and departments to speak to staff and patients to enable them to get a fuller picture of the quality of services; I am pleased to say that governors also now join directors on these visits; this has been extremely valuable.

We are very proud of our success in having no MRSA bacteraemia during 2010-11, indeed since February 2010. Our patient safety project ensures that all staff are involved and I am sure that the improvements reflect the higher levels of staff involvement. We have had fewer emergency incidents of patients becoming very unwell and requiring high dependency care. Patient falls have reduced through the year, we have introduced 'SBAR' (Situation, Background, Assessment, Recommendation), a communication tool to relay complex detail in a clear way and the World Health Organisation's (WHO) surgical safety checklist is fully implemented in our operating theatres.

There is, however, a long way to go until we achieve all that we aspire to. This year, a Patient Experience Committee was formed and a major project to improve all aspects of the patient experience will be launched later in the year. We have endeavoured to learn from the patient incidents that happened last year. Our priorities for improvement this year include; increasing the number of patients that have venous thrombo-embolism (VTE) assessment; reducing the number of patients who fall, and improved compliance with NICE fetal heart monitoring guidance. These are all directly related to our aspiration of reducing such incidents next year.

We are also committed to improving the way in which quality is managed through the year. This will involve implementing the NHS Quality Board's framework for quality governance, improving data quality and ensuring clinicians have the information they need to further improve their services.

The Board will continue to champion all aspects of quality in everything we do and I am confident that staff will continue to be totally committed to providing the best possible standards of care and treatment to our patients. I confirm that, to the best of my knowledge, the information you will find in this Quality Account is accurate and hope you find it interesting. I look forward to reporting our successes next year.

Mark Devlin
Chief Executive Officer

Part 2 – Priorities for improvement and statements of assurance from the Board

It is essential to the Board that as many people as possible are involved in developing the Quality Accounts, in particular the priorities.

The consultation for the priorities for 2011-12 started with the Medical Director and Director of Nursing agreeing on fourteen potential priorities. These were sent to NHS Medway, Medway LINKS and the Medway Overview and Scrutiny Committee. A consultation session was held with the Governors who also had discussions about which indicators should be used. They favoured falls, medication errors, the heart failure discharge process, diabetes care, neonatal outcomes, and discharge measures. They also suggested that information before admission, number of compliments, maternity figures and self medication would be good quality indicators. The proposed priorities were discussed with the senior nurses and also with the Executive Directors and Clinical Directors at the Clinical and Executive Group. This group highlighted that the objectives were all concentrated on the adult services and suggested that there should be priorities for the Women's and Children's services.

The Clinical Directors and Heads of Nursing/Midwifery for the Women's and Children's directorates then suggested indicators for inclusion, and the consultation continued with a larger set of indicators.

A meeting with the members took place in April, this updated them on the development of the Quality Account. The Clinical Directors and Heads of Nursing approved the Quality Account and the Chair of the Staff Side has also agreed the report.

Taking everyone's views into consideration, the nine priorities for improvement, in 2011-12 are in Table 1

Table 1: Priorities for improvement 2011-12

Patient Safety	• Increase number of patients who have VTE (blood clot) assessment • Reduce the number of patients who fall • Improve compliance with CTG reading (fetal heart monitoring) in line with NICE guidance
Patient Experience	• Increase number of patients who report nurse in charge asked them about their care every day • Improve appointment system resulting in fewer complaints to PALS • Increase the number of patients who report they were told about their medication prior to discharge
Clinical Effectiveness	• Increase the number of heart failure patients who receive discharge information • Improve compliance with Think Glucose (Diabetes) guidelines • Increase the number of postnatal women who breastfeed at discharge from community midwife.

Why these priorities were chosen

- **Increase the number of patients who have VTE assessment.**

It is recognised that this is very important clinical practice. Almost all patients in hospital have an increased risk of developing blood clots in the legs which can then travel to the lungs. These are known as venous thrombo-embolism (VTE). All inpatients should be assessed for their risk of developing such clots. The Trust has made significant progress in the last year to increase the number of patients being assessed (14% in September 2010 to 76% in March 2011) and plans are in place to ensure that progress continues to be made in all specialties.

- **Reduce the number of patients who fall.**

The Trust recognises that the number of falls is above the Strategic Health Authority's average number of 80 falls per month, however, since November 2010 the Trust has reached the average. It is the intention of the Trust to improve significantly on this performance. A Falls Practitioner has been appointed and will lead improvements through education and monitoring practice. Her appointment already appears to be bearing fruit and a detailed action plan is in place to reduce falls progressively.

- **Improve compliance with CTG NICE guidelines**.

There have been a number of incidents in the labour suite during 2010-11 which demonstrated that there is an issue with reading fetal heart monitoring (CTG) traces of women in labour, so this is a priority for improvement. An action plan including relaunching the policy, education and monitoring practice will be implemented.

- **Increase the number of patients who report the nurse in charge has discussed their care with them daily.**

The nurse/patient relationship is vital to ensuring the patient understands what is happening to them, and also for the nurse to be able to allay fears and concerns for the patient. During 2010, all senior sisters focused on ensuring that the nurse in charge of the ward spoke to each patient daily, and managed any concerns they had. This has been well received by patients but needs to be further embedded in practice.

- **Improve appointment system resulting in fewer complaints to PALS.**

During the year, a trend has been identified of a rising number of patients not having enough information about appointments or not being able to talk to someone to rearrange appointments. This has been discussed at the Board and raised with senior managers, it is therefore correct that it is a priority for improvement, and will be monitored across all specialties.

- **Increase the number of patients who report they were told about the side effects of their medication on discharge.**

A senior nurse for patient discharge has recently been appointed, who has made a number of immediate changes to the process which have resulted in fewer delayed discharges. There is, however, a need to review the discharge process across the Trust to ensure that all patients receive appropriate discharge information, including details of the possible side-effects of their medication. This is also a national priority.

- **Increase the number of heart failure patients who receive discharge advice.**

This is one of the criteria from the Enhancing Quality programme which was implemented during 2010. The programme has been implemented very successfully with a lot of commitment from clinical staff. This criterion is a particular priority for improvement, as it is clear patients are not always given all the information that they

need and, without effective discharge advice, patients are more likely to be readmitted.

- **Improve compliance with Think Glucose guidelines.**

The Trust implemented the National Think Glucose (Diabetic) guidelines during 2009. These guidelines are best practice for the care and treatment of diabetic patients. www.institute.nhs.uk/quality_and_value/think_glucose/welcome_to_the_website for_thinkglucose.html

During 2010 there were a number of incidents when patients' glucose levels were not being monitored correctly, resulting in the blood sugar becoming dangerously low. This has, therefore, been made a priority for improvement in 2011-12.

- **Increase number of women who breastfeed at discharge from Community Midwife.**

This important public health issue continues to be a priority for improvement, as breastfeeding leads to healthier babies. Following the improvement made during the last year, it is thought that further improvement can be made by March 2012.

Achieving our priorities

A corporate action plan will be produced covering all the priorities for improvement. Each directorate will be expected to develop a more detailed action plan for their own areas for improvement.

One of the key changes to the quality Governance systems in the Trust planned for 2011-12 is the Quality Performance Committee. The role of this committee will be to monitor closely the Trust's performance in relation to all quality indicators, and to take prompt action to improve performance. All of the priorities will be measured and monitored by the new Quality Performance Committee, which reports to the Quality Committee. This will include the priorities for improvement in the quality accounts and also the CQUIN targets. The meeting will be chaired by the Director of Nursing and the directorate management teams (Clinical Directors, Heads of Nursing and General Managers) will be the members of this committee.

STATEMENT OF ASSURANCE FROM THE BOARD

Review of Services

During April 2010 – March 2011 Medway NHS Foundation Trust provided and/or sub contracted 42 NHS services. The Medway NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these NHS Services.

The income generated by the NHS Services reviewed in April 2010 – March 2011 represents 100 % of the total income generated from the provision of NHS services by the Medway NHS Foundation Trust for April 2010 – March 2011.

Participation in Clinical Audits 2010-11

During 2010-11, 40 national clinical audits and five national confidential enquiries covered NHS services that Medway NHS Foundation Trust provides (*source: NCAs for inclusion in Quality Accounts 2011,* Department of Health, 2010).

During that period, Medway NHS Foundation Trust participated in 83% (33/40) of the national clinical audits and 80% (4/5) of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Medway NHS Foundation Trust was eligible to participate in during 2010-11 were as follows:

National Clinical Audits

Perinatal and Neonatal

- Neonatal intensive and special care (*NNAP*)

Children

- Paediatric pneumonia (*British Thoracic Society*)
- Paediatric asthma (*British Thoracic Society*)
- Paediatric fever (*College of Emergency Medicine*)
- Diabetes (*RCPCH National Paediatric Diabetes Audit*)

Acute care

- Emergency use of oxygen (*British Thoracic Society*)
- Adult community-acquired pneumonia (*British Thoracic Society*)
- Non-invasive ventilation - adults (*British Thoracic Society*)
- Pleural procedures (*British Thoracic Society*)
- Cardiac arrest (*National Cardiac Arrest Audit*)
- Vital signs in majors (*College of Emergency Medicine*)
- Adult critical care (*ICNARC CMPD*)
- Potential donor audit (*NHS Blood & Transplant*)

Long-term conditions

- Diabetes (*National Adult Diabetes Audit*)
- Heavy menstrual bleeding (*RCOG National Audit of Heavy Menstrual Bleeding*)
- Chronic pain (*National Pain Audit*)
- Ulcerative colitis and Crohn's Disease (*National Inflammatory Bowel Disease Audit*)
- Parkinson's Disease (*National Parkinson's Audit*)
- COPD (*British Thoracic Society/European Audit*)
- Adult asthma (*British Thoracic Society*)
- Bronchiectasis (*British Thoracic Society*)

Elective procedures

- Hip, knee and ankle replacements (*National Joint Registry*)
- Elective surgery (*National PROMs Programme*)
- Coronary angioplasty (*NICOR Adult cardiac interventions audit*)
- Peripheral vascular surgery (*VSGBI Vascular Surgery Database*)
- Carotid interventions (*Carotid Intervention Audit*)

Cardiovascular disease

- Familial hypercholesterolaemia (*National Clinical Audit of Mgt of FH*)
- Acute Myocardial Infarction and other ACS (*MINAP*)
- Heart failure (*Heart Failure Audit*)
- Acute stroke (*SINAP*)
- Stroke care (*National Sentinel Stroke Audit*)

Renal disease

- Renal colic (*College of Emergency Medicine*)

Cancer

- Lung cancer (*National Lung Cancer Audit*)
- Bowel cancer (*National Bowel Cancer Audit Programme*)
- Head and neck cancer (*DAHNO*)

Trauma

- Hip fracture (*National Hip Fracture Database*)

- Severe trauma (*Trauma Audit & Research Network*)
- Falls and non-hip fractures (*National Falls & Bone Health Audit*)

Blood transfusion

- O-negative blood use (*National Comparative Audit of Blood Transfusion*)
- Platelet use (*National Comparative Audit of Blood Transfusion*)

National Confidential Enquiries

- National Confidential Enquiry into Patient Outcome and Death (*NCEPOD*):
- Surgery in children
- Cardiac arrest
- Peri-operative care
- Centre for Maternal and Child Health Enquiry (*CMACE*):
- Maternal death enquiry
- Perinatal mortality

The national clinical audits and national confidential enquiries that Medway NHS Foundation Trust participated in, and for which data collection was completed during 2010-11, are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Since November 2010 the Quality Committee reviews and monitors the Trust's performance in all national clinical audits.

Table 2 – National Clinical Audits

Clinical Audit	% Participation
Neonatal & Child Health	
Neonatal intensive and special care (*NNAP*)	100% [1]
Paediatric asthma (*British Thoracic Society*)	100%
Paediatric fever (*College of Emergency Medicine*)	100%
Diabetes (*RCPH National Paediatric Diabetes Audit*)	100% [2]
Acute Care	
Emergency use of oxygen (*British Thoracic Society*)	100%
Adult community-acquired pneumonia (*British Thoracic Society*)	N/A [3]
Non-invasive ventilation - adults (*British Thoracic Society*)	N/A [4]
Adult critical care (*ICNARC CMPD*)	100% [5]
Potential donor audit (*NHS Blood & Transplant*)	100%

Clinical Audit	% Participation
Long-term conditions	
Heavy menstrual bleeding (*RCOG National Audit of Heavy Menstrual Bleeding*)	N/A [6]
Chronic Pain (*National Pain Audit*)	N/A [7]
Ulcerative colitis & Crohn's disease (*UK Inflammatory Bowel Disease Audit*)	N/A [8]
Parkinson's disease (*National Parkinson's Audit*)	*c.* 33% [9]
COPD (*British Thoracic Society/European Audit*)	N/A [10]
Adult asthma (*British Thoracic Society*)	71%
Elective procedures	
Hip replacement (*National Joint Registry*)	79%
Knee replacement (*National Joint Registry*)	74%
Ankle replacement (*National Joint Registry*)	N/A [11]
Elective surgery – PROMs: Hip replacement	92%; Patient response rate: 93% [12]
Elective surgery – PROMs: Knee replacement	76%; Patient response rate: 93%
Elective surgery – PROMs: Varicose vein surgery	18%; Patient response rate: 79%
Elective surgery – PROMs: Groin hernia surgery	6%; Patient response rate: 61%
Coronary angioplasty (*NICOR Adult Cardiac Interventions Audit*)	100%[13]
Peripheral vascular surgery (*VSGBI Vascular Surgery Database*) – Aortic aneurysm repair	81%
Peripheral vascular surgery (*VSGBI Vascular Surgery Database*) – Infra-inguinal bypass surgery	40%
Peripheral vascular surgery (*VSGBI Vascular Surgery Database*) – Amputation surgery	6%
Carotid interventions (*Carotid Intervention Audit*)	97%
Cardiovascular Disease	

Clinical Audit	% Participation
Familial hypercholesterolaemia (*National Clinical Audit of Management of FH*)	100%
Acute myocardial infarction & other ACS (*MINAP*)	100%
Acute stroke (*SINAP*)	100% stroke cases; < 25% TIA[14]
Stroke care (*National Sentinel Stroke Audit*)	100%
Renal Disease	
Renal colic (*College of Emergency Medicine*)	100%
Cancer	
Lung cancer (*National Lung Cancer Audit*)	41% [15]
Bowel cancer (*National Bowel Cancer Audit Programme*)	84%
Head & neck cancer (*DAHNO*)	100% [16]
Trauma	
Hip fracture (*National Hip Fracture Database*)	98%
Severe trauma (*Trauma Audit & Research Network*)	100% [17]
Falls and non-hip fractures (*National Falls & Bone Health Audit*)	100%
Blood Transfusion	
O-negative blood use (*National Comparative Audit of Blood Transfusion*)	100%
Platelet use (*National Comparative Audit of Blood Transfusion*)	100%

Please see notes at end of document.

Table 3 – National Confidential Enquiries

National Confidential Enquiry	% Participation
National Confidential Enquiry into Patient Outcome and Death (*NCEPOD*) – Cardiac Arrest	100%
National Confidential Enquiry into Patient Outcome and Death (*NCEPOD*) – Surgery in Children	100%

National Confidential Enquiry	% Participation
Maternal death enquiry (*CMACE*)	100%
Perinatal mortality (*CMACE*)	100%

Medway NHS Foundation Trust did not participate in the following national clinical audits and confidential enquiries during 2010-11:

- Paediatric pneumonia (*British Thoracic Society*)
- Pleural procedures (*British Thoracic Society*)
  - The Trust however, carried out a local audit: *Talc pleurodesis for malignant pleural effusions*
- Cardiac arrest (*National Cardiac Arrest Audit*)
  - The Trust participated in the NCEPOD Cardiac arrest enquiry (see above), and conducts a continuous audit of responses to, and outcomes of, in-hospital cardiac arrest emergency calls via the *Resuscitation audit*
- Vital signs in majors (*College of Emergency Medicine*)
  - There is an ongoing audit of vital sign recording throughout the Trust - the *Observations audit* - which has been in place for several years
- Diabetes (*National Adult Diabetes Audit*)
  - The Trust participated in the *National Diabetes Inpatient Audit of Acute Trusts*
- Bronchiectasis (*British Thoracic Society*)
- Heart failure (*Heart Failure Audit*)
  - The Trust audits all heart failure cases as part of the *Enhancing Quality Programme*
- National Confidential Enquiry into perioperative care (*NCEPOD*)

In addition to participation in the Department of Health Quality Accounts projects listed above, during 2010-11 the Trust also submitted data to the following:

Table 4

Clinical Audit	Specialty
Acute care	
National Audit of Patients undergoing Emergency Laparotomy (*Emergency Laparotomy Network*)	General Surgery / Critical Care
National Management of the Open Abdomen (*National Institute for Health & Clinical Excellence*)	General Surgery / Critical Care
Long-term conditions	
National Diabetes Inpatient Audit of Acute Trusts (*NHS Diabetes*)	Diabetes
Elective procedures	
Heart Rhythm Management (*National Clinical Audit and Patient Outcomes Programme*)	Cardiology

Clinical Audit	Specialty
Mastectomy and Breast Reconstruction Audit (*National Clinical Audit & Patient Outcomes Programme*)	General Surgery
Mental Health	
National Dementia Audit (*National Clinical Audit & Patient Outcomes Programme*)	Older People
Other	
Surgical Site Infection Surveillance (*Health Protection Agency*)	Orthopaedics
Venous Thromboembolism Risk Assessment Audit	Trust-wide

The reports of 11 national clinical audits and confidential enquiries were reviewed by the Board of Medway NHS Foundation Trust in 2010-11, and Medway NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Adult Asthma (*British Thoracic Society*)
The Adult Asthma audit is part of the British Thoracic Society's (BTS) ongoing programme of national audits. In general, the Trust's performance in 2010 was similar to that nationally, and showed a slight trend to improvement compared with 2009. The Respiratory team continue to educate all staff to meet the BTS standards. It is planned to develop the role of the Outpatient Allergy Nurse to ensure better education of ward staff, review on the wards, support patients, and review inhaler technique, produce individual written management plans and ensure appropriate follow-up, including prompt General Practitioners' follow-up as described in the national guidelines.

Emergency Oxygen Use in Adult Patients (*British Thoracic Society*)
This audit is part of the British Thoracic Society's (BTS) ongoing programme of national audits. The BTS position is that oxygen is a drug that should be prescribed on drug charts, however, few doctors nationally prescribe oxygen. In an attempt to improve this situation, the BTS organises a national Emergency Oxygen Use audit each autumn, assessing prescribing as well as other aspects of oxygen usage. The Trust has participated in the audit since 2008, and the lead respiratory consultant has promoted oxygen prescribing guidelines via audit presentation and staff education. The 2010 re-audit indicated that oxygen is being given appropriately, and that appropriate devices for disease/state of the patient are used. There was optimal monitoring of O_2 saturation levels and achievement of target range levels where specified. Progress had been made on all key criteria since the previous audit, but prescribing levels have remained low. This is to be addressed through education of the prescribers via audit presentation, teaching, and the respiratory training programme. Pharmacists and ward nurses will be asked to highlight, to the prescribing doctors, any failure to prescribe. It is planned to revise prescription charts to include pre-written oxygen prescription, so that the right option can be ringed and signed for.

Intensive Care National Audit & Research Centre (ICNARC) Audit
The ICU submits data nationally on a continuous basis and receives reports every six months. The most recent report shows that our usage of ICU beds remains very high but has been helped significantly by the opening of the Bronte Medical High-Dependency Unit, in addition to the Trafalgar Surgical High-Dependency Unit. Because of the constant pressure on beds, night-time discharges remain high but new strategies within the Trust to prioritize the availability of free critical care beds should help to reduce this. The Trust's survival figures, compared to the rest of the country, are at least as good as the national average, and our infection rates are very low compared to the Trust's peers.

National Audit of Continence Care (*Royal College of Physicians*)
Services for people with incontinence are provided by health professionals working in different disciplines in hospitals and in the community, and this audit looks at national progress towards integration of these services and improving quality of care. Medway NHS Foundation Trust has participated in all three rounds of the audit. In the 2010 round, organisational structure and clinical provision for patients under 65 with urinary incontinence were shown to be in line with standards nationally; the Trust's clinical provision for patients over 65 was in the top 25%. A Continence Care Group (CCG) has been set up to review audit outcomes, to put into place an action plan based on local recommendations, and to monitor progress towards its achievement. The group has multidisciplinary, multiprofessional representation from both Medway NHS Foundation Trust and Medway Community Healthcare (MCH) to promote partnership working. An Integrated Continence Services Coordinator has been nominated, and a Clinical Lead for Faecal Incontinence (a counterpart to the existing Clinical Lead for Urinary Incontinence) appointed. A Urogynaecology Nurse Practitioner, whose role will incorporate that of Continence Advisor (Urinary & Faecal) is being considered. Work will be done to raise incontinence awareness amongst staff through education, supported by Bladder and Bowel Foundation resources. Access to the MCH competency-based training course is to be extended to relevant Medway NHS Foundation Trust staff. The CCG will oversee the drafting of a Trust Continence Care Policy, compatible with that of MCH, and standardisation to a Trust-wide Continence Assessment tool, validated scoring system and Quality of Life tool. The close collaboration with MCH professionals will ensure that our patients receive the best possible care and support, both in hospital and at home.

National Comparative Audit of the Use of Red Cells in Neonates and Children (*NHS Blood & Transplant*)

Neonates:
With regard to neonates, the results of this national audit demonstrated clearly that the Neonatal Unit at Medway Maritime Hospital is adopting areas of good clinical practice in the field of red cell transfusion, however, further improvements are required. The following actions have been taken: design of a new blood transfusion record for infants; education to increase awareness of near patient testing analysers with low volume samples at induction for junior doctors; blood transfusion mandatory training; and re-audit of red cell transfusion practice, following the implementation of the new guidance. A formal policy for minimising red cell transfusion in the neonate is planned, with review of red cell transfusion protocol in June 2013.

Children:
The results of the national audit demonstrated that blood transfusion is an occasional event in General Paediatrics. Although there are no guidelines and policies on blood transfusion specifically for children, the general guideline for the Trust is followed, and there is a clear policy for patients on chronic blood transfusion programmes. The audit demonstrated that practice was above the national average in most of the other measures, which indicates following good clinical practice in the area of red cell transfusion. The audit did show certain areas for improvement, and an action plan is in place to achieve this. This includes: development of a local policy in General Paediatrics for blood transfusion, and clear guidelines for children with cancer or haemoglobinopathy (disease of the red blood cells); education and training for medical and nursing staff, and design of a patient transfusion record. Transfusion practice in the paediatric age group will be re-audited following implementation of the action plan.

National Hip Fracture Database (*British Orthopaedic Association / British Geriatrics Society*)
The Trust has been submitting cases to the National Hip Fracture Database since 2008. Significant progress has been made over the past couple of years in the way that the care of patients with a fractured neck of femur is managed, and the latest report demonstrates that the Trust is amongst the leading national performers in some areas as a result of the system changes that have been put in place, however, it also shows that there is a need for still more improvement in some aspects of care. More medical input through a consultant in Elderly Care Medicine, better pathways for bone health, and improved awareness about being in the best possible health for an operation and early surgery are expected to lead to even better results.

National Joint Registry
The National Joint Registry (NJR) was set up by the Department of Health and the Welsh Assembly Government to collect information on all hip, knee and ankle replacement operations, and to monitor the performance of replacement joints (implants). To date, reporting refers only to hip and knee replacements; national data collection relating to total ankle replacement did not start until April 2010. Before data can be submitted to the NJR, patients must give their consent. Consent rates are already high at Medway, but there is scope for further improvement through pre-assessment protocols. The NJR report does not give individual trust data on post-operative length of stay, but benchmarking data suggests that length of stay is significantly shorter at Medway compared to peers, probably thanks to the Enhanced Recovery Programme (*see below*). A large number of prostheses are available on the market, but it is recommended that implant choice should remain largely evidence-based and peer-supported, a practice which is encouraged through governance arrangements.

Notes:

- *Length of stay data supplied by CHKS, a UK provider of comparative information allowing hospital trusts to benchmark their performance against the service provided by demographically similar organisations.*
- *Medway NHS Foundation Trust is one of only 14 national innovation sites recruited by the Department of Health to its Enhanced Recovery Programme. The central principle of the programme is that patients are partners in their own care. See www.dh.gov.uk*

National Neonatal Audit Programme (*Royal College of Paediatrics and Child Health*)
The Neonatal Unit (NNU) at Medway Maritime Hospital has been participating in the National Neonatal Audit Programme for some years. Data is entered onto the Standardised Electronic Neonatal Database (SEND) and collated and compared with data from other neonatal units across the UK. The results of the latest round of the National Neonatal Audit Programme demonstrated clearly that the NNU is adopting areas of good clinical practice, however, the processes surrounding the care of infants can be further developed. The following actions have been taken: design of the SEND operational framework with clear roles and responsibilities for data entry; incorporation of SEND operational framework in the induction educational pack for junior doctors; regular SEND training during medical induction and refreshers during Wednesday Grand Round; embedding of simulation training in the neonatal setting to enhance processes of care; provision of nursing educational development days; re-audit of surfactant use in the NNU; and redesigning a role of SEND data manager among the existing clerical staff in the NNU.

National Parkinson's Disease Audit (*Parkinson's UK*)
Patients with Parkinson's disease at Medway Maritime Hospital have access to standard and advanced therapies, including neurosurgery, via the regional neuroscience centre at King's College Hospital. A Parkinson's disease nurse specialist (PDNS) coordinates multidisciplinary care and ensures access to information and follow-up, in line with NICE guidance (NICE Clinical Guideline 35: *Parkinson's disease: diagnosis and management in primary and secondary care*). All patients are to be referred to the PDNS to ensure these roles are carried out effectively. A new recording system has been set up within the Neurology team to ensure that the PDNS is notified of all new referrals.

Parenteral Nutrition: National Confidential Enquiry (*NCEPOD*)
The NCEPOD report: *A Mixed Bag: An enquiry into the care of hospital patients receiving parenteral nutrition* published the results of a national study on assessment and care of patients receiving total parenteral nutrition (TPN). In TPN, all nutritional needs of the body are met by dripping nutrient solution directly into a vein, bypassing the digestive system. It is given in a number of situations, including in patients not having the ability to manage oral nutrition, in cases where the small intestine is not absorbing nutrients properly, in those with bowel obstruction, or where there is a need to rest the bowel, just to name a few examples. TPN is widely used and well established, but can give rise to serious complications. A comparison of the service provided by the Trust with the national recommendations indicated that some improvements were needed. An action plan has been put in place to ensure that the Trust policy on parenteral nutrition reflects national policy and that all TPN is to be sanctioned by the Nutrition Team, with none being set up out-of-hours without the knowledge of the team. Furthermore, there is to be a Trust-wide re-launch of the latest TPN blood form, which has been devised to ensure the occurrence of regular, documented biochemical monitoring to avoid metabolic complications. The Clinical Nurse Specialist in Nutrition is undertaking an ongoing audit of all patients receiving TPN, to assess the appropriateness of usage, and also to monitor that standards have been met whilst the patient is undergoing treatment. There are separate national recommendations for neonates. A review of the neonatal service showed appropriate guidelines and policies are in place and are implemented by the multidisciplinary team. A TPN audit is planned for 2011-12 by the Neonatal Audit Lead.

Notes
NCEPOD: National Confidential Enquiry into Patient Outcome and Death.
www.ncepod.org.uk

Potential Donor Audit (*NHS Blood & Transplant*)
Many valuable organs from deceased patients in this country are not made available for transplant due to a variety of reasons. Nationally, NHS Blood and Transplant (NHSBT) is coordinating a Potential Donor Audit to assess the number of missed organs and the reasons behind this. As this is too early to glean concrete information about the local position, as the numbers are too small, we have put in place interim measures to impact in a positive way and we analyse all potential donors on an individual basis. The Trust has appointed a Clinical Lead for Organ Donation and formed a Donation Committee to oversee the process. The Committee, through the Clinical Lead and Specialist Nurse, has produced a protocol, commenced a multidisciplinary trust-wide teaching programme and organised a study day and a Grand Round. We have also attempted to influence local opinion and knowledge by planting a commemorative tree, which was widely publicised. We plan to produce "Road Maps" for managing potential donors. We continue to audit prospectively.

The reports of 33 local clinical audits were reviewed by the Board of the Medway NHS Foundation Trust in 2010-11, and Medway NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Admission temperatures of babies born at less than 28 weeks gestation
This audit demonstrated improvements in all areas surrounding thermal care of newborn infants of less than 28 weeks gestation. Actions taken have been to ensure immediate recording of infants' temperature on admission to intensive care, and enhanced application of practices about the use of plastic bags and keeping body and head warm.

Antibiotic prophylaxis in surgery
The World Health Organisation (WHO) Surgical Safety Checklist was introduced in 2009 and has been praised and accepted nationally. One of the key components of the checklist is whether antibiotics are given before the commencement of surgery. Research has unequivocally shown that antibiotics given before the start of surgery reduce surgical site infection and hospital stay. A well-designed, blinded (un-biased) audit on a good-size sample across five surgical subspecialties, was conducted, and compliance with the policy was found in 96% of cases. As the national target is 100%, it is planned to promote adherence to best practice, monitor practice and re-audit in six months' time.

Antimicrobial prescribing – continuous audits
In 2003, the Chief Medical Officer's report *Winning Ways* set out a strategy for managing infectious diseases and controlling antimicrobial resistance. This strategy was made legal in the Health Act 2006 (updated Health and Social Care Act 2008), which required organisations to provide evidence of prudent antimicrobial prescribing, and an active stewardship programme. In 2007 a rolling work programme of compliance audits with *Surgical Prophylaxis and Prescribing Guidelines* in the 25 adult wards began. Surgical prophylaxis has shown a 65% improvement in adherence over the years. Improved compliance has also been demonstrated in the antibiotic guidelines year on year. Each year, these audits include new criteria to develop skills and ensure compliance. Improvements have been achieved through education of junior doctors, easy access to guidelines on the intranet and credit-sized prompt cards, dissemination of results through governance leads, education at audit meetings, consultant microbiologists and antibiotic pharmacists ward rounds, and holding clinical directors and clinical leads to account, by way of individual letters and open challenge at corporate Quality Committee and Clinical and Executive Group meetings. The combined efforts of the Antibiotic and Infection Prevention and Control work programmes have led to a significant reduction in infection rates, namely zero MRSA bacteraemia in 2010-2011 and an approximate 80% drop in *Clostridium difficile* infection since 2007.

Availability of patient medical records in Orthopaedic outpatient clinics
To ensure continuity of care and reduce risk to patients, availability of patient medical notes in Orthopaedic clinics is paramount. Following an initial audit, which highlighted issues with the current system, a robust process has been introduced to maintain workflow, whilst backlog of clinic letters is being cleared. Part of the workload is outsourced to ensure letters are available in a timely manner. A specific person has been seconded and made responsible to oversee this process. Process mapping with service development and changes within the support and pathway secretaries are being developed to promote excellence in care for patients.

Babies born to HIV-positive mothers
The audit demonstrated generally good compliance with Trust protocol, however, there is a need to ensure that PEP (post-exposure prophylaxis) is given promptly and paired maternal blood samples are sent in all cases. Actions have been taken to ensure collaboration between neonatal and maternity teams to administer PEP to infants within a window of four hours, and to raise maternity department awareness of the need to send maternal samples early.

Care of the newborn with suspected sepsis
The audit showed that three-quarters of infants received intravenous antibiotics within two hours of the decision being made to treat them, however, the final outcome in those for whom antibiotics were delayed was similar - all did well. Actions taken as a result of the audit have been to raise awareness of junior doctors at induction and address staffing issues at governance meetings. It is planned to ensure adherence to the two hours timeframe for antibiotic administration, and highlight this in the protocol book.

Central line insertion practice
Critically ill patients may require a central venous catheter (CVC) to allow fluids, drugs and/or nutrition to be given, however, this makes them vulnerable to infection. Steps have been put in place to minimise the chance of this occurring, with adoption of the *Saving Lives* guidelines for CVC insertion as Trust policy, and extensive staff training and education. A series of audits have taken place since 2007, looking at use of sterile procedures for insertion, post-insertion care and complication rates. The re-audit, presented in 2009, prompted further reinforcement of *Saving Lives* guidelines amongst ITU and anaesthetics staff. The 2010 re-audit demonstrated that this had resulted in increased use of full sterile technique and a significant reduction in infection rates. This re-audit also showed a substantial increase in use of ultrasound-guided placement, as recommended by NICE (Technological Appraisal 49: *Use of ultrasound locating devices for placing central venous catheters*). Actions arising from the 2010 re-audit include continued promotion of the guidelines via education and training; reviewing supply of sterile equipment to theatres and A&E; and future re-audit to confirm continued improvement.

Chest drains
A chest drain is a flexible tube inserted through the side of the chest into the pleural space to remove air, blood, fluid or pus. Insertion and management of chest drains has been audited locally for some years and, in 2008, audit was made a national requirement by the National Patient Safety Agency. The 2010 re-audit showed considerable improvements in current practice compared with that in 2008-09, with consultants carrying out a larger proportion of drain insertions, and senior supervision of all procedures performed by junior doctors. All insertions were carried out under ultrasound guidance compared with a quarter in the first round of the audit. Documentation has also improved. Actions arising are to provide education of all junior doctors at induction on the need for formal written consent, and to consider ultrasound guidance for pleural aspiration procedures.

Chronic kidney disease management
A baseline audit on management of chronic kidney disease (CKD) according to NICE guidelines (NICE Clinical Guideline 73: *Early identification and management of chronic kidney disease in adults in primary and secondary care*) was carried out and presented to the Department of Medicine with the purpose of raising awareness. The key messages from the audit were early recognition of CKD and use of urine protein:creatinine ratio in diagnosis. Communicating the diagnosis of CKD to primary care colleagues was emphasised and this is being facilitated by the introduction of an electronic discharge notification system.

Consent for surgical procedures
The Trust undertakes an annual audit of compliance with its consent policy to ensure that best practice is followed. This year's consent audit implemented actions agreed from the 2009-10 audit and demonstrated further improvements with regard to documentation of discussions regarding consent, and also showed that more senior staff are involved. Consent training is now mandatory across the Trust for clinicians using a bespoke consent e-learning package, designed by staff at Medway. This will further improve the quality of consent discussions with patients.

Delayed discharge from the Recovery Ward
The findings of the audit were used to improve awareness among anaesthetists about anaesthetic causes of delayed discharge, such as postoperative nausea & vomiting, pain and hypothermia, and to encourage better management of postoperative care. The results were also communicated to health professionals of other disciplines including recovery staff, surgeons, other nursing staff and managers involved in patient care, to allow better planning of patient discharge. The clinical nurse lead for discharge management is helping to improve efficiency of surgical discharge. To facilitate this, there are plans to improve the current discharge lounge to free up surgical beds for patients in recovery. We intend to carry out a larger audit in the coming year.

Drug chart documentation in Orthopaedics audits: (1) Documentation of allergy status and weight in drug charts on Orthopaedic wards; (2) Documentation of drug chart prescription in adult Orthopaedic wards
The junior doctors are being constantly made aware, through regular audit meetings, of the pitfalls in prescribing medicines. We are in the process of including the topic of documentation in drug charts and notes in induction sessions.

Effectiveness of handover in the surgical setting
Given the new shift-type pattern of working for doctors, transferring information between doctors, and other healthcare professionals, at the change of each shift has become of utmost importance to ensure quality and continuity of patient care. This audit highlighted areas in which improvements are required. It will, therefore, be presented at the surgical directorate teaching meeting to increase awareness of importance of handover and information required. This will also allow agreement to be reached on the appropriate time and place for handover, and the required personnel can be made aware. Tools have been prepared to implement more effective handover, which include new documentation for admissions and a reminder tool, for personal use, and to be displayed on the surgical wards.

Inadvertent perioperative hypothermia during day surgery
Surgical patients are at risk of developing hypothermia at any stage of the perioperative pathway. This audit looked at body temperatures before, during and after day surgery, and found that some patients had low body temperatures on arrival at theatre, and some lost more than 1°C during the operation. Hypothermic patients then required re-warming in recovery for an extended period to prevent further loss of body heat, however, no hypothermia-related adverse outcomes were found. The results of the audit have been used to promote greater awareness of the risk of perioperative hypothermia and its prevention (which has a cost implication), and to educate staff on the proper use of tympanic temperature measurement. The Clinical Lead for Day Surgery is investigating different temperature measurement devices with a view to improving accuracy of monitoring.

Investigation of suspected pulmonary embolus
Pulmonary embolism (PE) is a blockage of one of the blood vessels in the lungs. It can be life-threatening if the obstruction is very large and blocks the main blood supply to the lungs. PE is a difficult diagnosis to make, because symptoms may be non-specific, however, early diagnosis is essential. This audit looked at current decision-making in the diagnosis of PE at Medway NHS Foundation Trust, based on consideration of risk factors and the use of diagnostic tests and investigations. The focus was on the use of chest x-rays, testing for D-dimer (a breakdown product of the protein fibrin, which is involved in blood clotting) and the specialised radiographic techniques, CT pulmonary angiography (CTPA) and ventilation/perfusion (V/Q) scanning. As a result of the audit, the Trust pathway for investigation of suspected PE has been revised by putting in place a 3-step protocol: (1) Clinical decision using a risk stratification rule; (2) application of D-dimer test; (3) use of CTPA or V/Q scan. The issues raised were highlighted to a multidisciplinary audience by presentation of the audit at the Grand Round. When use of the new protocol is embedded in everyday practice, the process will be re-audited.

Laparoscopic hysterectomy
Hysterectomy is a very common gynaecological procedure, which can be done in different ways. Vaginal hysterectomy is considered to be the route of choice, however, it is not always possible. In addition, removing the ovaries during vaginal hysterectomy can be challenging. The main benefit of laparoscopic hysterectomy is to avoid the abdominal incision (abdominal hysterectomy), with less postoperative pain, shorter hospital stay and quicker return to normal activities. The team at Medway Maritime Hospital started performing this kind of advanced surgery a few years ago, however, there was no data supporting the method. This audit is the baseline data collection (retrospective) for the laparoscopic hysterectomies. The period 2008-2010 was audited, looking at the safety of the procedure, and concluded that it is as safe as abdominal and vaginal hysterectomy, with advantages and benefits for patients (less pain, shorter hospital stay, quicker return to normal activities) and also for the hospital, reducing bed occupancy and hence increasing capacity. The recommendation is to replace the abdominal approach with the laparoscopic one whenever possible. As a result of this audit, a special proforma is being designed to help in prospective collection of data.

Management of brain tumours
A neuro-oncology local implementation group has been formed. There is a well-established referral pathway to the multi-disciplinary neuro-oncology team at the regional neuroscience centre, King's College Hospital. Where possible, patients are admitted under the care of the stroke physicians, who access the pathway in a timely manner. Early referral to the neurology team is recommended for patients under the care of other general physicians. The aim is to include the brain tumour pathway in the junior doctors' clinical induction and make it available on the intranet.

Management of first trimester miscarriage at Medway Maritime Hospital
The terminology used in the early pregnancy scan reporting has been updated to include those terms recommended by the Royal College of Obstetricians & Gynaecologists. A new service was introduced offering women the option of having uterine evacuation under local anaesthetic. The medical management of first trimester miscarriage has become an outpatient treatment. Finally, a robust system of checking the Rhesus status for women diagnosed with first trimester miscarriage has been introduced, to avoid the delay in giving these women Anti-D ,which may have serious implications for future pregnancies.

Management of metastatic spinal cord compression
Work is currently ongoing at the cancer regional network to produce guidelines on the management of metastatic spinal cord compression (MSCC). The neuro-oncology local implementation group at Medway have produced an interim pathway based on NICE guidance (NICE Clinical Guideline 75: *Metastatic spinal cord compression*), to guide management of patients presenting with MSCC, and this has been submitted to the regional network. The pathway is available on the Medway intranet.

Non-invasive ventilation audit
Non-invasive ventilation (NIV) uses a machine that is designed to help patients breathe more easily. Not only does this machine help to push some air into the lungs, but it also helps to get more oxygen into the lungs by holding them open. The audit, which collected data over a whole year, demonstrated good use of controlled oxygen therapy and nebuliser management prior to starting NIV. There was a good response to therapy, even in patients with a poor starting pH, who had better outcomes than expected. Patients' respiratory acidosis (acidity caused by a build-up of carbon dioxide in the blood) was corrected within 12- 24 hours of commencing therapy. Oxygenation was maintained well throughout. The audit confirmed the effectiveness of NIV and, to enable more staff to be trained in its use, a competency-based training document is being prepared, with a planned completion date of June 2011. Monthly training dates have been booked until December 2011. This year, the respiratory nurses are taking part in the latest round of the British Thoracic Society NIV audit, to allow comparison to other trusts.

Trust-wide Observations audit

Early recognition and action on signs of deterioration in patient condition play a key role in reducing in-hospital cardiac arrests and mortality rates (Patient Safety First Campaign: www.patientsafetyfirst.nhs.uk). Physiological observations (of temperature, blood pressure, pulse rate, respiratory rate, etc.) should be carried out on all inpatients on a regular basis, to enable staff to identify if a patient is deteriorating, and results giving rise to concern must be communicated to relevant colleagues and prompt action taken. Every month, at Medway NHS Foundation Trust, the Critical Care Outreach Team assesses the observation charts on every ward with adult inpatients and reports on the outcomes to all clinical areas and key healthcare professionals. A huge amount of work has been carried out by the team, promoting understanding of physiological observations amongst nursing staff, the importance of timely completion of observation charts, and prompt and appropriate response. The success of the team's efforts is reflected in the steady improvements demonstrated by the audit. In August 2010, the Acute SBAR Communication Tool (*see below*) was introduced, designed to help staff communicate essential information about a deteriorating patient quickly and effectively. The Outreach Team is monitoring the use of the tool and working hard to implement a graded response strategy throughout the Trust.

Notes:

Institute for Innovation and Improvement. *Safer care: leading improvement in patient safety.* Acute SBAR (Situation/Background/Assessment/Recommendation) communication tool. www.institute.nhs.uk/safercare

Obstetric anaesthesia: spinal & epidural outcomes

The Royal College of Anaesthetists has published national standards for best practice in obstetric anaesthesia (*see* www.rcoa.ac.uk).There is unequivocal evidence that regional anaesthesia (RA) is safer than general anaesthesia (GA) for caesarean section (CS), and the proposed standards aim for (i) > 95% RA for elective CS; (ii) < 1% conversion of RA to GA for CS; (iii) < 1% dural puncture during epidural. The team retrospectively reviewed practice over 12 consecutive months in 2009-10. The results indicated that the Trust compares fairly favourably with the set standards, achieving (i) 99.3% RA for CS (putting performance in the top 10% nationally); (ii) 1.45% conversion of combined RA (epidural + spinal) to GA (slightly under the standard); (iii) 1.16% dural puncture (slightly under the standard). The intention is to monitor our practice on a yearly basis, aiming to maintain good practice and improve in under-performing areas.

Pain Management Programme (PMP): Initial PMP assessment outcomes and appropriateness of referrals

As the Pain Management Programme is currently under review, intended actions after reinstatement of the programme are to establish a web page, with clear information for referring practitioners, and a pain education day for patients. This will help to ensure that the most appropriate patients are being considered for Pain Management Programmes.

Pain relief after total knee arthroplasty
100 patients were audited after total knee arthroplasty over 5 days and most patients stated that they were satisfied with pain relief, however, we found that during the first 24 to 48 hours, up to a third of patients experienced moderate to severe pain and that oral analgesics are not effective enough to control postoperative pain. Alternative methods of pain relief, such as continuous wound infiltration with local anaesthetics, in addition to oral analgesic, targeting pain in the immediate postoperative period, is being investigated.

Procalcitonin in Critical Care
Procalcitonin (PCT) is a new biomarker used at Medway Maritime Hospital to help diagnose sepsis in critically ill patients and optimise antibiotic use, thereby reducing unnecessary antibiotic administration and minimising the development of antibiotic associated diarrhoea and multi-drug resistant organisms such as MRSA. This audit demonstrated that the Trust is over 90% compliant with the protocol, during the audit period, which led to a net saving of approximately £2000 for the 65 patients included in the audit. The actions following the audit were to ensure continuous, round-the-clock availability of the test, and optimise compliance with the protocol.

Quality of physiotherapy clinical records
The glossary of approved abbreviations for use by physiotherapists in patient records has been updated and re-launched to promote safer, inter-professional communication about patient care and progress.

Rituximab in patients with rheumatoid arthritis
The audit demonstrated that Trust prescribing practice closely adheres to NICE Technological Appraisal 126: *Rituximab for the treatment of rheumatoid arthritis* in patient selection, treatment initiation and specialist supervision. The audit outcome was, therefore, to confirm that services should be maintained at current levels, no other action being necessary.

Surfactant use on the Oliver Fisher Neonatal Unit
The presence of surfactant in the airways helps the lungs to inflate; it may be insufficient in premature infants, contributing to respiratory distress syndrome (RDS). Two surfactants are recommended by local guidelines in the treatment of RDS: Curosurf and Survata. The audit demonstrated more use of Curosurf than of Survata, consistent with the guidelines, despite dosing variability in heavier babies. It is planned to review the guidelines and use single agent surfactant, combined with fraction of inspired oxygen, as an indication for administration rather than oxygenation index.

Use of blood and blood products in the Neonatal Unit
The audit showed that indications and efficacy of blood transfusion in the neonate were not documented clearly in the notes. As a result, a new blood transfusion record for infants was designed, which should be used on all requiring a blood product. New doctors are informed of this at induction.

Use of pasteurised expressed breast milk (PEBM) on the Oliver Fisher Neonatal Unit

The audit demonstrated good adherence to guidelines for the choice of first feed, but improvement was needed in documentation of consent. As a result of the audit, the PEBM guidelines are to be included in the feeding protocol. Education of nursing staff has taken place to ensure consistent documentation of consent in the baby's bedside folder.

Utilisation of neonatal resuscitation forms

A form should be completed whenever neonatal resuscitation takes place. The audit demonstrated that improvements are required in use of the form and completion of essential details. Actions being taken to rectify this are to educate and train staff at induction and simulation. It is planned to modify the current form to highlight the need for documentation of insertion of a nasogastric tube and/or umbilical venous catheter.

Vaginal birth after caesarean section (VBAC)

This audit looked at compliance with the Royal College of Obstetricians & Gynaecologists (RCOG) guideline *Birth after previous caesarean birth,* which sets out how obstetricians and midwives should guide women in the planning of their next delivery following one or more caesarean sections. The chances of a successful vaginal delivery, the woman's personal wishes and future fertility plans, are all to be considered when making the decision about vaginal birth or caesarean delivery. Following the audit, new pathways for care have been put in place. (1) All women having their first caesarean delivery receive a letter giving the reason for the caesarean birth, and informing them how to access a birth debrief. (2) Women booking in pregnancy who have had one previous caesarean are offered an opportunity to attend a VBAC workshop. (3) Women who have had a caesarean for a non-recurrent reason are given an appointment with the consultant midwife, where the previous pregnancy is reviewed and risks and benefits of VBAC versus repeat caesarean are discussed. A second appointment is offered later in the pregnancy for women who remain unsure of their choice for mode of delivery, and further counselling is given to support their decision. (4) Women for whom there are any clinical concerns arising from previous deliveries are reviewed by the consultant obstetrician. Those who are considered suitable for vaginal delivery then go on to VBAC counselling, so that they can decide which mode they prefer. These actions were implemented in February 2011; to date, 71% of women have chosen VBAC.

Waiting times for X-Rays in Orthopaedic outpatient clinics

In order to improve patient experience and reduce waiting times for patients requiring X-Rays in Orthopaedic outpatient clinics, a new pathway is being developed. The fracture clinic proforma has been modified to highlight patients who will need X-Rays during their next clinic visit. This information will allow administrators to give more patients earlier clinic slots. Where possible, patients living near peripheral hospitals (Sittingbourne Memorial Hospital and Sheppey Community Hospital) are encouraged to have X-Rays there, to reduce waiting times in the main hospital. Regular staffing of a dedicated X-Ray unit in the Orthopaedic clinic will also help achieve our reduced waiting times target.

Commitment to research as a driver for improving the quality of care and patient experience

The number of patients receiving NHS services, provided or sub-contracted by Medway NHS Foundation Trust, between the period 1st April 2010 and 31st March 2011, that were recruited during that period to participate in research approved by a research ethics committee was 1684.

Participation in clinical research demonstrates Medway NHS Foundation Trust's commitment to improving the quality of care we offer, and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities, and active participation in research leads to successful patient outcomes.

Figure 2 represents Medway NHS Foundation Trust's involvement in conducting 186 clinical research studies in specific medical specialties during the period 1st April 2010 and 31st March 2011. Over the same period, the number of trials that the Investigators stated that they definitely contributed to the reduction in overall mortality is 5. The outcome of one such study indicated that '…Yearly mammography in women with a medium familial risk of breast cancer is likely to be effective in prevention of deaths from breast cancer.' (Mammographic surveillance in women younger than 50 years who have a family history of breast cancer, tumour characteristics and projected effect on mortality in the prospective, single-arm FH01 study. The Lancet Oncology, Volume 11, Issue 12, pages 1127-1134, December 2010).

The improvement in patient health outcomes in Medway NHS Foundation Trust demonstrates that a commitment to clinical research leads to better treatments for patients.

There were 148 clinical staff participating in research approved by a research ethics committee at Medway NHS Foundation Trust during the period between 1st April 2010 and 31st March 2011. These staff participated in research covering 41 of medical specialties.

In the period between 1st April 2010 and 31st March 2011 there were 23 publications declared by the Investigators.

The Medway NHS Foundation Trust is actively involved in National Institute of Health Research (NIHR) supported research. Figure 1 represents the number of participants recruited into NIHR supported projects since 1st April 2007. The increased research activity indicates the Trust's commitment to transparency and desire to improve patient outcomes and experience across the NHS. One such example is ADDRESS study (After Diagnosis Diabetes Research Support System) which has been opened at Medway NHS Foundation Trust to establish a fast, reliable and accurate support system to facilitate future research into type 1 diabetes mellitus (T1DM). This is mainly to be achieved through the set-up of a confidential database system which will record individuals recently diagnosed with T1DM, who have given consent for their details to be entered onto a national database, and to be informed of any future research studies.

The engagement with clinical research also demonstrates Medway NHS Foundation Trust's commitment to testing and offering the latest medical treatments and techniques.

Figure 1. Represents the number of participants in NIHR supported projects (within Medway NHS Foundation Trust) in the years 2007 – 2011.

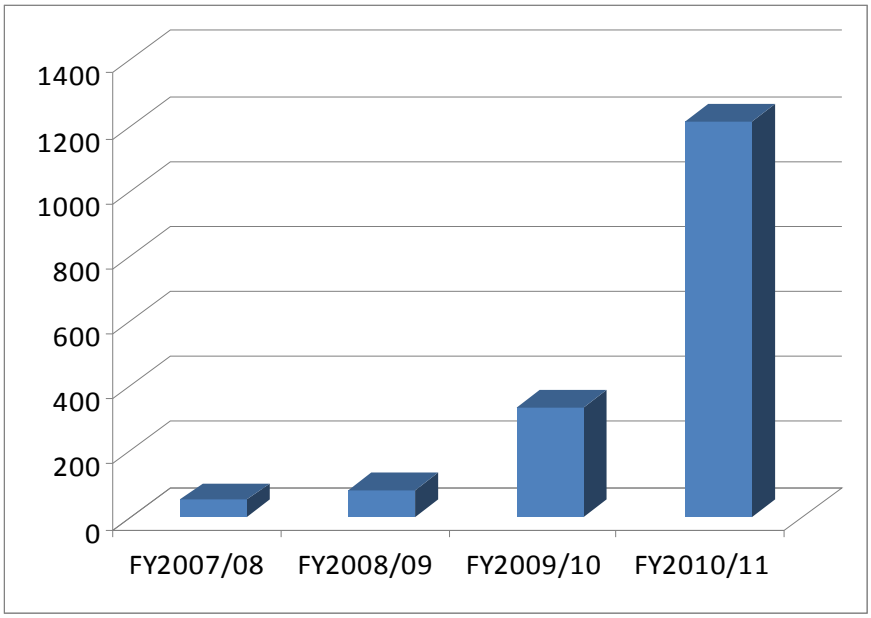
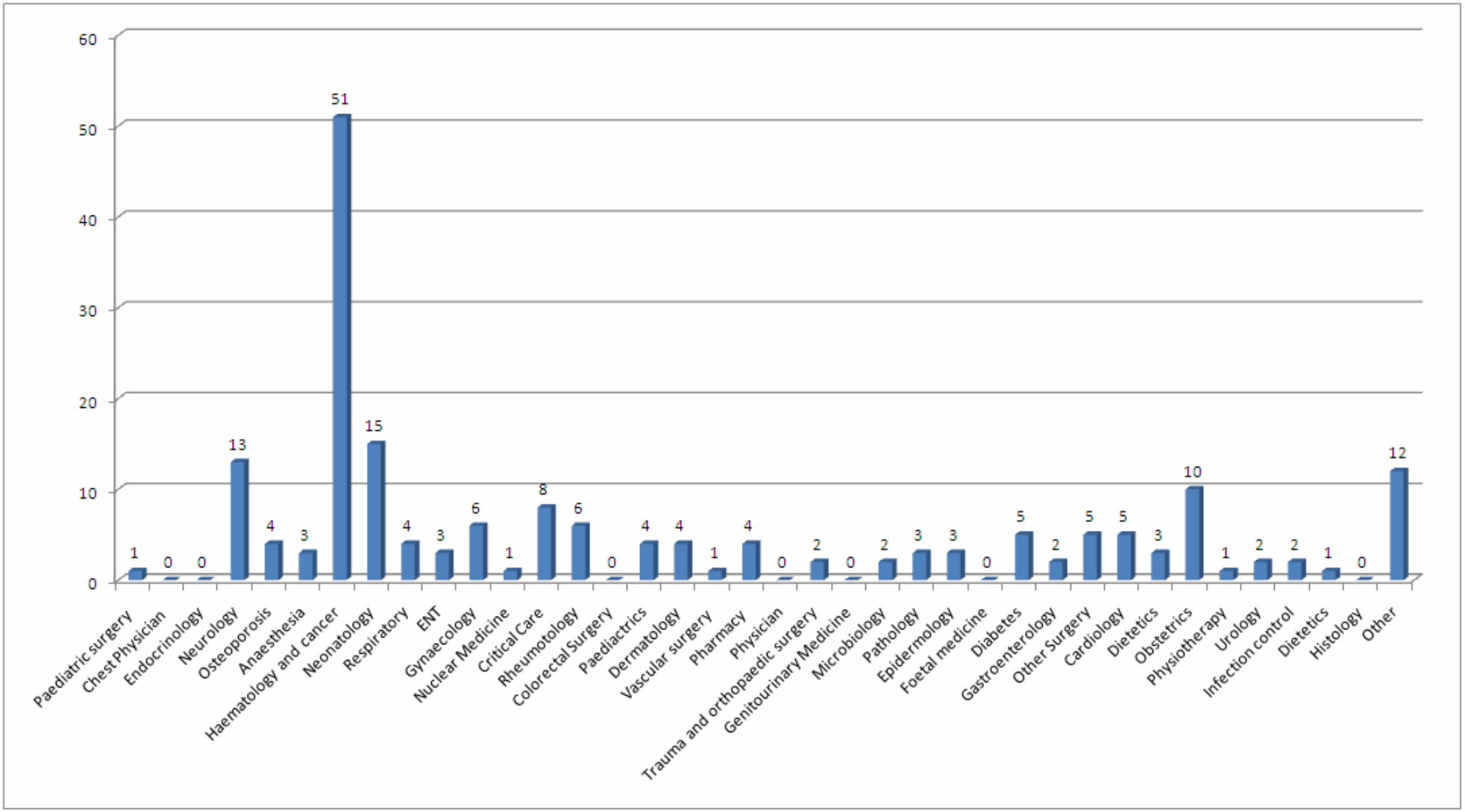


Figure 2. The number of research projects taking at Medway NHS Foundation Trust in specific medical specialities (between 1st April 2010 and 31st March 2011). 'Other' means studies outside of clinical speciality, relating to for example education or overall patient experience



CQUINs

A proportion of Medway NHS Foundation Trust's income in 2010-11 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2010-11, and for the following 12 month period, are available electronically at www.medway.nhs.uk.

The Commissioning for Quality and Innovation (CQUIN) framework has been the foundation of discussions about quality of service between the Trust and the two main commissioners. The framework has enabled a dialogue to develop between the organisations about what is important to the local population. 1.5% (£1,831,155) of the Trust's projected income is dependent on the Trust achieving the CQUIN targets, which are composed of national, regional and local targets. Performance against the CQUINs is in Table 5.

Table 5 – 2010-11 CQUIN Performance

Description	Achievement
% of all adult inpatients who have had a VTE risk assessment on admission to hospital	Not Achieved
Patient Survey results relating to "responsiveness to personal needs"	Not Achieved
Undertake an agreed number of patient surveys to include, as a minimum, certain questions	Achieved
Over-arching Trust action plan to be developed as a consequence of patient surveys	Achieved
% of mothers' breastfeeding at time of discharge from midwife	Partially Achieved
Breastfeeding status recorded on discharge from midwife	Achieved
Delayed transfers of care due solely to Medway NHS Foundation Trust	Partially Achieved
% of outpatient appointments that are cancelled by provider	Partially Achieved
% of eligible staff trained in Mental Capacity Act	Partially Achieved
Number of patients referred to the Stop Smoking Services (Medway, ECK and West Kent providers) during an admission episode	Achieved
Proportion of patients with higher risk of threatened stroke who are scanned by carotid doppler and provided blood test results to facilitate a treatment plan within 24 hours	Not Achieved
Number of patients admitted as an emergency via A&E who are referred to the alcohol service	Partially Achieved
% of observations carried out to include MUSTT assessment (nutritional assessment), waterlow (skin assessment) and fluid balance completed. Quarterly audits to be undertaken.	Achieved
Grade 2 and above pressure damage (newly acquired)	Partially Achieved
Improve the quality of patient care by improving care for the five patient specific pathways as part of the Enhancing Quality Programme (EQ)	Achieved
Improve performance against established baseline of the four Acute patient specific pathways as part of the Enhancing Quality Programme	Achieved

The two national targets, venous thrombo-embolism (VTE) assessment and patient satisfaction, reflect the national priority of improving patient safety via a risk assessment, to ensure the correct VTE prophylaxis is prescribed and the need to improve patient satisfaction in relation to:

- being involved in decisions about care and treatment;
- finding someone to talk to about worries;
- being given enough privacy when discussing their condition and being examined;
- being told about medication side effects when going home ;
- being informed who to contact if worried about condition after leaving hospital;

The regional target was associated with implementing the Enhancing Quality (EQ) programme and then improving practice. The EQ programme is being led by NHS South East Coast, with every NHS Trust involved.

There are five clinical pathways:

- Knee replacement.
- Hip replacement.
- Community acquired pneumonia.
- Heart attack.
- Heart failure.

Each of these pathways has best practice guidelines, which, if followed, should result in the patient having fewer complications, a shorter length of stay, and a better quality experience. To achieve the CQUIN, the Trust had to demonstrate that it had implemented the programme and that it has improved compliance with the guidelines.

The local CQUIN targets either reflect priorities for public health in the area or priorities for improvement within the Trust.

The local CQUINs were:

- improving in-patient satisfaction survey scores;
- improving breast feeding rates and data collection;
- reducing delayed discharges;
- reducing cancelled outpatient appointments;
- improving Mental Capacity Act training;
- increasing the number of patients referred to the smoking cessation service;
- increasing the number of patients at risk of Transient Ischaemic Attack (TIA) (mini stroke) who are scanned within 24 hours;
- increasing the number of patients referred to the alcohol service;
- increasing the number of patients who have skin and nutrition assessments and their observations performed consistently;
- reducing the number of patients who develop pressure ulcers as inpatients;

All of the CQUINs in 2010-11 are very important quality indicators, indeed a number of them will continue to be CQUINs in 2011-12, however, those that are not will continue to be monitored by other committees, for example the outpatient appointment is a priority of the Patient Experience Committee.

The CQUIN targets for 2011-12 are below:-

- VTE assessment.
- Improve National Patient Survey scores.
- Implement a local patient satisfaction survey.
- Improve local patient survey scores.

- Increase number of women who breast feed.
- Implement UNICEF baby friendly environment.
- Full participation in safety express (monthly audit of all patients at a point in time to count how many patients had acquired harm, in that they had acquired a pressure sore, a fall or a urinary tract infection) and, therefore, decrease patient "harm" rate.
- Increase number of patients from Emergency Department who are assessed for falls risk.
- Improve system for managing patient's medication when transferring and being discharged.
- Increase number of patients who have smoking cessation advice.
- Improve compliance with diabetic care guidance.
- All nurses to be trained in dementia in the elderly care wards, orthopaedic wards and Emergency Department.
- Further improvement in practice via the EQ programme.

Care Quality Commission (CQC)

The Medway NHS Foundation Trust is required to register with the Care Quality Commission, and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against the Medway NHS Foundation Trust during April 2010 – March 2011.

The Medway NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC had applied four conditions to the Trust's Registration status in April 2010. The Trust implemented all of the actions set out by the CQC within the timescales set, and these conditions were formally removed in December 2010. The Trust has robust governance arrangements in place which ensure that all of the essential standards are embedded and compliant at ward and departmental level, and that the Board, via the Executive team, regularly receive assurance that this is the case.

When the CQC removed the four conditions mentioned above, they identified four minor concerns and one moderate concern with regard to sustaining the new arrangements that had been put in place. A well developed action plan was put into place to ensure that these were fully implemented and met by 31st March 2011. This action plan was formally signed-off by the Board in March 2011.

In January 2011, the Trust submitted the required Provider Compliance Assessment to the CQC prior to the unannounced planned compliance review during the week of 22 February. The CQC carried out a planned compliance review of all four of the Trust's registered locations in February 2011. The CQC has reported that three of the Trust's locations are compliant with the CQC essential standards of quality and safety. In relation to the fourth location, a children's respite facility, the CQC had two moderate concerns that two standards were not fully compliant. These relate to Outcome 9 : Management of Medicines and Outcome 21 : Records. The CQC found that, in relation to outcome, nine labels on bottles or boxes of medication were not always consistent with the dosage to be given, there was lack of verification of consent from parents for staff to administer medication to children, and that the required hazard notice for stored oxygen was not found. The improvements that the Trust has agreed to implement include:

- ensuring that suitable systems for clear and up to date information to be available on the prescribed drugs and dosages to be given and that this has been communicated, in writing, to the nursing staff and that this is filed within each child's healthcare record. Actions to ensure compliance with this recommendation have been put in place;
- ensuring that suitable systems are in place for obtaining parents' consent for registered nurses to administer medicines. Actions to ensure compliance with this recommendation have been put in place;
- ensuring that an oxygen hazard warning is visible in the area where the oxygen cylinder is stored. This has now been completed.

The CQC found that, in relation to Outcome 21, most records were well maintained and kept up to date, however there was a lack of evidence to confirm that all personalised risk assessments were thoroughly re-evaluated each year and that there was no evidence of parental consent for giving of medication. The improvements that the Trust has agreed to implement include:

- ensuring that the personalised needs assessments for each child must be thoroughly completed at each review. Actions to ensure compliance with this recommendation have been put in place;
- ensuring that suitable systems are in place for obtaining parents' consent for registered nurses to administer medicines. Actions to ensure compliance with this recommendation have been put in place.

Plans are in place to ensure that all of the actions are completed in the shortest possible timeframe and progress against these actions will be reported back to the CQC.

Data Quality

The Medway NHS Foundation Trust will be taking the following actions to improve data quality.

The Trust has a well established Information Governance Steering Group which is chaired by the executive director of Governance & Risk. Secondary Uses Service (SUS) data quality is discussed at these meetings where a SUS data quality dashboard has been developed to indicate any areas of concern.

During 2010-11, the Trust developed a Data Quality Policy which formally set responsibilities for data quality throughout the Trust. The Executive Director responsible for ensuring that the policy is adhered to is the Deputy Chief Executive/Director of Operations.

The Trust also established a Data Quality Group which meets bi-monthly and has an agreed work plan including:-

- **Clinical Coding**

  Comprehensive audits are carried out at bi-monthly intervals. Audits are undertaken using the latest audit methodology as recommended by Connecting for Health (CfH). All internal audits are carried out by the Clinical Coding Service Manager who is an Accredited Clinical Coder, CfH Registered Clinical Coding Auditor and Experienced Clinical Coding Trainer.

Table 6 – Clinical Coding audits

Month	Specialty
May 2010	Trauma and Orthopaedics
July 2010	Ear Nose and Throat
September 2010	Vascular Surgery
November 2010	Gynaecology
January 2011	General Surgery
March 2011	Cardiology

NB: An internal review of General Medicine was carried out as a pilot in March 2010.

In addition to the above audits, the Trust is required to carry out a coding audit to satisfy the Information Governance Toolkit requirements (IG505). This Audit was carried out in June 2010 and concentrated on the quality of coding for deceased patients. The results of the Audit were presented to the Patient Safety Committee in October 2010.

During 2011-12 the Trust will continue to build on the work of the recently established Data Quality Group, particularly with regard to clinical coding audit, training and review. It is planned to recruit a Deputy Coding Manager in the spring of 2011 who will take an active role in training coders in preparation for the ACC qualification, and for checking their work on a regular basis.

The system of 'Peer Review' of data will be reviewed in the Spring to ascertain the value of continuing the process beyond 2010-11.

The Data Quality Group will be responsible for ensuring that the recommendations of the External Audit Report on 2009-10 Quality Accounts are implemented as appropriate. Work has already commenced on establishing a Data Quality Risk Register and this will be updated throughout the year and reported to the Information Governance Committee at regular intervals.

Other areas to be reviewed will be internal communications concerning the importance of data quality and ensuring that data quality becomes an integral part of staff appraisal and training needs assessment.

- **Data Checks**

  Coding Reviews & Peer Reviews
  Internal Audit (IA) undertakes a series of reviews to assure the Trust that the system of data collection and methodologies used for calculating performance is robust, however, the amount of time and resource that they offer is limited by other priorities in the Annual Audit Plan. Therefore, alongside the more formal reviews carried out by IA, a process of 'Peer Review' has been introduced to provide assurance that data is robust. The work of IA and the Peer Reviews will be complimentary as IA will carry out a full audit of the data, whilst the Peer Review process will be a "lighter touch" and will include spot checks of data. If any problems are found as a result of the review, these will then be escalated via a process of 'data alerts' to the Deputy Chief Executive/Director of Operations.

  Areas reviewed in 2010-11 are:

  - MRSA screening.
  - 4 hour target in the Emergency Department.

- Pressure sores.
- Discharge letters.

The Peer Review process involves an audit of the data included in the Trust Performance Scorecard and the definition and methodology for constructing the target. The reviewer will work back (reverse engineer) from the published score to the raw data. If necessary, spot checks are undertaken at patient level.
Peer Reviews are carried out by selected Trust staff who have a background in data accreditation, information governance or information management. A work plan for the reviewers has been drawn up which prioritises key targets or those which will attract a financial penalty if not achieved during the year. The plan has been shared with Internal Audit.

Areas to be reviewed include:

- Emergency Department Quality Indicators.
- Healthcare Acquired Infections (C. Difficile & MRSA).
- Tissue viability.
- Discharge letters- Quality and timeliness.
- Cardiac access.
- 18 week admitted.
- 18 week non-admitted.
- Breast Cancer.
- Dermatology Cancer.
- Stroke.

Reports on the findings of the all reviews are made to the Data Quality Group and to the Integrated Audit Committee. Where appropriate, reports are also to be made to the Patient Safety Committee.

As this process is new it will be developed over the coming months in the light of experience, and a formal evaluation carried out in April 2011.

- **Other Data Quality Checks**

Hospital Standardised Mortality Rate (HSMR) - The Trust reviews a monthly HSMR report. This includes an analysis of areas of potential clinical concern and a full coding review of patient case notes where appropriate. The review is undertaken by the Mortality Group, chaired by the Chief Executive and the results are reported regularly to the Trust Board. The variations in the HSMR do not represent underlying changes in the quality of care the patients receive. The crude, unadjusted mortality rate has been stable or even fallen slightly over a long period of time. Regular inspection of case notes selected by Dr Foster for review has not shown any shortcomings in care but has demonstrated issues with coding. There has been a Grand Round, to explain to the medical staff the importance of clear and full medical records, to facilitate accurate coding both in terms of the Trust's HSMR and remuneration. Coders have now been allocated to specific clinical teams with regular meetings to discuss any coding issues.

The Trust is following national guidance on the palliative care codes (Z51.5 and Z51.8), this initially led to a significant rise in the HSMR. Each month, there is a reconciliation between the coding department and the Hospital Palliative Care Team (HPCT), to make sure that all patients who die under the care of the HPCT

are appropriately given a Z51.5 code and are, therefore, excluded from the Trust's HSMR.

Among the patients dying in the Trust were a significant number of patients whose "end of life" care could more appropriately have been delivered outside hospital. The Trust is working with partner organisations to review "end of life" care pathways. In addition, the Trust has recently appointed an End of Life Care Matron.

The HSMR has been within "normal" parameters during the last six months of the year and it is intended that, in future, the Mortality Review Group will report to the Trust Board via the Patient Safety Committee and the Quality Committee, rather than reporting directly to the Board as at present.

In December 2010, the Care Quality Commission (CQC) received two mortality alerts relating to the Medway NHS Foundation Trust. These alerts raise the possibility that more patients than expected have died with a particular illness or following a particular operation or treatment and, therefore, require investigation to be sure that there are no deficiencies in care or treatment.

The first alert suggested excessive deaths in patients admitted to the Trust as an emergency with pneumonia from April 2009 onwards, and CQC requested that the Trust review the treatment of a sample of 30 patients. The Trust reviewed a total of 38 patients, having previously reviewed the deaths of 8 patients on its own initiative. The principle findings were:

1. Many of the patients were elderly and had other illnesses including Chronic Obstructive Pulmonary Disease (COPD) which greatly increased the chance of dying from the pneumonia for which they were being treated.
2. A third of the patients had cancer and were in the late stage of their illness when they became ill with pneumonia.
3. Younger and previously fit, patients die of pneumonia even with the best treatment.
4. All the patients received appropriate medical treatment which, in some cases included treatment with artificial ventilation in the Intensive Therapy Unit

A detailed report was sent to the CQC and in Feb 2011 the CQC closed the alert without any further action, as it was satisfied that there were no deficiencies in the care received by the patients.

The second alert concerned patients who died with “complications of device, implant or graft”. This would include patients who had, for instance, a urinary catheter, a replacement joint or a pacemaker. CQC then analysed the information further and found that the 8 patients in this group had a variety of devices, implants or grafts with a wide range of complications, were elderly, and six of eight had at least one serious illness. Under these circumstances, CQC withdrew the alert and informed the Trust that no further action was needed.

GP Codes- Reports on the accuracy of GP codes are produced monthly and circulated to Clinical Directorates. The Report shows performance in aggregate and also by ward so that areas of non-compliance can be investigated.

Ethnic Reports- Reports on the ethnicity of admitted patients are produced monthly and circulated to all Clinical Directorates for checking, prior to being included on the main Trust performance scorecard, which is discussed at the Performance & Investment Committee.

'Un-cashed Outpatient Clinics'- Each month a report is sent to Clinical Directorates and the Outpatients Team to indicate the number of outpatient clinics where the outcome of patients who attended remains unrecorded. This helps the Trust to maximise income and also to ensure that each patient's treatment details are properly recorded on the Patient Administration System (PAS).

Inpatients Data- Reports on 18 week Referral to Treatment targets are sent to Clinical Directorates monthly for validation to ensure that access targets are met, and that no patients are unrecorded on Patient Administration System (PAS) thereby delaying their admission.

CHKS Data Quality Dashboard - The Trust accesses a monthly Data Quality Dashboard from its CHKS benchmarking system to share with commissioners. This compares the Trust performance with a wide peer group. The latest results show that the Trust is performing to a higher level than our peers.

Table 7: CHKS benchmarking data

	April to December 2010		
DATA QUALITY INDICATOR	**TRUST VOLUME**	**TRUST RATE**	**PEER RATE**
Data Quality Index	59,784	93.3	90.7
Data Quality Index (HRG v4 based)	59,784	93.3	90.5
Blank primary diagnosis	337	0.56%	2.02%
Unacceptable primary diagnosis	222	0.37%	0.13%
Diagnosis conflicts with age or sex	52	0.09%	0.16%
Diagnosis non-specific	9,179	15.44%	14.47%
Procedure non-specific	1,309	2.20%	2.36%
Sign and symptom as a primary diagnosis	6,701	11.27%	13.67%
Admitting diagnosis emergency for elective admission	344	1.82%	1.21%
Volume of coded FCEs with Palliative care code	439	0.74%	0.57%
Volume of deaths with Palliative care	198	19.94%	15.28%

code			
Date conflicts	4	0.01%	0.14%
HRG U Groups	27	0.05%	0.04%
HRG U Groups (HRG v4)	36	0.06%	0.33%
Average diagnosis per coded episode		3.9	3.7

Source- CHKS

NHS Number and General Medical Practice Code Validity

- **NHS Number**

  The Medway NHS Foundation Trust submitted records during April- November 2010 to the Secondary Users Service (SUS) 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:-

  - 98.8% for admitted patient care;
  - 99.3% for outpatient care; and
  - 95.6% for accident and emergency care.

- **General Medical Practice Code Validation**

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

  - 99.9% for admitted patient care;
  - 100% for outpatient care; and
  - 99.8% for accident and emergency care.

Information Governance Toolkit (IGT)

The Medway NHS Foundation Trust's Information Governance Assessment Report overall score for April 2010-March 2011 was 69% and was graded red.

The score and progress towards completion of the IG Toolkit is monitored at each meeting of the Information Governance Committee, which reports in to the Clinical and Executive Group.

The score of 69% compares fairly favourably with other Trusts in the SHA, coming in at 8thout of the 26 Trusts which also submitted a Toolkit declaration. The Trust declared a score of level 2 or above in all bar one of the standards, meaning that it falls into the category of "unsatisfactory" performance (satisfactory performance is represented by a score of 2 or above in all standards). Only five of the Trusts across the SHA achieved a satisfactory rating. Two other Trusts missed the "satisfactory" rating by one standard, and others had as many as 17 scores of less than two.

The one standard against which the Trust scored only level 1 concerned data quality, and is a quantitative score assessed by the audit commission annually. There is a comprehensive programme in place to improve data quality across the trust, which will be monitored principally by the Data Quality Group, with regular reports to the IG Committee, so that progress against the action plan can be monitored and assessed.

Coding Error

The Medway NHS Foundation 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 (clinical coding) were:-

- Primary Diagnoses Incorrect – 8.7%
- Secondary Diagnoses Incorrect – 15.9%
- Primary Procedures Incorrect – 20.9%
- Secondary Procedures Incorrect – 27.6%

The Services reviewed within the sample included:-

- Paediatrics.
- Clinical Haematology.
- Female Reproductive System Procedures.
- Kidney or Urinary Tract Infections without Complications.

Part 3 - Other information

Priorities for improvement 2010-11

The priorities for improvement in quality during April 2010-March 2011 are shown in table 8.

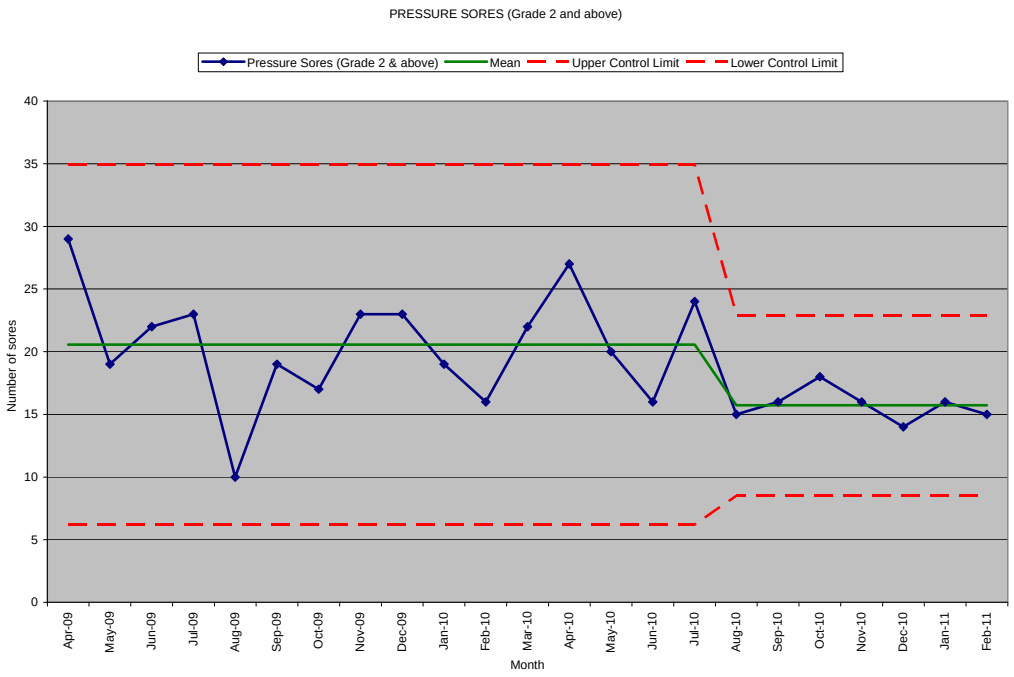
Table 8: Priorities for improvement 2010-11

Patient Safety	Reduce the number of hospital acquired pressure ulcers Reducing the rate of avoidable harm Reducing the rate of avoidable deaths
Patient Experience	Involving patients in their care Providing same sex accommodation Treating patients with dignity and respect
Clinical Effectiveness	To improve the uptake of breastfeeding after discharge Implement Enhanced Recovery pathway Implement Enhancing Quality Programme

Patient Safety

- **Reduce the number of hospital-acquired pressure ulcers**
During April 2010-March 2011, Root Cause Analysis (RCA) investigations were instigated for all hospital-acquired pressure ulcers. This has proved to be effective in demonstrating if the care and treatment have been compliant with policies. It has also shown a number of trends across the Trust, for example, ward staff not ordering pressure relieving equipment, such as an air bed promptly enough. By highlighting these trends, practice has improved across the Trust. Figure 3 shows a step reduction in the number of pressure ulcers from September 2010. This is extremely positive because the Trust had not seen any reduction in the number of pressure sores in previous years.

Figure 3

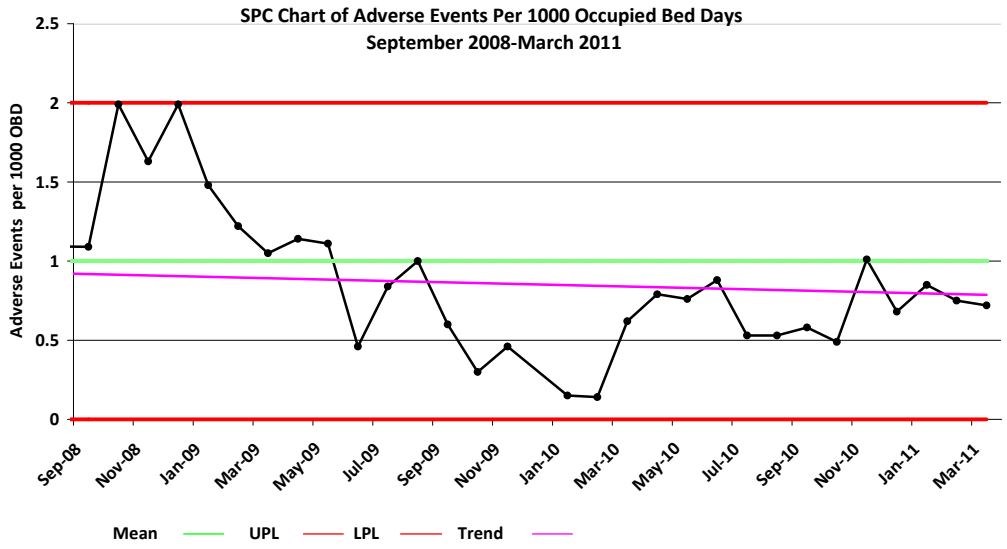


- **Reduce rate of avoidable harm**

  A random selection of patient stays between September 2008 and March 2011 were assessed using the Global Trigger Tool (GTT) for evidence of events leading to avoidable harm. The median number of events was 1.0 per 1000 bed days with a downward trend.

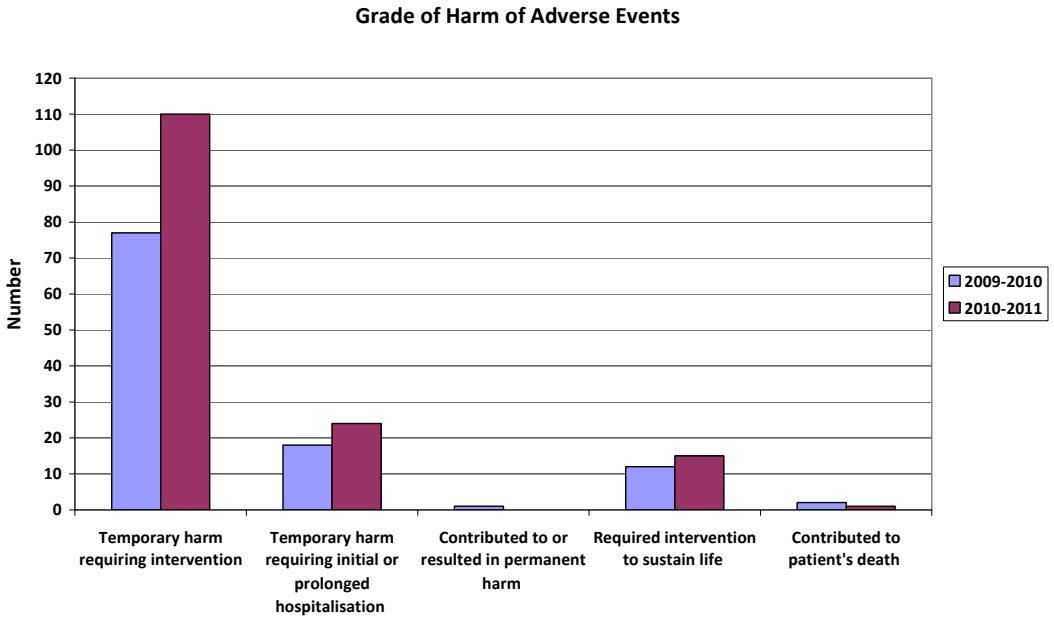
  There has been a sharp reduction in events between 2008-11, despite fluctuations in the numbers, the trend is still on a downward trajectory.

  Figure 4



  The level of harm sustained during April 2009 – March 2011 was reviewed, and the analysis shows that there has been an increase in the number of adverse events which reflects the Trust's open reporting policy, so that more events are reported than was previously the case. It also shows that the number of events that result in serious harm is very low.

Figure 5



- **Reduce rate of avoidable deaths**

  A number of patient safety initiatives have been implemented across the Trust to reduce avoidable deaths and avoidable harm; these are in line with the priorities of the National Patient Safety First campaign.
  www.patientsafetyfirst.nhs.uk/content.aspx?path=/

  The initial part of this project concentrated on patient observations and the response to deterioration in the patients' observations as a way of preventing patient deterioration on the wards.

  In August 2010, the SBAR (Situation, Background, Assessment and Recommendation) communication tool was launched across the Trust to be used specifically in cases where a patient's condition was deteriorating and medical and / or Outreach Team review (highly skilled senior nursing staff with training in intensive care) was needed. Ward nursing staff were trained to start the call stating that this was an SBAR call, to alert the person they were calling that the patient was deteriorating.

  Another objective of the project is to improve the quality of the prescribing of medication to ensure rapid, effective drug treatment for patients. All newly qualified doctors in the hospital will take a prescribing test when they start at the Trust from August 2011 and extra training will be given to those who do not reach the required standard.

  Considerable work has been done by the Pharmacy Department to implement the National Patient Safety Agency's Safety alert on "delayed and omitted medications", to ensure that essential drugs, such as antibiotics or heart medication, are given at the times that they are prescribed, however, the incident data suggests that the number of reports of omitted medications continues to rise. This could be either due to increased reporting of drug omissions or to an actual increase in omissions. Further work will be done to improve this during 2011-2012.

Patient Experience

- **Involving patients in their care**

  This was measured by the quarterly local survey between October 2010-April 2011. The results in Q3 and Q4 showed that 82% of patients felt that they had been involved in their care. There is room for further improvement and this is part of the national CQUIN, an action plan is in place.

- **Providing Same Sex accommodation**

  The local patient survey has demonstrated a high percentage of patients saying that they slept in same sex accommodation. The Trust is confident that this is due to the number of adjustments made to the patient pathway.

  Over the last two years the Trust has changed the specialties of wards to allow them to become completely male or female, rather than mixed sex, this has also resulted in some changes to ward layouts to split wards into a male section and a female section.

  During 2010 there was a change in leadership of the operational bed management team, which has resulted in a change in culture whereby there is zero acceptance of patients sleeping in mixed sex bays.

Table 9: Percentage of patients who reported they slept in same sex accommodation.

April-June 2010	July-September 2010	October-December 2010	January-March 2011
88%	87%	92%	88%

The Trust will be fined if patients are sleeping in mixed sex accommodation from April 2011. Revised definitions of same sex accommodation were published in December 2010. Since December, 42, 3, 14 and 0 patients have been in mixed sex accommodation in December, January, February and March 2011 respectively.

- **Treating Patients with respect and dignity**

  It is very important to ensure patients feel they are treated with respect and dignity. This is a question in the local survey and through the year there has been a very positive response from patients about how they are treated.

Table 10: Percentage of patients who reported they were treated with respect and dignity.

April-June 2010	July-September 2010	October-December 2010	January-March 2011
96%	97%	95%	95%

Clinical Effectiveness

- **Improving the uptake of breastfeeding after discharge**

  The focus lay on supporting mothers to initiate breast feeding and supporting them in the early post natal period, sustaining them in their choice. At the start of the year the percentage of mothers breastfeeding on discharge from maternity services was recorded at 34%, the performance at the end of year is 48%. There are significant actions that have taken place in the last twelve months to deliver this improvement in practice including; breast feeding training for all maternity staff, drop-in breast feeding clinics and promoting the benefits of breast feeding in the antenatal period.

- **Implementing the Enhanced Recovery Pathway**

  Enhanced recovery is a new approach to pre-operative, intra-operative and postoperative care received by patients undergoing colorectal, gynaecological and urological surgery. Enhanced recovery begins when a decision for an operation is made. During pre-operative assessment, patients are given verbal and written information about the enhanced recovery programme, including a diary containing daily goals to achieve. The diary is used as a way to encourage and allow the patients to have an understanding of what they are able to achieve and what they can expect to happen during their hospital stay. The patients also receive written discharge information to enable them to plan their discharge with family and friends.

  On the day of surgery, patients are admitted to hospital, receive carbohydrate loading and reduced length of pre-operative starvation. During surgery the physical stresses of surgery are reduced by the use of regional anaesthesia, local anaesthesia and sedation (if applicable). Laparoscopic or minimally invasive surgery is recommended, optimised fluid management, and individualised goal directed fluid management. Post-operatively the patient commences fluid and diet once awake and intravenous drips are discontinued. Early mobilisation is encouraged and if the patient's condition allows they are helped to get out of bed 6 hours after surgery. Regular oral pain killers are given to the patients to ensure that they are kept comfortable. Patients are discharged home as planned. The effectiveness of the programme is currently being evaluated.

- **Implementing the Enhancing Quality Programme (EQ)**

  EQ is a clinical change programme which uses quality measures which indicates whether the patient has received care that ensures the best possible outcome. The programme aims to measure standards of hospital treatment and to improve patient care and experience. It also aims to improve safety and reduce costs through the delivery of standardised clinical processes which should reduce complications, length of hospital stays and readmissions. Tables 11-14 show the early results from the programme.

Table 11 - Acute Myocardial Infarction (Heart attack) pathway

Acute Myocardial Infarction

Measures	Data Type	Jul	Aug	Sep	Oct	Nov
ACEI or ARB for LVSD	Percentage	100%	100%	100%	100%	100%
Adult Smoking Cessation Advice/Counselling	Percentage	100%	100%	100%	100%	100%
Aspirin at arrival	Percentage	100%	100%	100%	100%	100%

Aspirin Prescribed at discharge	Percentage	100%	100%	100%	100%	100%
Beta Blocker prescribed at discharge	Percentage	100%	100%	91%	100%	95%
Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	Percentage	n/a	n/a	n/a	100%	n/a
Primary angioplasty Received Within 90 Minutes of Hospital Arrival	Percentage	n/a	n/a	100%	n/a	100%

Table 12 – Results for Heart Failure pathway

Heart Failure

Measures	Data Type	Jul	Aug	Sep	Oct	Nov
ACEI or ARB for LVSD	Percentage	100%	100%	100%	92%	100%
Adult Smoking Cessation Advice/Counselling	Percentage	0%	0%	0%	50%	n/a
Discharge instructions	Percentage	0%	0%	9%	4%	0%
Evaluation of LV Function	Percentage	100%	92%	100%	100%	100%

Table 13 Results for Community Acquired Pneumonia pathway

Community Acquired Pneumonia

Measures	Data Type	Jul	Aug	Sep	Oct	Nov
Adult Smoking Cessation Advice/Counselling	Percentage	17%	0%	30%	38%	15%
Blood Cultures Performed in the A&E Prior to Initial Abx Received in Hospital	Percentage	74%	100%	56%	90%	100%
Initial antibiotic received within 6 hours of hospital arrival	Percentage	62%	58%	67%	81%	64%
Initial antibiotic selection for CAP in immunocompetent patients	Percentage	100%	97%	89%	98%	92%
Oxygenation assessment	Percentage	100%	88%	99%	91%	98%

Table 14 – Hip and Knee Replacement pathway

Hip and Knee Replacement

Measures	Data Type	Jul	Aug	Sep	Oct	Nov
Prophylactic antibiotics discontinued within 24 hours after surgery end time	Percentage	98%	100%	100%	96%	93%
Prophylactic antibiotic received within 1 hour prior to surgical incision	Percentage	58%	76%	82%	89%	78%
Prophylactic antibiotic selection for surgical patients	Percentage	78%	60%	89%	92%	100%
Received appropriate VTE Prophylaxis within 24 hrs Prior to surgery to 24 hrs after surgery	Percentage	89%	93%	97%	98%	98%

Review of Quality Performance

The quality of the Trust's services is monitored at a Trust-wide level by a number of systems. The first is a Quality Dashboard which amalgamates the quality indicators that have been agreed between the Trust and the Primary Care Trust (PCT) at directorate performance meetings. The indicators and year end performance can be seen in Table 15. There is also a set of Quality Performance indicators which is monitored by the Nursing and Midwifery staff through the Trust's Nursing and Midwifery Accountability System. This is a well established tool which enables the senior nursing

team to monitor, challenge and share practice across the Trust. External assurance is provided through the Clinical Quality meeting, this is chaired by the Medical Director from NHS Medway. The agenda provides opportunity for support and challenge in relation to all the Quality Indicators, CQUINs, or any issue about quality that has given cause for concern and national reports, for example, the recent Ombudsman report "Care and Compassion" (2011). Benchmarks are provided by CHKS, Dr. Fosters and the South East Coast Strategic Health Authority Quality Observatory. These are extremely helpful in enabling the Trust to measure performance in comparison to our neighbouring trusts.

Table 15 – Clinical Quality Indicators

CLINICAL QUALITY INDICATORS

For period covering April 2010 to 2011

Target / Indicator	Description	Target	Performance
Infection control	C Diff reduction (stretch target)	71	**49**
	MRSA reduction	4	**0**
Falls	Number of falls per 1,000 admission	5	**6.17**
Single sex accommodation	Same sex accommodation breaches	0	**197**
Hand hygiene audit	Hand hygiene score	95%	**98.9%**
Child safeguarding training	% of eligible staff trained in child safeguarding	95%	**96.1%**
Adult safeguarding training	% of eligible staff trained in adult protection	95%	**95.8%**
Enhanced CRB check	% of eligible staff with enhanced CRB	100%	**100%**
Discharge letters	% of discharge letters sent to GP within 24 hours	100%	**95.7%**
Serious Untoward Incident (SUI)	Number of SUIs	24	**51**
Never Events	Number of Never Events	0	**1**
Bed utilisation	Bed occupancy	90%	**90.18%**
Mortality rate - HSMR	Risk-adjusted mortality rate	100	**106.4**
Delayed discharge	Bed days lost due to delayed discharge	7,200	**6,394**
Complaints	Number of complaints received	480	**552**

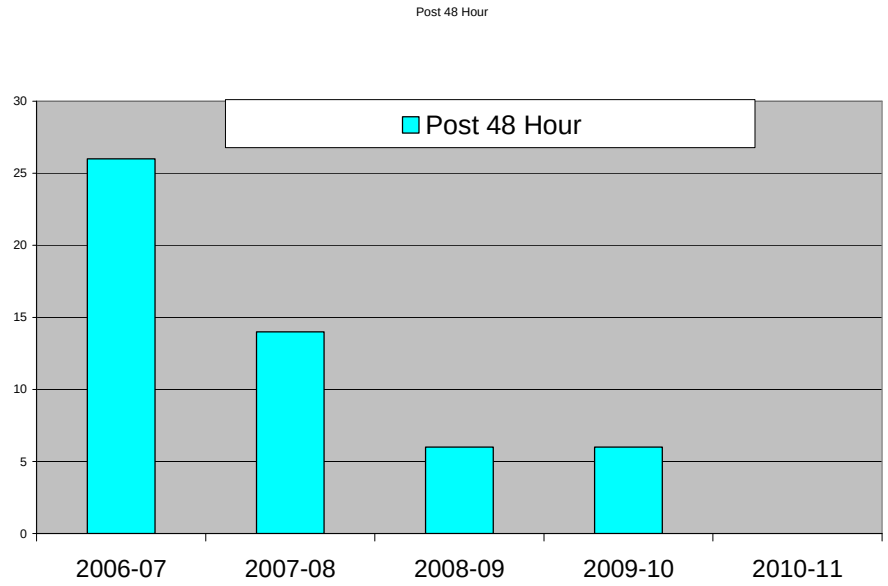
Table 15 shows that there are a number of indicators that require further improvement. Falls and same sex accommodation are discussed in part 2 of this report, complaints are highlighted below. The number of serious incidents has been rated on red as there have been more incidents than last year. All of these have been investigated and have action plans. Our aim is to reduce the number of serious incidents, however, it should be noted that good reporting is a sign of an open culture. One never-event was reported in 2010-11, however, it happened in 2009. The incident was a wrongly placed feeding tube; all practice was reviewed following notification of the incident.

Achievements relating to quality are highlighted below:

MRSA Bacteraemia

The Trust is proud to state that it has the best performance across the South East Coast region and one of the best performances in the country.The Trust has had a decreasing number of MRSA bacteraemia when measured year on year. During the reporting period April 2010 – March 2011, the Trust has had zero MRSA bacteraemia and, at the time of reporting, the last bacteraemia was reported on 17 February 2010.

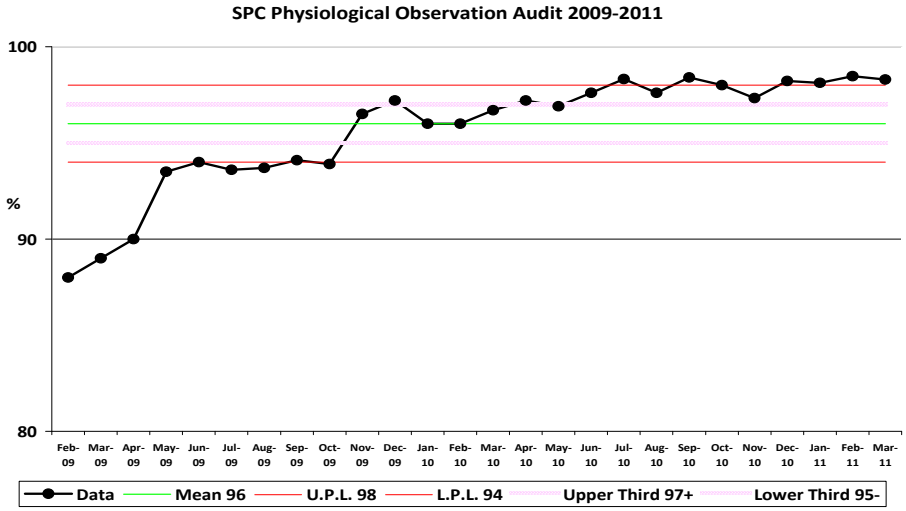
Figure 6: Graph showing MRSA bacteraemia



Patient Observations

In 2009 the Outreach Team started monthly audits on how well the nurses were performing patient observations in response to previous poor results in annual audits. The criteria for how observations should be done were agreed and the audit continued into 2010-11. There continued to be improvement from April 2010 – 97.2% to March 2011 - 98.3%.

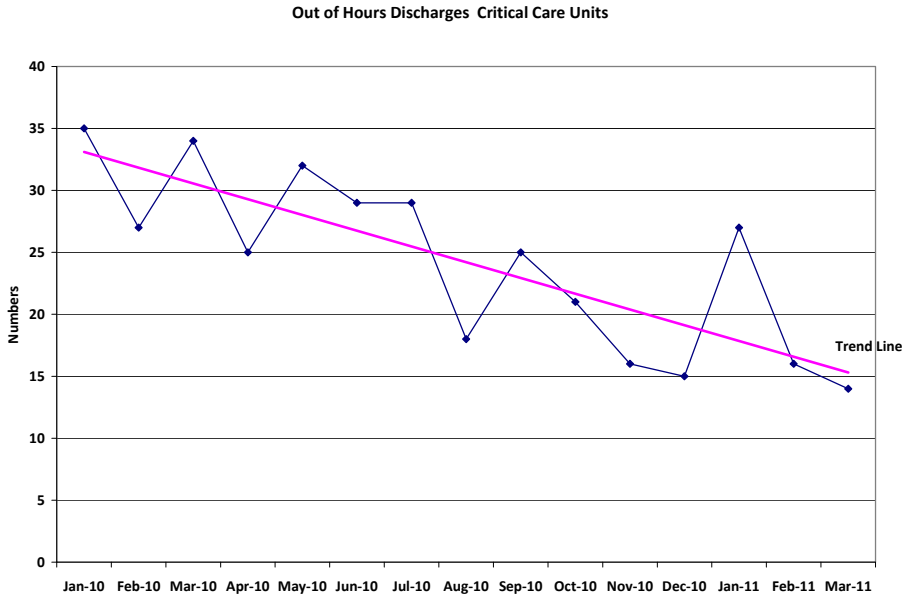
Figure 7



Night Time Transfers

It is not good practice to transfer patients out of critical care units to general wards at night time. The Trust has focused on reducing the number of times this happens. The graph in figure 8 demonstrates how successful the Trust has been, with a clear downward trend through the year.

Figure 8



Below are a couple of examples of service developments which have improved the quality of care to the patients in fetal medicine and cardiac care.

The Fetal Medicine Unit at Medway has successfully implemented combined serum and Nuchal screening for chromosomal abnormalities. Audit of the first 6 months has shown more than 97% uptake (2746 expectant mothers) with 100% pick-up. We will offer this excellent service to our neighbouring catchment areas and provide an alternative for tertiary referrals of complex cases.

Since 2000 the aim of the Rapid Access Chest Pain Clinic, which is now nurse led, has been to offer a one-stop clinic to ensure that patients presenting with chest pain, thought to be cardiac in origin, have a cardiac opinion and access to cardiac investigations and treatment within the waiting time target of 2 weeks, as previously recommended in standard 8 of the National Service Framework for CHD (2000).

The 14 day target wait (Table 16) is consistently met for all patients and 60% of patients are seen, assessed, investigated, discharged and are reassured from clinic with a non cardiac cause for their symptoms. Patients with cardiac symptoms have further investigations planned from the clinic.

Table 16 Number of patients seen April 2010-March 2011

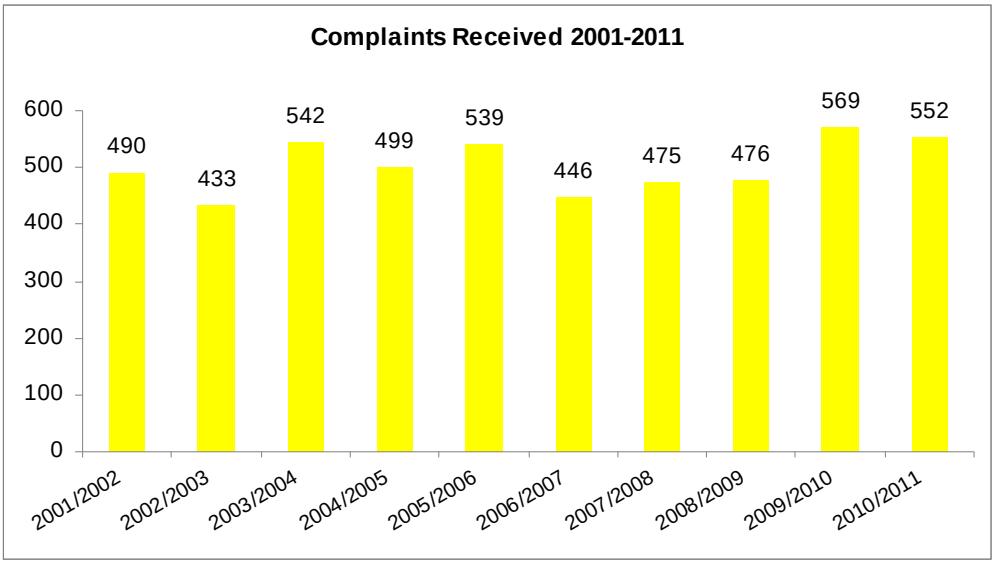
Source of referral	GP/PCT	A&E	MAU	Total
Number of patients seen	602	63	40	755
Number of patients seen within 14 days	100%	100%	100%	100%

Complaints

Based on the principles for remedy, Medway NHS Foundation Trust has been more open and transparent with complaint handling. Complaints are seen as an integral part of service improvement and an opportunity to learn from patient feedback.

A total of 552 complaints were received during 2010-11 compared to 569 in 2009-10 which represents a 3% decrease.

Figure 9 – Complaints Received



To date 458 of the 552 complaints received were responded to within 25 working days, giving an overall performance of 83%. Following the appointment of a new Complaints Manager in late June 2010 the 85% expected target response rate has been consistently met (June 2010-March 2011 87% of complaints were responded to within 25 working days). The administration systems within the department have been completely reviewed and overhauled to improve and update the complaints process. In-house training for Clinical and Senior Sisters has been arranged and is due to commence, starting in the areas where it has been identified that training is necessary.

The Complaints Manager works with the directorates to ensure that complaints are managed in accordance with the NHS complaints procedure and to ensure that lessons are learnt within the organisation.

During 2010-11, 15 files were requested by the Health Service Ombudsman for information. One Complaint was upheld.

The themes of complaints in 2010-11 were:

- **Clinical Care and Treatment**

  There were 250 complaints relating to clinical care and treatment. The main areas for these were A&E (36), General Medicine (36), Orthopaedics (43) and General Surgery (30). The trends within these were failure to diagnose, particularly fractures and lack of nursing care. These trends have been investigated and action taken, where necessary, this has included a review of

clinical practice. It is worth noting that Elderly Care received only 11 complaints relating to clinical care and treatment.

- **Attitude of Staff**

  There were 47 complaints relating to attitude of staff. The main areas for this were A&E (6), Paediatrics (8) and Gynaecology (5). There has been some formal management of nursing staff in A&E, with the staff being refocused on customer care. Although there were the same amount of complaints relating to attitude in the Paediatric department, there was no staff group in particular responsible. It is worth noting that Maternity only had one complaint relating to staff attitude.

- **Communication**

  There were 74 complaints relating to communication and information to patients. The main areas in which communication was poor was in Orthopaedics (11), Gynaecology (7), Other (7) and Dermatology (7). The Orthopaedics department has been through some restructuring and the clerical staff have been reminded of their role within the directorate. A great number of communication issues relate to telephone calls not being returned and promises to contact patients not being honoured. A particular problem is patients not being able to have their calls answered or messages returned. An automated voicemail service is due to be installed to reduce this problem. It is worth noting that Paediatrics only had 1 complaint relating to communication and A&E only 2 complaints.

  There were no complaints in 2010-11 for Critical Care and Theatres.

Patient Advice & Liaison Service (PALS)

The Patient Advice and Liaison Service (PALS) have assisted over 3,000 patients, relative and visitors with problems, concerns and advice during 2010-11. This is an increase of over 500 on the previous year's total.

A large proportion of the work this year has related to contact and communication problems, probably due to changes taking place within the departments. By far the largest number of queries was in respect of outpatient appointments, where patients may need information regarding when and where they are to be seen and whether their appointments are booked. We have been able to assist patients in over 800 of these queries. This is one of the priorities for improvement in 2011-12.

Although PALS are not always able to solve problems entirely to every patient's satisfaction, the majority of people are satisfied with the assistance given and a very small minority have resulted in formal complaints.

We have found that people who contact PALS for assistance are inclined to return when they have further queries and use the service frequently. We have also been able to pass on a number of compliments, to various wards and departments, from patients who have been very happy with their care.

Patient Surveys

The Trust participates in all the Adult National surveys including Inpatients, Outpatients, Maternity and Cancer. It also conducts its own local surveys on a quarterly basis.

The 2010 National Inpatient Survey was published in April 2011.The key findings highlight the care and discharge elements of the survey as being areas for significant improvement.

- Patients felt they were not involved as much as they wanted to be in decisions about their care and treatment.
- Patients could not find someone to discuss their concerns with.
- Patients were not given enough privacy when discussing their condition or treatment.
- Patients not told of side effects of medication.
- Patients not told who to contact if they were worried about their condition or treatment after they had left hospital.

The results are disappointing and show no significant improvement from the 2010 survey. The Director of Nursing has met with the Senior Sisters to discuss the results and develop an action plan to improve aspects of the patient experience, this includes implementing patient led visiting, to have greater involvement of relatives and reviewing and improving all aspects of care planning and the discharge system.

The survey highlighted a number of positive aspects of the patient experience and included the following scores:

- overall rating of care as good/excellent =86/100
- patients stated that doctors and nurses worked well together =85/100
- patients stated toilets and bathrooms were fairly clean =85/100
- patients reported that hand washing gels were visible and available to use =94/100

All results are shared with the directorates to provide patient feedback on how the services could be improved. Action plans are then implemented to demonstrate changes and learning.

The key findings from the Maternity Survey published in December 2010 found that:

- 87% of maternity patients rated their hospital care as excellent, very good or good.
- 92% of maternity patients rated their hospital care during labour and birth as excellent, very good or good.
- 88% of maternity patients rated their hospital care during pregnancy as excellent, very good or good.

The area most in need of improvement was the Antenatal Pathway, both in relation to screening tests and the provision of information to mothers.

The feedback provided by the maternity patients will enhance the services we provide by ensuring we implement changes.

Local surveys from all the wards show that ward staff continually listen and respond to patient needs. Each ward specifically target areas that patients have highlighted in order to bring about change.

The correlations across all the wards demonstrate that overall patients feel that:

- The hospital ward areas and toilets are clean.
- Hand gels are in use and that staff do wash their hands between patients.
- Explanations were given if patients were not in a single sex bay.
- Staff did introduce themselves and ask patients if they had any concerns.
- Assistance is given to control pain.
- Overall the care was excellent, very good or good.
- Patients were treated with respect and dignity.

Areas for improvement were:

- Enhancing the quality and choice of food provided to patients.
- Assistance at meal times.
- Receiving answers from doctors and nurses that patients could understand
- Being involved in decisions about care and treatment.
- Explanations around the side effects of medication when discharged.

Performance against key national priorities

The Trust's performance against targets in the 2010-11 operating framework are shown in tables 17 and 18. Table 17 shows good performance across all targets that contribute to the Monitor governance rating. In table 18 performance against existing commitments and national priority targets is generally very good. The action planned to improve data quality is described earlier in part two of this report. The delayed patient discharges, although above the target in the first half of the year, has been improving quarter on quarter and there are plans to further improve this throughout the year. There were seven patients who waited longer than 13 weeks for an outpatient appointment. All of these seven were investigated and action taken to stop recurrence. The aim of the Trust is to have no further occurrences of this.

Table 17

SECTION A - MONITOR WEIGHTED TARGETS

TARGET	DESCRIPTION	Green	Amber	Red	Monitor Weight	2010/11 Plan	YTD Plan	YTD Actual	Trend
Infection Control	C Diff reduction	<= Plan		> Plan	1.0	89	89	49	
	MRSA reduction	<= Plan		> Plan	1.0	4	4	0	
	MRSA screening - Elective	>= 100%		< 100%	0.5	100%	100%	115.6%	
Cancer Access	2-ww all cancer (* tbc)	>= 93%		< 93%	0.5	93%	93%	94.4%	
	2-ww symptomatic breast (* tbc)	>= 93%		< 93%		93%	93%	95.7%	
	31-day first treatment	>= 96%		< 96%	0.5	96%	96%	98.1%	
	31-day subsequent treatment - Surgery	>= 94%		< 94%	1.0 (failure of any = 1.0)	94%	94%	97.2%	
	31-day subsequent treatment - Anti Cancer Drug	>= 98%		< 98%		98%	98%	100.0%	
	62-day GP referral	>= 85%		< 85%	1.0 (failure of any = 1.0)	85%	85%	92.8%	
	62-day screening service	>= 90%		< 90%		90%	90%	98.6%	
	62-day consultant upgrade				-			97.2%	
A&E Access	4-hr wait LHE	>= 95%		< 95%	0.5	95%	95%	97.64%	
	4-hr wait Trust only	>= 95%		< 95%	-	95%	95%	96.66%	
	4-hr wait QMAE (validated)	>= 95%		< 95%	-	95%	95%	97.81%	
Reperfusion	Thrombolysis - 60 min call to needle (no. of patients)	>= 68%		< 68%	0.5	68%	68%	100.0%	

Monthly Service Performance Rating	Green (G)	Amber-Green (AG)	Amber-Red (AR)	Red (R)	
	0 - 0.9	1 - 1.9	2 - 2.9	>= 3.0	

Table 18

SECTION B - EXISTING COMMITMENTS AND NATIONAL PRIORITY TARGETS *

TARGET	DESCRIPTION	Green	Amber	Red	2010/11 Plan	YTD Plan	YTD Actual
18 Weeks RTT	Admitted patients	>= 90%		< 90%	90%	90%	91.1%
	Data completeness - admitted	90-110%	75-89% or 111-125%	< 75% or > 125%	90-110%	90-110%	107.0%
	Non-admitted patients	>= 95%		< 95%	95%	95%	98.7%
	Data completeness - non-admitted	90-110%	75-89% or 111-125%	< 75% or > 125%	90-110%	90-110%	102.8%
	Direct access audiology patients	>= 95%		< 95%	95%	95%	100.0%
	Data completeness - audiology	90-110%	75-89% or 111-125%	< 75% or > 125%	90-110%	90-110%	97.4%
GUM Access	Access to GUM clinic within 48 hours of contacting service	>= 98%	95-97%	< 95%	98%	98%	100.0%
Cancelled Operations	Cancelled operations (no. of patients)	<= 0.8%	0.9-1.5%	> 1.5%	0.8%	0.8%	0.88%
	Not rescheduled in 28 days (no. of patients)	<= 5%	6-15%	> 15%	5%	5%	0.8%
DTOC	Delayed discharges	<= 3.5%	3.6-5.4%	>= 5.5%	3.5%	3.5%	3.8%
Access Wait Times	Outpatients waiting >13 weeks	0		>= 1	0	0	7
	Inpatients waiting >26 weeks	0		>= 1	0	0	1
Cardiac Access	Seen within 2 weeks of referral for Rapid Access Chest Pain	>= 98%	95-97%	< 95%	98%	98%	100.0%
Reperfusion	Primary PCI within 150 min from call	Tolerances not yet published					100.0%
Stroke	Patients spending 90% of time in Stroke Unit	>= 60%	51-59%	< 50%	60%	60%	80.1%
Diagnostic Waits	MRI waiting <6 weeks (no. of patients)	100%	96-99%	<= 95%	100%	100%	100.0%
	CT waiting <6 weeks (no. of patients)	100%	96-99%	<= 95%	100%	100%	100.0%

Monitor regulation

The Trust was notified by Monitor on 27 April 2011 that, as a result of a negative variance from forecast surplus for the year ending 31 March 2011, and the previous year surplus also not being achieved, it considered the Board level scrutiny and assurance processes concerning financial planning and performance at the Trust had not been effective and that there was insufficient assurance that these are now fully effective. As a result of this, Monitor was not assured that the Trust had a credible plan to return to a Financial Risk Rating of 3 on a sustainable basis, or that the Trust has the level of Board reporting and scrutiny in place to ensure that it's plan is delivered. As a result of this, Monitor has decided that the Trust is in significant breach of two terms of its authorisation, namely – the general duty to exercise its functions effectively, efficiently and economically, and its governance duty. This means that the Trust will be red rated for governance risk until Monitor is assured that the Trust is returning to full and sustainable compliance with its Authorisation.

The Trust has already put plans in place to address these issues and has commissioned external advisors to provide assurance over the 2011-2012 financial plan and review financial governance. This work has not been completed at the time of this report, however, any recommendations will be implemented. The Trust is reporting progress to Monitor on a monthly basis and the Board will be taking overall responsibility for monitoring progress throughout the forthcoming year.

The risk ratings for 2010-11 were:

Quarter	Financial Risk Rating (FRR)	Performance/Governance (PG) Risk Rating
Q1	2	Amber/ Green
Q2	2	Amber/Green
Q3	2	Amber/Green
Q4	2	Red (due to significant breach of authorisation)

The predicted risk ratings for the first two quarters in 2011-12 are:

Quarter	Financial Risk Rating (FRR)	Performance/Governance (PG) Rating
Q1	2	Red (due to significant breach of authorisation)
Q2	2	Red (due to significant breach of authorisation)

The performance/governance risk rating would have been amber/green for Q4 (2010-11), Q1 and Q2 (2011-12), however, due to the breech in authorisation, this is automatically overridden by Monitor to a red risk rating.

Workforce

The Quality Account includes, for the first time, a section on workforce factors. The Trust recognises that all its services are delivered through staff and the importance of ensuring its workforce is enabled to provide high quality services.

The 2010 NHS Staff Survey ranked the Trust in the best 20% for staff agreeing their role makes a difference to patients, effective team working and above average for the quality of job design.

The Care Quality Commission highlights the four key findings with which the Trust compares most favourably and least favourably with other acute trusts in England. These are provided below.

Four top ranking scores

Key factor	2010 Trust score	2010 national average score	2009 Trust score
Percentage of staff receiving health and safety training in the last 12 months	92%	80%	91%
Percentage of staff suffering work-related injury in the last 12 months	13%	16%	17%
Percentage of staff having equality and diversity training in the last 12 months	68%	41%	58%
Effective team working	3.76/5	3.69/5	Not available*

Bottom four ranking scores

Key factor	2010 Trust score	2010 national average score	2009 Trust score
Percentage of staff working extra hours	75%	66%	74%
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	20%	15%	Not available**
Percentage of staff experiencing physical violence in the last 12 months	3%	1%	Not available*
Trust commitment to work-life balance	3.24/5	3.38/5	3.44/5

The Trust has developed an action plan with Staff Side representatives to address areas for improvement in the staff survey.

This section of the Quality Account focuses on four themes:

- Planning and developing the workforce.
- Staff engagement and empowerment.
- Health and well-being.
- Leadership.

* Change in Clinical Quality questionnaire or analysis means comparative data for 2009 is not available.

- **Planning and developing the workforce**

The Trust anticipates that it will be commissioned to provide less activity in hospital in 2011-12. These changes may be as a result of care being delivered in different ways or reduced need. The Trust has developed workforce plans to reflect these changes and will work with partner organisations, where appropriate to implement them.

The Trust anticipates that the overall reduction to its establishment as a result of the Transforming Performance programme will be about 208 whole-time equivalent. The majority of these posts will be managerial and clerical rather than clinical posts, such as doctors and nurses.

The Trust aims to reduce pay costs by:

1. Eliminating agency expenditure.
2. Minimising bank expenditure.
3. Disestablishing vacancies and restructuring departments.
4. Closing excess capacity and redeploying staff to vacant posts.
5. Restructuring departments to improve efficiency.

The Trust recognises that the development of its workforce has a direct impact on quality. The annual personal development review is the key mechanism for agreeing individual learning needs. The 2010 Staff Survey shows that 78% of Trust staff were appraised in the previous 12 months, and 77% of staff had received job-relevant training, learning or development in the last 12 months. This placed the Trust in the average range for acute NHS trusts.

92% of Trust staff have received health and safety training in the last 12 months. This places the Trust in the top 20% of acute trusts.

The Trust has completed a self-assessment of its preparation for medical revalidation using AQMAR (Assessing the Quality of Medical Appraisal for Revalidation) and is well prepared for implementation within national deadlines.

- **Staff engagement and empowerment**

During 2010-11 the Trust has focused on improving senior clinical engagement in the management of the Trust, by the establishment of the Clinical Executive Group and Clinical Directors' Programme. The Trust executive has also promoted staff engagement through Chief Executive Open Sessions/Board Briefing and a more participative approach to the Leadership Forum for middle and senior managers.

The Trust will continue to focus on developing its approach to staff engagement to improve responses to the staff survey.

- **Health and well-being**

The Trust understands the importance of the health and well-being of its workforce. All staff have direct access to Occupational Health services to support their health and well-being at work. Counselling and other support services are available through occupational health. The Trust has developed an action plan to respond to the recommendation in the Boorman report.

The Trust's sickness absence rate of 3.3% is below the national average for NHS acute trusts of 3.8%.

- **Leadership**

The Trust recognises that excellent leadership is essential to high quality services and has invested in our leaders to ensure they are prepared for current and future challenges. The main focus of leadership development at the Trust is the Clinical Directors' Development Programme, Front Line Leaders Programme and the Senior Sisters' Development Programme. These are tailored to the organisation to ensure high-quality leadership at all levels of clinical and non-clinical management.

To improve how leaders engage with staff. The Trust plans to reduce layers of management in 2011-12.

Approach to Quality

During April 2010 - March 2011 a more coordinated approach to quality development and monitoring has been developed, led by the Director of Nursing and the Medical Director. The Board has been totally committed to ensuring quality of service is high on the agenda, this has been enhanced by Board meetings starting with either a patient safety or a patient experience story. The Board's patient safety visits have been changed to be quality visits and now look at the patient experience and staff experience, as well as patient safety. A Trust Quality Dashboard (see Table 18) has been developed which has removed patient safety and patient experience indicators from the Access and Operational Performance Dashboard and, therefore, given equal importance to these indicators.

Table 18 – Trust Quality Dashboard

Patient Safety: Performance Scorecard

Indicator	Detail	2010	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Mortality	*HSMR - Dr Foster*	106.4	98.7	112.2	108.5	120.0	127.9	115.3	97.8	108.1	110.7	102.9	95.2	79.6
	Mortality rate RAMI - CHKS - index (peer rate)	89 (90)	68 (93)	78 (97)	72 (86)	82 (84)	110 (91)	115 (85)	91 (93)	86 (90)	101 (95)	98 (96)	79 (82)	72 (81)
	Falls with injury per 1,000 admissions	6	6.97	6.90	6.97	10.17	9.02	8.71	3.76	5.86	5.63	4.21	4.01	2.25
	Patients with grade 2 and above pressure damage (newly acquired)	211	27	20	16	24	15	16	18	16	14	16	15	14
	Observations	96%	97.20%	96.90%	94.60%	98.30%	97.60%	98.40%	98.00%	97.30%	98.20%	98.10%	98.50%	98.30%
	% of adult inpatients who have had a VTE risk assessment on admission to hospital	N/A	N/A	N/A	N/A	N/A	N/A	14%	24%	39%	42%	64%	73%	76%
	Number of Hospital DVT	95	9	15	18	13	1	6	6	5	4	3	9	6
	Number of Hospital PE	25	0	2	3	3	4	4	3	0	1	1	3	1
Infection Control	*C Diff reduction (stretch target)*	49	3	4	9	4	3	5	3	3	7	3	3	2
	Incident rate of C Diff (per 10,000 bed days)	2	1.79	2.29	5.67	2.41	1.82	2.99	1.77	1.86	4.23	1.76	2.00	1.20
	MRSA reduction	0	0	0	0	0	0	0	0	0	0	0	0	0
	Incident rate of MRSA (per 10,000 bed days)	0	0	0	0	0	0	0	0	0	0	0	0	0
Incidents	*Number of incidents*	7,762	502	507	360	769	672	861	734	726	679	608	609	735
	Number of SUIs	50	3	5	8	4	4	0	11	5	3	3	1	3
	Number of Never events	1	0	0	1	0	0	0	0	0	0	0	0	0
	Number of repeated falls	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	NPSA reported per 100 admissions	11	9	6	13	11	15	12	12	11	11	10	8	12
	% patient accident	19.1%	21.70%	32.22%	16.78%	21.43%	14.63%	17.30%	17.63%	19.00%	17.27%	18.23%	17.80%	15.00%
	% treatment	4.0%	0.79%	4.17%	2.47%	4.32%	3.60%	4.36%	4.55%	5.01%	1.32%	7.72%	5.49%	4.00%
	% implementation of care	15.0%	24.06%	30.83%	12.87%	19.35%	10.92%	12.94%	13.22%	14.29%	12.34%	11.33%	12.31%	6.00%

Patient Experience: Performance Scorecard

Indicator			YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Trend	Q1	Q2	Q3	Q4
Complaints			513	65	39	56	46	53	53	53	46	22	38	42	39		160	152	121	119
PALs contacts			2,830	242	220	264	254	287	320	270	242	206	261	264	343		726	861	718	868
Ombudsman referrals			11	0	0	1	0	1	1	2	3	2	1	0	0	-	1	2	7	1
Same sex breaches			34									17	3	14	0				42	17
NHS Choices Comments			0														0	0	0	0
	positive		6	1	1	0	1	0	1	0	1	0	0	1	1		2	2	1	2
	negative		6	0	1	0	1	0	2	1	1	0	0	0	1		1	3	2	1
Health Watch referrals			1	0	0	0	0	0	0	1	0	0	0	0	0	-	0	0	1	0
Thank you card / letters			447	n/a	n/a	n/a	n/a	87	85	74	57	116	28	tba	tba		0	172	247	28
Patient Surveys				*Quarter 1*			*Quarter 2*			*Quarter 3*			*Quarter 4*							
	Mixed sex		89	88			87			92			88							
	Food:																			
		a: Quality	60	61			60			60			60			-				
		b: Assistance	86	83			86			85			88							
	Call buzzer time		75	73			73			75			77							
	Dr's answers to questions		84	84			85			83			85							
	Dignity and respect		96	96			97			95			95			-				
	Involved in decisions		82	n/a			n/a			82			82			-				
	Found someone to talk to		81	79			81			81			81			-				
	Privacy:																			
		a: Discussing	90	88			91			91			91			-				
		b: Examination	97	96			96			97			97			-				
	Told about medication		73	74			76			71			69							
	Told who to contact part d/c		83	82			84			81			83							
	Contact with nurse in charge			n/a			n/a			80			79							

The committee structure has changed during the year. The Quality Committee (previously Quality and Safety Committee) is a sub committee of the Board and the agenda very clearly covers the three aspects of quality. The main focus alternates on a monthly basis between patient safety and patient experience, however issues of both can be discussed. A new Patient Experience Committee has been formed under the chairmanship of the Director of Nursing, which reports to the Quality Committee, as does the already established Patient Safety Committee.

The last year has given the Trust a better foundation on which to develop the quality of services provided. The Trust has committed to improve Quality Governance during 2011-12.

Monitor defines quality governance as the combination of structures and processes at and below board level, to lead on trust-wide quality performance including:

- Ensuring required standards are achieved.
- Investigating and taking action on sub-standard performance.
- Planning and driving continuous improvement.
- Identifying, sharing and ensuring delivery of best practice.
- Identifying and managing risks to quality of care.

To do this, the Trust will use the National Quality Board's framework for quality governance as guidance to improve the system and processes. This will be led by the Director of Nursing and the Medical Director and be monitored by the Quality Committee, this was agreed by the Board in April 2011.

It is evident that, although clinicians and managers understand the Quality Indicators in the Quality Account and the CQUINs, central monitoring through the years has been lacking. In response to this a Quality Performance Monitoring committee has been formed and will meet monthly from April 2011. The remit of the committee will be to monitor achievement of all quality indicators, including those in the contract, CQUINs and the Quality Account. It will be chaired by the Director of Nursing and report to the Quality Committee.

Accurate and timely clinical data and information is essential if clinicians are going to improve their services. Providing this will be a priority during 2011-12 and improvements will be led by the Medical Director and the Director of Operations.

On reflection, although the 2010-11 Quality Account gave the Board and staff a focus on quality improvement, it could have been used more extensively. It is planned, therefore, that the Quality Account will be reviewed on a monthly basis at the Quality Committee. This will ensure more effective scrutiny about continuous improvement and the data quality to support this.

Part 4 – Annex

Statement from NHS Medway

NHS Medway welcomed the 2010/11 Quality Account from Medway NHS Foundation Trust for 2010/11. We can confirm that we have no reason to believe that this Quality Account is not an accurate representation of the activities of the Trust during the year 2010/11.

There has been good progress with reducing the incidences of mixed sex accommodation. Breaches are monitored by the PCT, (Primary Care Trust), on a monthly basis and, from April 2011, as per the national contract, the Trust could be fined by the PCT.

Falls and pressure ulcers are monitored monthly by the PCT. The Trust has demonstrated improvements over the last year and further work will be undertaken as part of the national Safety Express initiative to both set and achieve more stringent targets.

Significant progress has been made throughout year with increasing the number of VTE (venous thromboembolism), risk assessments. This places the Trust in a strong position to achieve the national CQUIN, (Commissioning for Quality and Innovation), target for 2011/12.

The Quality Account provides some recommendations from clinical audits. This is positive as it demonstrates that lessons are being learned and clinical practice continuously improved. It is very important that outcomes are documented in the account so that the public can gain confidence that services will continue to be monitored and improved.

It is useful that the account shows areas of underachievement as well as successes, for instance the CQUINs for 2010/11. The PCT stresses that where there are any concerns, plans for improvement are rigorously documented within the account.

It is important that acronyms are explained within Quality Accounts in order to provide the public with clarity. The PCT supports the continual monitoring of the Quality Account on a monthly basis at the Trust's Clinical Quality Committee.

Signed by Dr Peter Green

Medical Director Kent and Medway PCTs

17 May 2011

Medway Council

Overview and Scrutiny Committee statement

Medway NHS Foundation Trust – Quality Accounts

Last year the Health and Adult Social Care O&S Committee decided that future Quality Accounts should be commented on, if appropriate, by the Head of Scrutiny in consultation with the Assistant Director, Adult Social Care and the Chairman and spokespersons of Health and Adult Social Care O&S Committee. In view of the election held on 5 May it has not been possible to consult the Health and Adult Social Care O&S Committee Chairman and spokespersons on your Quality Account. However, the following comments have been shared with the Members who held that position last year:

"The NHS Choices guidance suggests that the priorities for improvement should take into account patient views. It is not clear from the Quality Account whether patient views have indeed been taken into account and the Health and Adult Social Care Overview and Scrutiny Committee would be interested to hear further what views and comments have been received from patients and the public on the Quality Accounts and will be interested to see the way in which those views have influenced your priorities".

The Medway LINk Response to Medway NHS Foundation Trust Quality Account – 2010-2011

Introduction

The Medway LINk would like to thank Medway NHS Foundation Trust for the opportunity to comment on their Quality Account. This commentary has been compiled using information assembled from:

- Medway LINk Governors comments, in line with Department of Health document "Quality Accounts: a guide for Local Involvement Networks".
- Medway LINk participants and service users, commenting on their experience of using the services, as well as the Trust's performance against last year's priorities and how appropriate they felt this year's priorities are, via an online and paper survey.
- Face to face interviews with service users and visitors within the Outpatients areas of Medway Maritime Hospital site, who were also asked to comment on the above key areas.

Note: Information assembled from over 150 responses male/female; predominantly white British, ranging from 17 – over 60 year old. A very small amount of feedback came from those of other Ethnic origin.

1. Is the Quality Account clearly presented for patients and public?

It is felt that the introductory statement from the Chief Executive is clear, positive and forward thinking and that the general public will be able to understand the content.

However it would seem that the document has been compiled by several different authors some of which are clearer to the lay reader than others.

The document also contains a large amount of management jargon, unexplained acronyms and many obscure tables/graphs, making elements of the document difficult to read for the patient and public. Whilst comments have been made on the draft version, it is hoped that the final version will include images to break up the density of the text. This element and the very fact that the Account is almost double the length of other Quality Accounts received by the LINk, makes it a very long and laborious read.

A contents page would have been very useful and presume that this will be included within the final document, allowing readers to be directed to those areas of interest to them. It should be noted that similar comments were made in last year's LINk commentary and the LINk is disappointed to see that these were not taken onboard in preparation of this year's Account.

2. Priorities for 2010-11

From feedback received it should be noted the majority felt that the Trust had met their last year priorities partly or well with very little negative feedback received. Two interviewees felt that the Trust had not met its priority in "Providing same sex accommodation" and one around "Treating patients with dignity and respect". From these results the overall impression was that the Trust had worked well to meet its priorities and had delivered what was promised.

3. Priorities for 2011-12

From feedback received it is evident that an overwhelming majority felt that the Trust had identified very appropriate priorities for the coming year. However some respondents commented on other areas they felt the Trust should focus on, which were mainly appointment systems, waiting times in out-patients and general communications between staff and patients.

Only two negative responses were received one of which made no further comments and the other having concerns around foetal monitoring which is being addressed in this year's improvement plans. From these results the overall impression was that the Trust had chosen its priorities well.

4. Safety, Communications and Staff

Respondents were asked to comment on their perceptions of the above three elements and commented as follows:

Safety – From those who took part in the survey the overwhelming majority felt safe both in terms of care and security and whilst in the Medway Maritime Hospital. Only three respondents felt that they did not feel safe due to the reasons below:

Preconception – "you hear so many horror stories and staff do not reassure you"
Opinion – "Not well maintained …… so I did not feel that high standards could be sought there".
Experience – "Left patient hanging off side of bed for over an hour – patient unable to move or buzz".

Communications – From all the questions posed to respondents, communications generated the most negatives. A minority of patients reported issues with staff who do

not have English as their first language, the lack of time staff have available to explain things properly and patients not being informed of long delays in Outpatients clinics.

Positive comments were primarily around staff clearly explaining procedures and in general communicating well with a friendly, positive attitude.

Staff Experience – Perceptions of staff were generally positive with the majority feeling confident whilst in their care commenting that they were competent, helpful and professional.

5. Who has been involved in the preparation of the Quality Account

From the Account we can find no clear statement about who was consulted when developing priorities for the coming year. Department of Health guidance for Trusts and LINks states that stakeholder engagement in the development of a quality account should be a year long process ideally starting at the beginning of the reporting year. The Medway Link would welcome the opportunity of working with the Trust throughout the year so that LINk participants are able to assess whether the Trust are meeting its priorities and also input to next years. Respondents to survey would have appreciated having input to the process therefore being better informed when commenting.

In summary the Medway LINk feel the Trust should be commended on the excellent feedback received regarding patient experience. The Medway LINk looks forward to working with the Trust next year and undertaking an ongoing process of engagement and consultation with the public.

For and on behalf of Medway LINk

Signed by David Harris – Chairman
Medway LINk Governors Group

19 May 2011

Statement of directors' responsibilities in respect of the quality report

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

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

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

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010-2011;

- The content of the Quality Report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2010 – 2011
- Papers relating to Quality reported to the Board over the period April 2010 to June 2011
- Feedback from the commissioners dated 17 May 2011.
- Feedback from governors dated 06 April 2011.
- Feedback from LINks dated 19 May 2011.
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31 May 2011
- The latest national patient survey dated April 2011.
- The latest national staff survey dated 16 March 2011.
- The Head of Internal Audit's annual opinion over the trust's control environment dated 19 May 2011.
- CQC quality and risk profiles dated September 2010

- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;

- The performance information reported in the Quality Report is reliable and accurate;

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- The date underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

By order of the Board.

Date: 6th June 2011

Signed: V Hull, Chairman

Signed: M Devlin, Chief Executive Date: 6th June 2011

Independent Auditor's Report to the Board of Governors of Medway NHS Foundation Trust on the Annual Quality Report

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

Scope and subject matter

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

Respective responsibilities of the Directors and auditors
The Directors are responsible for the content and preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Reporting Manual 2010/2011* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that the content of the Quality Report is not in accordance with the *NHS Foundation Trust Manual* or is inconsistent with the documents.

We read the other information in the Quality Report and considered whether it is materially inconsistent with those documented below:

- Board minutes for the period April 2010 to May 2011;
- Papers relating to quality reported to the Board over the period April 2010 to May 2011;
- Feedback from the commissioners dated 17 May 2011;
- Feedback from governors dated 6 April 2011;
- Feedback from LINKS dated 19 May 2011;
- The Foundation Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31 May 2011;
- The latest national patient survey April 2011;
- The latest national staff survey 16 March 2011;
- The Head of Internal Audit's annual opinion over the Foundation Trust's control environment dated 19 May 2011;
- CQC quality and risk profiles dated September 2010.

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

This report, including the conclusion, has been prepared solely for the Board of Governors of Medway NHS Foundation Trust as a body, to assist the Board of Governors in reporting Medway NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Board of Governors to demonstrate that they have discharge their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibly to anyone other than the Board of

Governors as a body and Medway NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- Making enquiries of management;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents.

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

Limitations

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

Conclusion

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

Leigh Lloyd-Thomas
for and on behalf of PKF (UK) LLP
London, UK

6 June 2011

The Trust aims to provide the best quality services and always welcomes feedback on how we can improve. We hope you found this report helpful and if you have any suggestions, or would like to be more involved in helping to improve our services, please contact:

Director of Nursing
Medway NHS Foundation Trust
Medway Maritime Hospital
Windmill Road
Gillingham
Kent
ME7 5NY

Jacqueline.mckenna@medway.nhs.uk

Appendix 1

Quality Accounts – Engagement in Clinical Audits

Notes from Clinical Audit Table

[1] *National Neonatal Audit Programme (NNAP):* Continuous submission of data to the Neonatal Data Analysis Unit (NDAU) on all admissions to the unit.

[2] *National Paediatric Diabetes Audit*: Submission is retrospective: participation rate is for 2009-10 cases, which were submitted in 2010-11; data submission on 2010-11 cases takes place in 2011-12.

[3] *Adult Community-Acquired Pneumonia Audit:* Data collection continues into 2011-12.

[4] *Non-Invasive Ventilation Audit:* Trust participation in this audit commenced February 2011; data collection for current round continues into 2011-12.

[5] *Intensive Care National Audit & Research Centre Case-Mix Programme Database (ICNARC CMPD):* Continuous submission of data on all ICU patients.

[6] *National Audit of Heavy Menstrual Bleeding:* Organisational audit completed 2010-11; data collection for patient-related outcome audit continues into 2011-12.

[7] *National Pain Audit:* Organisational submission completed in 2010-11; clinical audit (patient-related outcome measures) takes place in 2011-12

[8] *UK Inflammatory Bowel Disease (IBD) Audit:* Data collection continues into 2011-12.

[9] *National Parkinson's Audit:* Data submitted for 100% of eligible patients for one out of three consultant neurologists. A new system is now in place to record all new referrals for Parkinson's disease separately, to allow future audit of all eligible patients.

[10] *European Chronic Obstructive Airways Disease (COPD) Audit:* Data collection continues into 2011-12.

[11] *National Joint Registry – Ankle replacements*: Only 4 procedures in 2010-11.

[12] *Patient-Reported Outcome Measures (PROMs):* Patients undergoing elective surgery are invited to complete pre- and post-operative questionnaires. Patient participation is voluntary.

[13] *National Audit of Percutaneous Coronary Interventional (PCI) Procedures:* All PCI procedures are entered concurrently onto the British Cardiovascular Interventional Society (BCIS) database.

[14] *Stroke Improvement National Audit Programme (SINAP):* Trust participation commenced July 2010 with submission of all stroke cases that elicited a response from the Stroke Team; full participation re transient ischaemic attack (TIA) cases now in place for 2011-12.

[15] *National Lung Cancer Audit:* Participation rate is for 2009-10 cases, which were submitted in 2010-11; data submission for 2010-11 cases will be completed in June 2011.

[16] *National Head and Neck Cancer Audit:* Only referral data uploaded onto DAHNO (Data for Head and Neck Oncology), as patients treated elsewhere in the cancer network.

[17] Severe trauma (*Trauma Audit & Research Network*): Trust participation commenced February 2011.

Appendix 2

Glossary

ACS	Acute coronary syndrome
BTS	British Thoracic Society – their objective is to improve the standards of care of people who have respiratory diseases
CfH	Connecting for Health – national programme for Information Technology to bring modern computer systems into the NHS
CHKS	CHKS is the name of a company that is the UK's leading independent provider of healthcare intelligence and quality improvements services
CMACE	Centre for Maternal & Child Enquiries
CMPD	Case Mix Programme Database
COPD	Chronic obstructive pulmonary disease
CQUIN	Commissioning for Quality and Innovation – enable NHS commissioners to reward excellence by linking 1.5% of income to achievement of local quality improvement goals
CTG	Cardiotocography – means of recording the fetal heartbeat during pregnancy
DAHNO	Data for Head and Neck Oncology - national database of information about the treatment of head and neck cancer patients
EQ	Enhancing Quality – programme to improve treatment and care of patients who have hip replacement, knee replacement, heart failure, heart attack or pneumonia
FCE	Finished Consultant Episode – an inpatient or day care episode where the patient has completed a period of care under a consultant
GTT	Global Trigger Tool – a method of using triggers to identify adverse events
HDU	High Dependency Unit – wards for people who need more intensive observation, treatment and nursing care than is possible in a general ward
HRG	Healthcare Resource Group – a group of patient events that have been judged to use a similar level of resource
ICNARC	Intensive Care National Audit & Research Centre
ICU	Intensive Care Unit – a specialised department that provides intensive-care medicine
IG	Information Governance – a set of standards that the NHS must follow to ensure it carries out its duty to maintain full and accurate records of care provided
LINKS	Local Involvement Network – groups of local individuals working together to improve health and social care services
MCH	Medway Community Health – the organisation that provides care for people in the community
MINAP	Myocardial Ischaemia National Audit Project
MRSA	Methicillin-resistant Staphylococcus aureas – a bacterium responsible for difficulty in treating infections
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NHS MEDWAY	Medway PCT – the organisation responsible for commissioning healthcare in Medway
NICE	National Institute of Health and Clinical Excellence – an independent organisation responsible for providing national

	guidance on promoting good health
NICOR	National Institute for Clinical Outcome Research
NIHR	National Institute of Health Research – organisation that aims to create a health research system in the NHS
NNAP	National Neonatal Audit Programme
OSC	Overview and Scrutiny Committee – committee with a council that aims to improve efficiency, transparency and accountability in local government
PALS	Patient Advice and Liaison Service – a person or team who help answer concerns of patients and the public
PCI	Percutaneous coronary intervention
PROMs	Patient Reported Outcome Measures
rca	Root cause analysis – a way of conducting an investigation into an identified problem to allow better understanding of the cause of the problem
RCOG	Royal College of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatrics & Child Health
SBAR	A communication tool that uses 'Situation, Background, Assessment, Recommendation'. It alerts people that action is required
SINAP	Stroke Improvement National Audit Programme – the national audit about care of stroke patients
SUS	Secondary Uses Service – is the single source of date which gives a range of reporting and analysis.
THINK GLUCOSE	Major national programme to improve the management of people with diabetes in hospital
VSGBI	Vascular Society of Great Britain & Ireland
VTE	Venous Thromboembolism – is a condition in which a blood clot forms in a vein
WHO	World Health Organisation – directing authority for health within the United Nations system

Contact information

Medway Maritime Hospital
Windmill Road
Gillingham
Kent
ME7 5NY

Telephone: 01634 830000
Website: www.medway.nhs.uk

Patient Advice and Liaison Service (PALS)
The PALS office offers support, information and assistance to patients, relatives and visitors. The PALS team can be contacted between 9am and 5pm Monday to Friday by telephone on **01634 825004** or **01634 830000 extension 5793**, by email at **pals@medway.nhs.uk**, or on 'level 2' in the hospital's main entrance area.

Working for the Trust
Details of vacancies can be found on our website at **www.medway.nhs.uk**

Volunteering
Enquiries relating to volunteering should be made to the voluntary services coordinator on **01634 830000 extension 5426.**

Membership office
For membership related enquiries, please contact the membership team on **01634 825261**. You can also apply to become a member online or print off an application form from our website at **www.medway.nhs.uk**