

# Medway NHS Foundation Trust Annual Report and Accounts 2012-13



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## Chairman's welcome

I am pleased to introduce Medway NHS Foundation Trust's 2012/13 Annual Report which marks my first year as Trust chair. It has been an eventful year with many twists and turns.

The NHS has remained in the national media spotlight and you will no doubt have seen some headlines about our Trust over the year. Headlines don't portray the full picture that despite huge growth in demand our staff do a fantastic job in caring for patients with compassion and kindness. I see it daily and hear from a range of sources just how good the hospital is. Sadly there are also times when we do not do things as we should and we do need to improve the way we listen to patients and staff to make further improvements. We are opening up further opportunities for staff to voice their ideas and concerns through the 'Listening into Action' programme. The projects staff have undertaken to make changes through this initiative are inspirational. Lots of effort from a growing number of staff can really improve how we work and the service we provide. We will do more over the coming year to encourage patients to give us their thoughts and to take actions to make changes – no matter how big or small they may be.

Proposals were developed during the year on how the Board will apply the findings and recommendations in the Francis Report to its work. We fully share the vision that the hospital will be known for delivering compassionate and high quality care. We want to address cultural issues with openness, transparency and candour and equally the standards of behaviour and performance we demonstrate as an organisation. We want to grasp the opportunity the Francis Report has prompted to us to refresh and raise our ambitions for Medway. There is more detail about the work we have done, and that which we plan to do, within this report.

Our governors are vital to the running of Medway NHS Foundation Trust and we really value the input they give; providing that important link between the NHS hospital and the communities it serves. Our public, partner and staff governors have been involved in a wealth of work over the year to help meet the Trust's priorities and to shape plans for the future. Over the year governors have scrutinised the care of the elderly, the progress around improving mortality indicators and the proposed plans for integration with Dartford and Gravesham NHS Trust. They have also helped to shape the Annual Plan priorities and the respect policy. On behalf of the Board, I would like to thank the Council of Governors for their time, effort and work to make improvements at Medway.

Finally, I would like to take this opportunity to say farewell and thank you to Jacqueline McKenna, Director of Nursing and Lois Howell, Director of Governance and Risk. The Trust Board welcomes David Meikle, Director of Finance, Jason Seez, Director of Strategy and Governance and Raj

Bhamber, Director of Organisational Development and Communications, and looks forward to working with them to take the Trust's vision and priorities forward over the coming year. We have a great deal to do in shaping future services in partnership with our GP colleagues and improving the reputation and confidence in our hospital.

Denise Harker  
Chair, Medway NHS Foundation Trust  
30 April 2013

## Chief executive's message

It has been an interesting time throughout the NHS nationally during 2012/13 and no less so for Medway Maritime, as Kent's busiest hospital. With the new healthcare landscape in the process of being implemented; the requirement to do more within the same financial resource continued and serious failures in the NHS care were highlighted in the Francis Inquiry Report. All organisations have had to face the reality of the events that occurred and develop assurances that this will not happen again – anywhere in the NHS. There is no doubt that these failures were appalling and should not have occurred. The media headlines have, perhaps understandably in this context, somewhat overshadowed the great work the NHS does every single day; delivering new life, carrying out life saving procedures, providing care for patients and caring compassionately for those at the end of life.

This is what the NHS should be all about and at Medway we have been working even harder to empower and encourage staff to share ideas and best practice; putting patient safety at the forefront of everyone's mind. In February 2013, the Trust welcomed the review into mortality indicators announced by NHS England. Despite improving year on year, the Hospital Standardised Mortality Ratio (HSMR) at Medway remains higher than the national standard. It is a complex healthcare statistic, which is affected by many different factors. Experts agree that HSMR needs to be looked at in conjunction with other markers of the quality of healthcare. In respect to other markers, the Trust performs generally well; e.g. the incidences of pressure ulcers and falls in hospital have fallen continuously and are in line with or better than national rates, and the Trust's infection rates are among the lowest in the South East. The Trust has invested continually in patient safety, and in October 2012, committed to extending the critical care outreach team to further improve the treatment of critically ill and deteriorating patients 24 hour a day, seven days a week.

The Trust has undertaken a lot of work with its healthcare partners to understand the many factors that can lead to a higher than average HSMR result. To support this it set-up a working party, chaired by the local director of public health, including membership of Trust clinicians and GP colleagues to oversee its approach to improving mortality. The Trust welcomes further input and advice from the Keogh Review team through their review process. The purpose of the review team's involvement is to assure patients that the Trust has done and continues to do everything possible to provide the highest quality care.

In light of the Keogh Review, the Trust took the decision to pause integration plans with Dartford and Gravesham NHS Trust to ensure the new joint Trust was built on solid foundations and to

allow time to focus on the review. Collaborative working in delivering clinical services has and will continue and both trusts still firmly believe that integration can bring significant benefits to the communities of North Kent.

The Trust launched 'Our Behaviours' which sets out the way we expect all staff to work with each other constructively and a new 'Respect Policy' which encourages complaints of bullying to be raised. This has helped to surface issues and take appropriate actions. A new way of working at Medway – 'Listening into Action' has also been introduced through a number of Big Conversations on key issues such as patient safety. These conversations provide an arena for staff to raise their concerns, put forward their ideas and secure support and resource to make positive changes in their areas for the benefit of patients. Hundreds of staff have participated in the new way of working with very positive results. Focus on these approaches will continue; promoting a culture where negative behaviour should not be tolerated under any circumstance and where every member of staff feels valued, heard and empowered to make positive change.

Despite some of the circumstances which have meant the Trust has not yet reached the point it had hoped, overall, most aspects of the Trust's work are heading in the right direction. Performance has been good with the exception of the four hour access target for the Emergency Department which was marginally missed by one percent.

The Trust fully met the Care Quality Commission's standards in 2012 for the first time; a major milestone in the improvement journey. The patient and Emergency Department surveys were both greatly improved and the cancer patient survey was outstanding. The Trust met other key performance indicators and the financial year-end was closed on a more positive note with a smaller variance to plan than in the last few years. Details are available later in this report.

The dedication and ongoing commitment of staff at Medway NHS Foundation Trust is amazing and I commend all the work they do.

Mark Devlin  
Chief Executive, Medway NHS Foundation Trust  
30 April 2013

# Directors' report

## About us

Medway NHS Foundation Trust is one of four hospital trusts in Kent. It serves a population of over 260,000 in Medway and around 136,000 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. Swale has had a steady increase in population year on year and it is anticipated due to increased housing provision that this trend will continue.

The Trust employs 3,880 members of staff and is supported by 700 volunteers, 26 governors and currently has 11,397 public members of the 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 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.

The vision for Medway NHS Foundation Trust is to become a centre of effective, modern healthcare delivery for the growing communities it serves. The aim is for the Trust to be 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 the Trust 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 increasing.

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

- Adult Medicine
- Emergency Department
- Surgery and Anaesthetics
- Children and Women
- Diagnostics
- Facilities and Clinical Support Services

In April 2008, Medway NHS Trust became a foundation trust which means that patients and the public can become a member of the organisation and get involved with some of the hospital's work.

Through members and the governors, the Trust is in a better position to listen and respond to the views of local people, patients and our staff. As a foundation trust, we remain firmly part of the NHS, but have greater freedom from central government control.

### **Business performance**

The Trust met the main targets and indicators in relation to patient experience during the year except for the maximum waiting time of four hours in the Emergency Department from arrival to admission/transfer/discharge (94 percent achieved against a target of 95 percent).

The referral to treatment waiting times should be less than 18 weeks and for non-admitted patients, the Trust achieved 97 percent against a target of 95 percent. For admitted patients, the Trust achieved 93 percent against a target of 90 percent. For patients on the incomplete pathway, the Trust achieved 96 percent against a target of 92 percent.

Two main safety targets relate to hospital acquired infections. The Trust had a target of no more than two cases of MRSA and only one occurred. The Trust did achieve the target relating to clostridium difficile as there were 16 cases against a target of no more than 26.

Targets are in place to measure timeliness of a first outpatient appointment for patients suspected of having cancer and for subsequent treatments if cancer is diagnosed. Patients suspected of having cancer should be seen within two weeks of a referral being made. The Trust saw 96 percent of patients within two weeks against a target of 93 percent. The five targets for the timeliness of subsequent treatment have all been achieved.

### **Financial performance indicators**

The Trust returned a deficit of £1.945m (including impairments of £165k), compared with a planned deficit of £1m. The deficit was adverse to plan by £0.8m (excluding impairments), an improvement of £0.9m on the variance to plan at the end of 2011/12. The Trust faced pressure on its resources, most notably from the premium costs of significant levels of activity above commissioner's plans throughout the financial year. In particular, the main drivers within the Trust were the achievement of the 18 week access target in all specialties and towards the end of the financial year, significant

pressure from emergency activity, which is directly related to demand management and the lack of control the hospital can exercise over numbers presenting.

As part of the plans for next year (2013/14), the Trust expects activity levels to grow, particularly in Emergency Department attendances, emergency admissions and chemotherapy patients. In addition, the Trust will be impacted by a 1.1 percent reduction in the prices it can charge for activity. The Trust will also be making significant investments in permanent nursing and medical staff to enhance the services provided to patients. The Trust is planning to deliver a £1.2m deficit (excluding impairments) for the financial year, £0.5m better than the actual performance in 2012/13, and a financial risk rating of three for every quarter.

The Trust's capital investment programme this year amounted to £6.2m and included expenditure on projects such as new gamma cameras, the continued implementation of new anaesthetic machines and further investment in the IT infrastructure of the hospital in preparation for delivery of wireless across the main building and the replacement of the Trust's PAS (Patient Administration System) in 2013/14.

In terms of external validation of its performance, Monitor assigns financial risk ratings of between one and five to all foundation trusts, with one being the lowest performance and five the highest. In 2012/13, the Trust scored a 'three', the same score as achieved in the previous financial year. The Trust was placed in significant breach of its terms of authorisation by Monitor in 2011/12. Despite the achievement of a risk rating of 'three' in the past two financial years, the Trust remains in significant breach at the end of the 2012/13 financial year. This has been included in the Trust's new Monitor licence for foundation trusts within the enforcement undertakings. We are committed to maintaining a 'three' during 2013/14 to facilitate our exit from significant breach and our longer-term strategic objectives.

## **Highlights of the year**

### **Trust picks up international award**

The Trust was thrilled to have won the Journal of Wound Care's, International Pressure Care Award 2013 at an awards ceremony in London in March 2013. The award is the result of work carried out by tissue viability nurses Tarnia Harrison, Hayley Jones and Logan Watkins, to reduce the number of acquired pressure ulcers – further improving patient safety, care and experience.

### **Trust launches service pledge in partnership with Breakthrough Breast Cancer**

The Trust was pleased to be working in partnership with Breakthrough Breast Cancer to launch its service pledge; making this pledge known through a new information booklet for patients who have been diagnosed with breast cancer.

Breakthrough Breast Cancer support individual hospitals to develop their very own service pledges tailored to the needs of their local patients. “It’s the little things like bringing a friend to an appointment that can make a huge difference to breast cancer patients; this view is at the heart of Breakthrough’s service pledge for breast cancer” said Catherine Wood from Breakthrough Breast Cancer. “The service pledge helps patients to speak up about what matters most to them about their local service and helps the hospital to improve these things.”

### **Prestigious accreditation for Medway’s imaging service**

The imaging department were proud to announce their achievement of the United Kingdom Accreditation Service (UKAS) Imaging Services Accreditation Scheme (ISAS) accreditation. The Trust is one of only 12 in the country to achieve this prestigious award.

The ISAS is a patient focused scheme based on the principle of independent assessment against a recognised standard. It demonstrates that the Trust has the competence to deliver against key performance measures related to patient experience, clinical outcomes, patient and staff safety, and efficient use of resources.

### **Improving birthing experiences**

Medway Maritime Hospital’s birthing facilities will be given a further boost after the Trust successfully secured a bid of £275k from the Department of Health. The Trust is one of 100 hospitals across the country sharing the government fund, available to upgrade and improve maternity services nationally.

The aim of the project, which will be completed this summer, is to create more pleasing, calming and relaxing environments. This includes making clinical equipment less visible – which improves confidence in a woman’s ability to birth without intervention. Privacy and dignity will also be improved and all birth rooms will have single access en-suites.

### **Delivering better care for patients with dementia**

The Trust has been working hard to improve the care it offers to patients with dementia and on 19 March, launched the national Butterfly Scheme at Medway Maritime Hospital.

Created by a family carer with a teaching background, the Butterfly Scheme allows people with memory impairment to request a specific form of personalised care during hospitalisation. It was developed for people with dementia, but is now able to offer the same support to anyone who may have similar care needs because their memory isn't as reliable as it used to be, or whose memory is temporarily affected by illness – which could be any of us.

### **Medway recognised for excellent cancer care**

Designed to monitor national progress on cancer care, results of the Department of Health's second National Cancer Patient Experience Survey were published in August showing some excellent results for Medway. The survey was conducted on patients treated between September and November 2011 and included 393 responses from Medway patients. Their feedback showed that cancer services provided by Medway NHS Foundation Trust are among some of the best in the country.

The survey results identified that patients fully understand explanations of their diagnosis and it is communicated sensitively; they feel involved in their care and are given appropriate written information throughout the course of their treatment about their condition and the support available to them.

### **Privacy for friends and relatives of patients on the Liverpool Care Pathway**

Having a friend or relative in hospital at any time can be worrying, but it is particularly difficult for friends and relatives when their loved one has reached the end of their life.

At this time family and friends need care, comfort and privacy too. At the end of last year, with the kind donation of £8k from the Medway League of Friends, the Trust was able to open the new Cedar room – a quiet place of rest for the family and friends of patients on the Liverpool Care Pathway – a care pathway designed to ensure that dying patients and their loved ones receive the best care possible in the final hours or days of life.

### **Oliver Fisher Unit tops national neonatal league table**

The Trust's Oliver Fisher Neonatal Intensive Care Unit is thrilled to be recognised as one of the top five neonatal units in the UK in providing high quality care by the National Neonatal Audit Programme. This programme, which is funded by the Department of Health through the Healthcare Quality Improvement Partnership (HQIP) compares performances between neonatal units nationwide. It also sets standards of best practice and outcome of care. The neonatal unit at Medway NHS Foundation Trust has participated in this programme since 2006.

Each year more than 5000 babies are born at Medway Maritime Hospital. While many will go home with their families on the same day, some babies will need intensive, high dependency, transitional or special care before they are strong enough to do so. Each year, around 900 babies from Medway as well as from across the entire county and beyond spend time being looked after in the Oliver Fisher Neonatal Intensive Care Unit.

## **Future developments**

The Trust developed its range of general and specialist services during 2012/13 and has further developments planned for 2013/14.

The West Kent Centre for Urology, introduced jointly with Dartford and Gravesham NHS Trust, has continued to provide improved access, improved patient experience and improved treatment outcomes. In late 2012, all surgery for kidney cancer was successfully centralised at Medway. Furthermore, a joint clinical director for urology was appointed across both the Trust and Dartford and Gravesham NHS Trust in 2013, in advance of the planned integration.

Other developments during 2012/13 include the Trust achieving level two trauma centre status, making it just one of three in Kent and Medway, as well as the appointment of a second spinal surgeon and continued growth in both paediatric and maternity specialities. Paediatric surgery, in particular, has seen significant developments in recent years, with the appointment of a paediatric surgeon on a substantive basis and the establishment of clinics at Darent Valley Hospital. The Birth Place, the Trust's midwife-led unit, also continues to flourish, celebrating its first anniversary and the delivery of over 800 babies over the course of the past year.

In 2013/14 the Trust will focus on:

- Delivering safe high quality care
- Attracting and developing a first class workforce
- Running an efficient acute hospital
- Managing our finances prudently
- In partnership, developing great healthcare

We have an ambitious programme of service developments planned for 2013/14:

- The Trust's research and development team have secured funding for a new MRI scanner. This will be installed in 2013 and will not only improve access for patients, but it will also

enable the Trust to participate in more clinical trials, such as the MARBLE (Magnetic Resonance Biomarkers in Neonatal Encephalopathy) under-5s trial.

- The Trust was one of 100 hospitals that successfully bid for a share in a Department of Health fund for 'normalising birth' projects. At Medway Maritime Hospital, women moving from The Birth Place to other maternity service areas reported that they felt as if they were moving from 'a five star to a two star' area. This funding will enable the remaining maternity service areas to be upgraded, to create a calm and relaxing environment throughout, including ensuring all birth rooms have single access en-suites. This development is due for completion in summer 2013.
- Several transforming performance projects involving service developments are lined up for 2013/14, including: Improving 'theatre productivity project', Dementia Unit project and better care of the elderly project.
- New state of the art gamma cameras will be installed in 2013, to enhance specialist nuclear medicine. The services arising from this new equipment will also be made available to patients of Darent Valley Hospital, in advance of integration.
- A new Patient Administration System (PAS) will be procured and deployed.
- The Trust is investing £1m in the Medicine Directorate to recruit consultants; improving care in a variety of areas, including: respiratory medicine, diabetes, sleep medicine, cardiology, haematology, gastroenterology and elderly care.
- Clinical directors from the Trust and Dartford and Gravesham NHS Trust are also working together to identify which service would benefit from partnership working.

The Trust recognises the importance and mutual benefits of partnership working:

- The Trust will build on the preliminary relationships formed with shadow Clinical Commissioning Groups, which became legal entities on 1 April 2013, to ensure services are developed in line with local community needs.
- The Trust will continue to work closely with community service providers to empower patients to manage their long-term conditions effectively at home, reducing their number of hospital visits.
- The Trust has firm relationships with a number of specialist service providers, enabling these services to be provided more locally to our patients and offering an additional choice to London hospitals. One example of this is the Trust's partnership with King's College Hospital, London, enabling foetal medicine and neurology services to be provided at Medway Maritime Hospital.

Further details on the Trust’s plans for future developments can be found within the Integrated Business Plan for integration with Dartford and Gravesham NHS Trust, published on the Trust’s website at [www.medway.nhs.uk](http://www.medway.nhs.uk)

## Trends and factors

The Trust uses trends, and takes into account factors affecting its local area and population, to inform its strategy and service development planning. These include demographic, social and health trend information. The Trust is committed to working with local stakeholders to manage and tailor services to meet the local population’s needs.

## Population

The Office of National Statistics (ONS) produces population estimates based on census findings – the latest mid-year estimate was released in September 2012, based on the results of the 2011 census. The overall populations of Medway and Swale for 2011 were 264,900 and 136,300 respectively. Figures are provided in the table below:

Medway			Swale		
Total	Male (%)	Female (%)	Total	Male (%)	Female (%)
264,900	131,400 (49.6%)	133,500 (50.4%)	136,300	67,400 (49.4%)	68,900 (50.6%)

(Source: ONS website)

## Population projections

*“The population of Medway is forecast to increase from 264,885 in 2011 to 290,337 in 2021; this represents an increase of 9.6% (+25,500). The rate of population growth in Medway at 9.6% is above the forecast growth for England (+8.6%) and the South East (9.3%). The largest growth in the Medway population is seen amongst those of retirement age, with over 64s increasing by 28% (+10,400), 0-15s increasing by 11% (+5,800) and those of working age up by 5% (+9,300). Natural growth – i.e births exceeding deaths – is the major component of population growth in Medway accounting for around +17,000 increase, with inward migration contributing a further 9,000 residents up to 2021.”*

Population projections, Medway Council (November 2012)

This suggests that the Trust should expect an increase in demand for both elderly care services and maternity services over the coming years. With the population living longer, and therefore having a greater incidence of long-term conditions, the Trust will be working closely with primary care and community care providers to ensure that such conditions can be effectively managed in the community.

### **Health and social trends**

The existing health profile for Medway (Department of Health 2011) also highlights several health and social trends, which have been factored into the Trust's planning:

- An aging population
- Younger age groups with a significant prevalence of obesity, diabetes and other long-term conditions
- Pockets of severe deprivation
- Increased prevalence of lung disease and other long-term conditions due to similar historical activities such as men working at the Dockyard and within the paper and cement industries
- Increased incidence of early deaths from cancer and an increased prevalence of coronary heart disease

### **Arrangements to govern service quality**

Governance and risk management processes are covered in more detail within the annual governance statement, which is presented towards the end of this Annual Report. The Trust has an established and robust approach to monitoring service quality, with a 'Board to Ward' governance approach through which both executive directors and non-executive directors visit clinical areas regularly. The Quality Committee supports the Board by gaining assurance on the development and monitoring of quality systems to ensure that clinical effectiveness, patient safety and patient experience are the key components of all activities of the Trust and there is a Trust lead for each of these elements of the quality circle. The Quality Committee reviews internal and external reports and audits about the Trust's services and ensures appropriate action is planned and implemented.

Each directorate also has its own audit, governance and safety leads, and each directorate holds regular directorate governance meetings which are regularly attended by a member of the central governance and risk team. This ensures there is a systematic and focused approach which is coordinated and consistent throughout all areas of the Trust.

Each directorate is required to produce, through its management team and governance lead, a monthly statement of its compliance or otherwise with all relevant essential standards. Action plans to address areas of actual or threatened non-compliance are completed, along with evidence to support the statements of compliance. Collection of the evidence and its collation into a Trust-wide resource is carried out by the central governance team.

Responsibility for overseeing the assessment of evidence in respect of the essential standards has been shared amongst the executive directors through a governance panel. Each governance lead comes before the panel to comment on the monthly statements produced by his/her directorate. The governance panel members challenge the governance leads and management teams and generally ensure that the information coming through from the directorates is robust and reliable.

The panel format, and the allocation of responsibility for particular standards amongst the executives, ensures that there is an executive with particular knowledge of each of the standards and of the evidence produced by all of the directorates in respect of those standards, who can lead the challenge each governance lead.

The Care Quality Commission has no outstanding quality concerns or conditions on the Trust's registration.

### **Principle risks and uncertainties**

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

At the start of 2012/13, the Trust's BAF was comprehensively revised in order to identify the principal risks to the achievement of the Trust's strategic objectives for the year and set out mitigation plans. The BAF has been re-visited and updated throughout the year to ensure the Board is kept apprised of threats to its strategic success and assured in respect of the measures in place to address those risks.

The BAF is reviewed and updated bimonthly by the company secretary and the lead executive for each of the annual corporate objectives that he or she 'owns'. At the same time, progress against each of the strategic objectives is considered and the Board receives a bi-monthly report on both the risk and progress updates.

The Trust's BAF and associated processes were audited during 2012/13 by the Trust's internal auditors. The results of the audit were that the BAF provides the Board with 'significant assurance' about the risks to achievement of its strategic objectives and their management.

The corporate risk register also continued to play a significant part in enabling effective risk management of the Trust. The corporate risk register is reviewed 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.

### **Adult inpatient bed capacity**

Patient experience and outcomes arising from adult inpatient bed capacity has been the most frequently cited top risk on the risk register. The Trust has put in place further measures to address capacity issues, including the refurbishment and expansion of the Admission and Discharge Lounge, the expansion of the Hospital @ Home service through the introduction of a surgical bridging team and revised the patient pathways in adult medicine to redesign the wards to incorporate short stay and specialty specific conditions. The Trust continues to review its resources and their use to ensure efficiency and has planned to enlist the support of the emergency care intensive support team in early 2013/14 to help address the capacity risks that have emerged within the Emergency Department this year.

### **Patient care**

The Trust approach to patient safety has been entirely focused on reducing harm and avoidable deaths. The Board of Directors recognise that the Trust has an ongoing issue with Hospital Standard Mortality Ratio (HSMR) and we are fully committed to both identifying the causes and acting swiftly and comprehensively to make improvements. Our results demonstrate sustained improvement in key elements of our patient safety metrics. We do, however, recognise that our HSMR has not improved correspondingly and in December 2012 set up the Mortality Working Party, a multi-agency group to support us in an increased focus on improving patient safety and reducing our HSMR. The working party is independently chaired by the director of public health for Medway. This work has been supported internally by actively engaging with our staff utilising the Listening into Action programme, of which the Trust is a national pioneer.

On 6 February, the Prime Minister announced that he had asked Professor Sir Bruce Keogh to review the quality of care and treatment provided by those NHS trusts and NHS foundation trusts that are persistent outliers on mortality indicators. Fourteen hospital trusts will be investigated as part of this review on the basis that they have been outliers for the last two consecutive years on

the Summary Hospital-Level Mortality Indicator or the Hospital Standardised Mortality Ratio. Medway NHS Foundation Trust has been identified as one of these hospitals.

The Trust is expecting the visit to take place over two days and there will also be one unannounced visit. At the time of writing this Annual Report the review report was not available.

More information on patient safety indicators can be found in the Quality Report, presented later in this Annual Report. Complaints handling, staff and patient survey results, service developments and targets agreed with the commissions can be found in other sections of the report.

### **Meeting savings targets**

National and local demand for savings has been cited throughout the year as a risk to the development of new services. However, innovative approaches to efficiency have meant that the Trust has been able to introduce many of the new services contemplated, despite these concerns. The Trust has had to make significant savings throughout the year. The impact of all savings plans has been monitored throughout the year to ensure that the drive for efficiency has not compromised patient safety or other quality indicators.

### **External audit services**

The Council of Governors agreed that PKF (UK) LLP should be the Trust's external auditor for 2011/12. On 28 March 2013, PKF (UK) LLP merged its business into BDO LLP and the Trust has notated the contract for the supply of statutory audit services to the merged firm. Accordingly, the auditor's report is in the name of the merged firm.

The Trust incurred £76,000 in audit services fees in relation to the statutory audit of the Trust to 31 March 2013, which included the fees for auditing the Trust's Quality Report for 2012/13 (see note 5 of the annual accounts). In addition to the above, £1,700 was paid in respect of the auditor's involvement in providing information to other advisers to support the Trust's proposed merger with Dartford and Gravesham NHS Trust.

## **Statement as to disclosure to auditors**

For each individual who is a director at the time that the report is approved:

- So far as the director is aware, there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware; and
- The director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information.

## **Going concern**

In March 2012 the Trust agreed a renewal of its working capital facility with Lloyds Bank Plc until the end of May 2014. This, combined with the cash balances held at the end of March 2013, and the projected cash flows under the current business plan, provide Trust directors with the reasonable expectation that Medway NHS Foundation Trust has adequate resources to continue to operate for the foreseeable future.

It should also be noted that the principal risks and uncertainties affecting the Trust have been disclosed within the Directors' report and the directors consider that the actions taken to address these factors do mean that there are no material uncertainties that would cast significant doubt about the ability of the Trust to continue as a going concern. For both this reason and the aforementioned levels of liquidity, the Trust continues to adopt the going concern basis in the preparation of its accounts.

## **Community 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.

The Trust is committed to partnership working and wishes to nurture and develop relationships further in 2013/14. Through participation in joint working, the Trust intends to review how it provides services to patients and will make every effort to re-design and enhance services in order to respond to patient choice and commissioning strategies and ensure appropriate use is made of hospital capacity. The Trust will also utilise the valuable resource of its membership to progress these endeavours.

## Handling complaints

While the Trust is always concerned when a patient or visitor has a dissatisfying experience, it is pleased to receive feedback and encourages anyone who feels it necessary to raise their concerns, to do so through the Trust process. Medway NHS Foundation Trust believes concerns raised by the patient or their relative/representative is an opportunity to learn from their experience of our service. It is important that complaints are investigated thoroughly under the NHS complaints procedure and the results of the investigation shared with the complainant in an open and honest way. We value the feedback provided by our local community and view it as an opportunity to learn and make changes to the service we provide. Complaints handling is an integral part of service improvement and can be an early indication of a problem within a service or department.

The complaints team provides training to staff including nurses, junior doctors and new members of staff joining our organisation. This training helps to give staff an overview of why it is important to listen to feedback given, how they can help in responding to a complaint, how we investigate complaints, what is done with the information gained and how the information is shared within the organisation. A particular emphasis is placed on customer care and the importance of it. The Trust continues to work to improve the complaints procedure and to ensure staff learn from feedback in order to improve experiences for patients, relatives and visitors.

The complaints team has conducted a further survey in quarter two this year to assess the complainant's view of the complaints process. Thirty-seven percent of complainants responded to the survey. Responses show that 95 percent of complainants indicate that an acknowledgement letter and leaflet were received, 88 percent of complainants stated the chief executive's letter was written in terms which were entirely understandable. Fifty percent of complainants indicated that their complaint was resolved with continued local resolution and 52 percent felt satisfied with the way in which their complaint was handled. Effective complaint handling demonstrates the learning needed to ensure changes are implemented and improvements are made.

A total of 569 formal complaints were received this financial year. This is an increase of 17.5 percent from the previous year. This is within the context of increases to activity levels in the Trust this year.

The Trust was pleased to receive 740 WOW award nominations in the same period where patients commended staff for going above and beyond their call of duty to provide excellent care.

<b>Financial year</b>	<b>Total number of complaints received</b>
2009-2010	569
2010-2011	552
2011-2012	484
2012-2013	569

The 72 complaints received in March were being investigated at the time of writing this report. Of the 497 complaints received for the first 11 months of the year, 83 percent were responded to within the Trust's target of 25 working days. This equals the performance of 83 percent in 2010/2011.

The complaints manager works closely with the directorates to ensure that complaints are managed in accordance with the NHS complaints procedure and to ensure that any actions taken and lessons learnt are meaningful and captured by the directorates so that positive actions are shared within the organisation. The complaints manager attends directorate complaints/governance meetings on a monthly or bi-monthly basis and provides complaint data and feedback to ensure the senior management team within each directorate is made aware of the trends and concerns being raised.

A scorecard has been introduced to provide each directorate with a snapshot of their complaint data. This enables them to compare complaints received with the previous financial year and to quickly see where the problems are within the directorate.

There has been a change of Parliamentary and Health Service Ombudsman this year; although the guidelines remain unchanged at the present time. The Trust is aware of 11 complaints referred to the Ombudsman in 2012 /13 and of these the Ombudsman has upheld one.

## **Sustainability and climate change**

The Trust recognises that due to the scale and diversity of its operations it has the potential to significantly affect the environment, on both a local and global scale. In order to better manage our impact, we now have a Board approved sustainable development management plan.

Although there was an increase in gas consumption during the last 12 months from a total of 46953 MWh in 2011/12 to 47354 MWh in 2012/13. A number of energy saving initiatives were implemented this year to reduce heat loss, including the latest design of valve wrap pipe insulation. Despite this we have still seen an increase in consumption of gas and that is attributable to a colder than average year. The NHS uses degree days as a way of monitoring the way we heat our buildings; 2012/13 had ten percent more degree days than the 20 year average and, more

significantly, 20 percent more than 2011/12, so we are pleased that we managed to minimise the impact of the unusually cold weather through other measures.

This year was the first year of the government's 'Carbon Reduction Commitment' scheme and, as we are a large user of electricity, the Trust had to pay a sum of £92k for the purchase of credits in relation to the carbon we emitted through our activities. The aim of the scheme is to encourage organisations like ours to reduce our energy use by the incentive of reducing the amount of credits we need to purchase.

The Trust has continued to implement energy saving projects and has recently completed the installation of LED lights to the top deck of the car park and installed a number of new drives for the ventilation fans which reduce the amount of electricity they consume. This year has seen an increase in staff engagement with the energy saving message and the knowledge that all of us can make a difference to our impact on the environment.

Last year we again provided workplace mentoring for a trainee clerk of works from Brompton Barracks RSME. We are able to give real life experience of equipment and environmental controls to enable them to put into practice their academic training prior to being qualified to work in the field, UK or elsewhere. In addition, the energy team have assisted Mid Kent College in developing a sustainability module and provided learning support in the classroom.

## **Valuing our staff**

### **Workforce statistics**

We are one of Kent's largest employers with around 3,880 staff from a variety of backgrounds. Sixty-six percent are clinical staff comprising 29 percent qualified nursing, 12 percent medical and dental, three percent allied health professionals and 22 percent other clinical. Thirty-four percent are non-clinical staff groups incorporating 12 percent maintenance and 22 percent administrative and clerical staff.

## 2012/13 data

Ethnicity		
White	3006	77.47%
Asian	412	10.62%
Black or black British	146	3.76%
Mixed	60	1.55%
Other	256	6.6%
<b>Total</b>	<b>3880</b>	<b>100%</b>

The table below shows the national data by ethnicity

### Medical staff

% White	% Asian or Asian British	% other ethnic group	% unknown ethnicity
55%	27%	12%	7%

### Non-medical staff

% White	% Asian or Asian British	% other ethnic group	% unknown ethnicity
82%	6%	8%	4%

<b>Age</b>		
16 - 20	7	0.6%
21 - 25	316	8.17%
26 - 30	400	11%
31 - 35	452	10.93%
36 - 40	471	12.22%
41 - 45	528	13.17%
46 - 49	473	11.52%
50 - 55	628	17.06%
56 - 60	400	10.36%
61 - 64	147	3.87%
65+	26	1.11%
<b>Total</b>	<b>3,880</b>	<b>100%</b>

<b>Gender</b>		
Female	3,131	80.77%
Male	717	19.23%
<b>Total</b>	<b>3,880</b>	<b>100%</b>

The table below shows national data by gender

#### Medical staff

% Female	% Male
44%	56%

#### Non-medical staff

% Female	% Male
81%	19%

The Trust is committed to equality of opportunity for everyone and strives to provide an environment free from discrimination, harassment or victimisation and one where everyone receives fair and equal treatment regardless of gender, sexual orientation, race, colour, age, nationality, ethnic or national origins, marital status, religious belief or disability.

The Trust has been awarded the Disability Symbol; part of this means that disabled applicants will be given an interview for a job if they meet the essential skills criteria for that post. The Trust is, therefore, committed to guaranteeing an interview for all disabled applicants meeting essential criteria for the role. In order for the individual to receive an invitation to attend for interview under this criterion, they must disclose that they have a disability on their application form.

### **Staff survey**

The Trust has sought to improve staff engagement in 2012/13 and will continue to do so in 2013/14. Staff engagement is encouraged through a range of means, from chief executive open door sessions and monthly briefings, to a Leadership Forum and formal engagement with local trade unions. In 2012 a new approach to staff engagement known as 'Listening into Action' was launched and continues to grow in terms of implementation and cultural change.

Staff feedback is also gathered through the annual staff survey, patient safety visits and staff appraisal.

The Trust took part in the tenth national staff survey in October to December 2012. This survey ranks the Trust compared to other acute trusts on 28 key findings.

<b>Staff survey results</b>	<b>Trust 2011</b>	<b>National average 2011</b>	<b>Trust 2012</b>	<b>National average 2012</b>
Response rate	45%	54%	43%	50%
Overall staff engagement	3.59	3.62	3.61	3.69

### Five top ranking scores

Key factor	Trust 2011	Trust 2012	National average 2012
Percentage of staff witnessing potentially harmful errors, near misses, or incidents in the last month	32%	30%	34%
Percentage of staff saying handwashing materials are always available	67%	63%	60%
Percentage of staff feeling under pressure in the last 3 months to attend work when feeling unwell	30%	28%	29%
Percentage of staff having well structured appraisal in the last 12 months	32%	37%	36%
Percentage of staff able to contribute towards improvements at work	61%	68%	68%

### Five bottom ranking scores

Key factor	Trust 2011	Trust 2012	National Average 2012
Percentage of staff working extra hours	70%	78%	70%
Work pressure felt by staff (score out of 5)	n/a	3.25	3.08
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	94%	86%	90%
Percentage of staff receiving job-relevant training, learning and development in the last 12 months	81%	77%	81%
Percentage of staff agreeing that their role makes a difference to patients	88%	87%	89%

The Trust recognises that there have been improvements in a number of areas in which we concentrated our efforts. Staff satisfaction and staff engagement both recorded higher scores than 2011. There was also an increase in people feeling like they can contribute to making improvements in their work areas and also that our appraisal process is giving people the opportunity to have a valuable discussion about their progress and performance over the year. We also can see an increase in the number of staff who would recommend the Trust to a family member or friend if they needed treatment. This shows a positive and open commitment to the care that we give every day in our hospital. These are all positive indications that these actions are the moving us in the right direction and ones that we need to continue to work with and embed.

The Trust is pleased to see that this year there have been some signs of improvement for us; we have taken some clear steps to improve many aspects of working at Medway. Some of the steps and actions we have taken are:

- We have introduced 'Our Behaviours' as a core set of behaviours for everyone working at Medway.
- We have started to work in a new way, using the Listening into Action work as a different way to address what is important to staff.
- We have continued to embed our new appraisal process across the Trust and this appears to be working very well.
- We have revised our approach to harassment and bullying by promoting respect.
- Our infection control record and availability of hand washing materials remain high.

There were some disappointing results within the survey as well and more work is needed to improve in some areas. The focus of improvements in 2013/14 will continue with a number of the themes described above, but will also focus on reviewing staffing levels in key clinical areas, ensuring we reduce our reliance on temporary staff, and targeted action at directorate level.

### **Future priorities and targets**

We are developing our plans within the Trust and an established sub-group of the Board, including the interim director of human resources and non-executive directors, oversee the development of the plan. The plan will focus at a corporate, directorate and team level to drive actions at all levels to make a positive improvement and engage all staff to support changes.

## **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 working environment. We believe that every member of staff has a right to work in an organisation that commits to caring for and developing its staff. The Trust's staff are its greatest asset and we realise that improving 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 a member of the IWL group in the workplace. Staff are recognised amongst peers by way of verbal recognition from a member of the executive team, and receive a certificate and a small financial reward.

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
- promotion of extensive list of discounts for Medway staff
- working with the Trust Board to develop an action plan and implement any findings to improve the results of the staff survey
- continue with commitment to deliver a work plan to improve the working lives our staff – examples of these are investments in staff areas and projects suggested by staff
- continue to develop an effective work plan to improve the working lives of our staff
- supporting health and wellbeing initiatives such as Weight Watchers and subsidised exercise classes via the occupational health team

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. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

## **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 understanding of what is important to people who use the Trust's services, based on their needs and preferences.

The Trust recognises that this requires giving due regard to race, sex, disability, age, religion or belief, sexual orientation, gender reassignment, pregnancy and maternity and marriage and civil partnership, collectively known under the Equality Act 2010 as the 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's equality, diversity and human rights training needs analysis has been updated to ensure that training is provided for all staff and covers the required elements of information.

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

## Regulatory ratings

As a foundation trust, we are required to provide Monitor, the foundation trusts' regulatory body, with quarterly reports on our performance. In 2012/13, the Trust's declarations to Monitor were as follows:

	Q1	Q2	Q3	Q4
<b>Financial Risk Rating</b>	2	3	3	3

The Trust's governance risk rating declarations to Monitor were 'red' throughout the year because the Trust was in significant breach of its authorisation. But for the automatic 'red' override applied to the Trust's governance risk rating, the Trust's governance risk ratings would have been as follows:

	Q1	Q2	Q3	Q4
<b>Governance Risk Rating</b>	Amber-green	Green	Green	Red-Amber

## Financial Risk Ratings (FRR)

The Trust achieved an FRR of three from quarter two onwards, having had an FRR of two in quarter one. This trajectory has meant that the Trust has delivered its FRR in accordance with the 2012/13 Annual Plan and improved from 2011/12, where only quarter four achieved an FRR of three.

The Trust's reported financial position has been close to its planned position for the 2012/13 financial year. In delivering the year end position, the Trust has had to manage significant activity demand, over contracted levels. This has necessitated maximising the use of capacity and incurring premium costs, eroding the financial benefit from providing the additional activity. It has also meant that the full spectrum of planned cost savings could not be delivered, with the Trust delivering £16m of its planned £17.4m efficiency programme.

The Trust has continued to improve its liquidity position during 2012/13. The Trust did not have any need to access its working capital facility during the year and ended the year with a cash balance of £7.1m.

It is the policy of the Trust to maintain trade creditors at the lowest and most effective operating levels whilst also maintaining effective levels of liquidity. Prioritisation is given to the payment of non NHS trade creditors in order to ensure continuity of supply at all times.

The Trust remained in significant breach of its terms of authorisation with Monitor during 2012/13.

### **Governance risk ratings**

The Trust's consistent 'red' governance risk rating throughout 2012/13 arose from the Trust being in significant breach of its authorisation as a foundation trust.

In April 2011, Monitor advised the Trust that it was in significant breach due to insufficient Board level scrutiny and assurance processes concerning financial planning, and the Trust's consequentially poor financial outturn at the end of 2010/11. The Trust has worked with Monitor throughout 2011/12 and 2012/13 to help to address Monitor's concerns. A range of actions have been implemented to improve financial governance and these actions have resulted in demonstrable benefits to the Trust's position. Work to assure Monitor that these improvements are embedded and sustainable is continuing.

In April 2013, a new provider licence was introduced by Monitor. Monitor's view is that the circumstances that led to the Trust being in significant breach of its terms of authorisation could also give rise to breaches of its provider licence. As a result, there are limited conditions on the Trust's provider licence, requiring a financial plan and urgent care plan to be put in place and implemented in 2013.

In the Trust's 2012/13 Annual Plan, risk was identified in two areas: the four hour access target in the Emergency Department and incidences of C. difficile. In quarter one, the issue preventing the Trust from reaching a green risk rating was performance against the four hour access target in the Emergency Department. In quarter four, the issues preventing the Trust from achieving a green risk rating were performance against the four hour access target in the Emergency Department and greater incidence of C. difficile than planned for.

In 2013, the Trust is focusing on developing and implementing an urgent care action plan to ensure that the four hour access target in the Emergency Department can be met consistently.

Although the Trust saw a greater incidence of C. difficile than planned for in quarter four, it was still well below the planned target for 2012/13 overall, and is the best year's performance to date.

Failure to meet this target in quarter four was due to an isolated cluster of C. difficile on one ward and the Trust has taken appropriate action to reduce the likelihood of this happening again. These actions include:

- ‘Enhanced measures’ audits instigated following each case of post 72 hours C. difficile
- Wards remain in enhanced measures until 28 days from the last C. difficile case and all indicators reach 95 percent
- Compliance scores are incorporated into the infection control monthly statistics
- Clinical teams present the outcomes, lessons learned and action plans from C. difficile root cause analyses to directorate governance meetings, to ensure that clinical practice and staff understanding of infection control policy is embedded into the daily working practices of the wards’ routine.

## Income disclosures required by Section 43(2A) of the NHS act 2006(As amended by the Health and Social care Act 2012)

The Trust has complied with the requirement of section 43(2A) in that income from the provision of goods and services from the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes. The levels of other income received by the Trust has had little or no impact upon the its provision of goods and services for the purposes of the health service in England.

## Quality Report

### Part 1 - Statement on quality from the chief executive

It is my great pleasure to introduce you to our Quality Report and to highlight some of our improvements in the quality of the services we have provided over the last year.

Quality could not have a higher profile in the NHS in the context of the recent Francis Inquiry Report publication. At Medway NHS Foundation Trust, we have been working to improve the quality of our services for some time and across a range of issues, with a good deal of success. For example, established measures of “harm free” care have shown steady improvement and pathways for important conditions, such as dementia have also improved.

Notwithstanding this, the Hospital Standardised Mortality Ratio (HSMR) has only shown modest improvement year on year and continues to be higher than average. This has led to the Trust being identified as one of fourteen to be reviewed in early 2013/14. We welcomed this review and the

opportunity to share our work to date. We know that we have more to do and can always learn from the experience of others. Therefore, in the course of the year we have been working openly with other organisations on several fronts and are grateful for their input.

Although a challenging year, the Trust has continued to improve the quality of its patient services, working towards a culture that supports the delivery of the very best healthcare for our communities. The feedback from patients in the inpatient and Emergency Department surveys published last year has shown significant improvement. The results of the 2012 cancer patient survey were quite outstanding and compare favourably with the best in the NHS.

The Trust quality programme for 2012/13 and beyond is focused around three themes:

- Patient safety
- Patient experience
- Clinical effectiveness

Delivering high quality care is the key strategic objective of the Board and each director has responsibility for improving the quality of care, with the director of nursing and medical director taking particular lead roles. Members of the Board have continued to make quality of care visits to clinical areas throughout the year; these have enabled the directors to engage first hand with patients and staff about issues of safety and experience.

The Trust also continues its work on Enhancing Quality (EQ) a clinical change programme that uses quality measures which indicate 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 patient experience.

A new initiative adopted by the Trust, as one of ten national pioneers in 2012, called 'Listening into Action' provides an opportunity for frontline staff to put forward ideas and solutions that would ensure a better experience for both patients and staff alike. Approximately 700 staff have participated in 'Big Conversations' this year, with the latest in March 2013 being focussed on patient safety.

Our strategy of delivering 'Better Care Together' with Dartford and Gravesham NHS Trust means improved local services for patients and their families, better health outcomes and better use of resources. In 2012/13, we continued to forge partnership working between our two trusts in preparation for integration.

In 2012/13 we have worked hard and successfully to further improve our excellent infection prevention and control record. Our team and their results are leaders in the field.

In part two of this report you will see in more detail what we will do in the year ahead to further improve quality and safety. Part three shows the outcomes of our focus on quality and safety for 2012/2013.

It is my responsibility, as chief executive officer to ensure the Trust presents an honest and accurate account of the work done by staff at Medway NHS Foundation Trust. I hope that as you read this Quality Report you will be reassured by the commitment and dedication of our staff without whom, these achievements would not be possible.

I confirm that to the best of my knowledge the information you will find in this Quality Report is accurate.

M Devlin, Chief Executive

Date: 29 May 2013

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

Part two of the Quality Report looks forward over the next financial year 2013/14 and explains clearly what areas have been identified as priorities for improvement, why these priorities have been chosen, how improvement will be achieved and how it will be measured.

There are also Board statements in relation to the quality of services the Trust provides.

### Looking forward: Priorities for improvement 2013/14

It is essential that as many people as possible are involved in developing the priorities for next year. The consultation for the priorities for 2013/14 started with a review of last year's performance on the chosen priorities.

Nine priorities (Table 1) were then recommended for next year. These were presented to the Council of Governors, members' meeting, executive directors, clinical directors, general managers and heads of nursing / midwifery for consultation. Consultation was also sought from the NHS North Kent Clinical Commissioning Group and Medway LINKS

Taking everyone's views into consideration, the nine priorities for improvement for 2013/14 are set out in Table 1 below. Following the table an explanation has been given for each priority chosen.

**Table 1: Looking forward – priorities for improvement for 2013/14**

<p><b>Patient safety</b></p>	<ul style="list-style-type: none"> <li>• Ensure harm free care</li> <li>• Improve HSMR</li> <li>• Improve access and reporting in diagnostics</li> </ul>
<p><b>Patient experience</b></p>	<ul style="list-style-type: none"> <li>• Improve the patient experience in outpatients</li> <li>• Improve the patient experience in the Emergency Department</li> <li>• Improve the discharge experience for patients and their carers</li> </ul>
<p><b>Clinical effectiveness</b></p>	<ul style="list-style-type: none"> <li>• Improve aspects of care given to the frail elderly</li> <li>• Improve aspects of care within maternity care</li> <li>• Improve aspects of care within the paediatric services</li> </ul>

Each priority has been given measurements targets that will allow us to demonstrate the improvement made over the coming year. A concise table indicating these measurements can be seen in Table 2 below.

**Patient safety**

- **Ensure harm free care**

Almost all patients in hospital have an increased risk of developing harm while in hospital. Specific areas of practice have been noted in recent years to have an effect on patient safety. We want to deliver safe care and remove avoidable harm and preventable death. We will do this by measuring four main areas:

- Using the national safety thermometer tool which looks at the four harms; pressure ulcers, falls, blood clots and infections with in-dwelling catheters.
- Ensuring our patients are assessed on admission for risk of blood clots / thromboembolic event (VTE).

- Ensuring our patients are prescribed the appropriate prophylaxis to avoid a thromboembolic event (VTE).
- Ensuring there is a failsafe process to avoiding 'never events'; these are defined as serious, largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented. While the term 'never' signals an aspiration, the occurrence of one of these events is potentially an indication that a hospital may not have put in place the correct systems and processes to protect patients. The Department of Health first introduced a policy on never events in 2009, with a core list of eight. The list has now been expanded to 25, of which 23 apply to acute trusts. The full list can be found at [www.dh.gov.uk](http://www.dh.gov.uk)  
Any never event reported is escalated via our serious incident process and is subject to a detailed analysis and review called a Root Cause Analysis (RCA), so that learning is identified and shared. An example of a never event would be wrong site surgery.
- Ensuring there is a concerted effort to manage patients with sepsis, the Quality Account omitted medications audit will concentrate on antibiotics in 2013/14.

- **Improve Hospital Standard Mortality Ratio (HSMR)**

HSMR is a measurement system which compares a hospital's actual number of deaths with their predicted number of deaths. The prediction calculation takes account of factors such as the age and sex of patients, their diagnosis, whether the admission was planned or an emergency. If the Trust has a HSMR of 100, this means that the number of patients who died is exactly as predicted. If HSMR is above 100 this means that more people have died than would be expected. An HSMR below 100 means that fewer than expected died. The Trust recorded an annual HSMR of 112 in 2011/12 which is an improvement from 115 in 2010 /11; however it does remain a concern. The main areas of measurement that we believe could demonstrate improvement are:

- Reduce actual HSMR rate by reducing the 'relative risk' score in four main areas:
  - Septicaemia (except in labour)
  - Acute cerebrovascular disease
  - Acute and unspecified renal failure
  - Chronic obstructive pulmonary disease and bronchiectasis

- **Improve access and reporting in diagnostics**

A number of patient safety reviews have indicated in the past year that delays in diagnostic imaging could be influencing patient safety. To that end we will measure time of request to investigation completed and report sent for review.

## **Patient experience**

### **• Improve patient experience in outpatients**

The NHS national outpatient survey is administered and used in the same way as the annual inpatient survey. The outpatient survey was conducted during 2012 and is sent to patients who attended an outpatient appointment. The survey asks a range of questions in the following categories: Before the appointment, waiting in the hospital, hospital environment and facilities, tests and treatments, seeing a doctor, seeing another professional, overall about the appointment, leaving the outpatients department and overall impression. We want to improve the experience for outpatients and intend to measure four areas that will indicate that we have achieved that goal.

The four areas are:

- Reduce the number of cancelled and changed appointments
- Number of formal complaints received and upheld
- Increase the number of PALS contacts to improve immediate resolution
- Increase the number of patients who wait < 15 minutes to be seen

### **• Improve patient experience in Emergency Department**

One of the most important questions within the Emergency Department National Survey, which is used as a proxy measure to gauge how well we are doing in looking after our patients is “overall, how would you rate your care”. A higher rating is indicative that patients are having a good experience and are generally satisfied with the quality of care they have received. The Trust scored 70 percent in 2012/13 and are aiming to increase that to 80 percent next year. This remains one of the measurements that will be used in 2013/14 to ensure improvement in this area as seen below:

- Friends and Family test
- National overall experience

### **• Improve the discharge experience for patients and their carers**

There has been concern raised from our community partners that this is not as effective as it needs to be. To that end it was decided to focus on areas of the discharge process that could enhance the experience for our patients and their carers. We will measure:

- Number of ‘transfer of care’ concerns
- Inappropriate discharges at night

- Delays to discharge reported in the national survey
- Inappropriate readmissions

### **Clinical effectiveness**

- **Improve aspects of care given to frail elderly**

There continues to be a national focus on patients living with dementia. We need to be aware of all inpatients that are diagnosed or require memory assessments. There is also a strong link with patient safety and hydration with this group of patients and we will monitor that over the coming year. The main measurements that we have chosen to demonstrate improvement are:

- Continue to identify all inpatients > 75yrs, assess for memory loss and refer appropriately
- Implement the dementia 'Buddy' scheme across the Trust
- Develop dementia friendly environments
- Improve hydration

- **Improve aspects of care within maternity care**

There are two main areas within maternity that are believed to enhance safety for mothers. The WHO checklist has been implemented for surgical procedures within the general theatre environment but not wholly implemented within the obstetric theatre – this will be rectified over the coming year. The other main area is ensuring a safe staffing level of midwives. The current established ratio of midwife to woman is 1:34. This will be improved to 1:33 over the next year.

- Implement the WHO checklist in the obstetric theatre
- Improve midwife to mother ration to 1:33

- **Improve aspects of care within paediatrics**

Medway Foundation Trust has a large paediatric department which includes community services. Two main areas were indicated that would influence the care our babies and young people receive. Medication errors relating to gentamicin were chosen as they have a direct correlation with harm and health assessments for 'Looked after Children' (LAC) was chosen as we have a large cohort of LAC within Medway.

- Eliminate medication errors relating to gentamicin in neonates
- Ensure LAC children have an individual health plan

### **Achieving our priorities**

Similar to last year, each priority will have a lead in each directorate and an executive lead who will implement appropriate actions to achieve better results.

The Quality Performance Monitoring Committee, implemented during 2011/12 will continue. Its success was evident last year in closely monitoring the Trust's performance in relation to all quality indicators (CQUIN, priorities in the Quality Account and indicators in the contract) and to take prompt action to improve performance. The meeting will continue to be chaired by the director of nursing with a representative from each directorate management team as members of the committee.

The table below gives more details about what will be measured. Each priority has been given a target for improvement which will be monitored through the Quality Performance Monitoring Committee. The list of priorities and how they will be measured with targets is tabled below:

**Table 2: Quality priorities for the year ahead – 2013 /14**

<b>Category</b>	<b>Priority</b>	<b>What we will monitor</b>	<b>Where we are now</b>	<b>Target improvement</b>
<b>Patient safety</b>	Ensure harm free care	Increase the percentage of patients who have 'harm free' care within 4 areas: falls, pressures ulcers, blood clots and infection with an in-dwelling urinary catheter	92% average (2012 – 13)	Increase to 94%.
		Percentage of patients who are assessed for risk of VTE on admission.	95% (2012 – 13)	Increase to 97%
		Percentage of patients prescribed the appropriate VTE prophylaxis (random audit 10pts per month)	94% (local audit)	Increase to 98%
		Ensure no 'never event' happens	3 (2012 – 13)	0
		Omitted antibiotic doses	Achieve baseline Qtr 1	50% reduction
	Improve HSMR	Reduce HSMR	112 (2011 – 12) 105 (April 2012 – Jan 2013)	100 by 2014-15
		Septicaemia (except in labour)	110.4	100 by 2014-15
		Acute cerebrovascular disease	114.7	100 by 2014-15
		Acute and unspecified renal failure	103.5	100 by 2014-15
		Chronic obstructive pulmonary disease and bronchiectasis	109.3	100 by 2014-15
	Improve access and reporting of diagnostics for inpatients	Reduce time of request to investigation to report available for all in-patients and within all imaging modalities	2-3 days	1 day (24hrs)
	<b>Patient experience</b>	Improve the patient experience in outpatients	Number of cancelled and changed appointments	13.5%
Number of formal complaints received			569	Reduce by 20%
Increase the number of patients who wait < 15 minutes to be seen			56% average	Increase to 80%

	Improve patient experience in emergency department	Friends and Family Test	0	15% response with a 70% positive result
		Local survey in Emergency Department	70%	80%
		Delays to discharge from national survey	Red (score of 5.2)	Amber
		Ensure EDN/discharge notice to GP within 24 hours	94%	>95%
		Reduce readmissions	3.9% elective 10.8% emergency	<3% elective <10% emergency
<b>Clinical effectiveness</b>	Improve aspects of care given to frail elderly	Sustain the 3 areas of dementia assessment – find, assess and refer	>90% all areas x 3 mts consecutive	>90% all areas x 6 mts consecutive
		Improve hydration	Improve fluid balance audit (73.3%)	Achieve and sustain 75%
		Develop dementia friendly environment	0	3 wards
	Improve aspects of care within maternity care	Implement WHO checklist into obstetric theatre for surgical procedures excluding vaginal deliveries	Nil	90% all obstetric cases
		Improve midwife to mother ratio 1:33	1:34	1:33
	Improve aspects of care within paediatrics	Increase the number of LAC health assessments carried out in statutory time frames	445	834 cases
		Improve medication errors relating to gentamicin in neonates	10 in year	Zero

## Statement of Assurance from the Board

### Review of services

During April 2012 to March 2013, the Trust provided and or subcontracted 42 NHS services. The Trust has reviewed all the data available to them on the quality of care provided in all of these NHS services. The income generated by the NHS services reviewed in 2012/2013 represent 100

percent of the total income generated from the provision of NHS services by the Trust for 2012/2013.

### Participation in clinical audits 2012/13

During 2012/13, 36 national clinical audits and four national confidential enquiries covered NHS services that Medway NHS Foundation Trust provides (*source: NCAs for inclusion in Quality Accounts 2012/13, Department of Health, 2012*).

During that period, Medway NHS Foundation Trust participated in 94 percent of the national clinical audits and 100 percent of the national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries in which Medway NHS Foundation Trust was eligible to participate during 2012/13, together with 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, are shown in Table 3.

The reports of 17 national clinical audits and confidential enquiries were reviewed by the Board of the provider in 2012/13 and the actions that Medway NHS Foundation Trust has taken or intends to take to improve the quality of healthcare provided are detailed in Table 4.

The reports of more than 60 local clinical audits were reviewed by the Board of the provider in 2012/13 and the actions that Medway NHS Foundation Trust has taken or intends to take to improve the quality of healthcare provided are detailed in Table 5 for a sample of these.

### Participation in national clinical audits and national confidential enquiries in 2012/13

(a) Table 3: National clinical audits and registries

National clinical audits and registries	MFT	% cases submitted
<b>ACUTE</b>		
Adult community acquired pneumonia ( <i>British Thoracic Society</i> )	✓	100%
Adult critical care ( <i>ICNARC Case Mix Programme</i> )	✓	100%
Emergency use of oxygen ( <i>British Thoracic Society</i> )	✓	100%
National Joint Registry ( <i>NJR Centre</i> )		
• Knee replacement ( <i>355 procedures</i> )	✓	90%
• Hip replacement ( <i>412 procedures</i> )	✓	78%

<b>National clinical audits and registries</b>	<b>MFT</b>	<b>% cases submitted</b>
• Shoulder replacement ( <i>32 procedures</i> )	✓	19%
• Elbow replacement ( <i>8 procedures</i> )	✓	0%
• Ankle replacement	N/A	N/A
Non-invasive ventilation - adults ( <i>British Thoracic Society</i> )	✓	91%
Renal colic ( <i>College of Emergency Medicine</i> )	✓	100%
Severe trauma ( <i>Trauma Audit &amp; Research Network</i> )	✓	40%
<b>BLOOD AND TRANSPLANT</b>		
Intra-thoracic transplantation ( <i>NHSBT UK Transplant Registry</i> )	N/A	N/A
National Comparative Audit of Blood Transfusion programme ( <i>NHSBT</i> )		
• Blood sample collection and labelling	✓	100%
Organ donation ( <i>NHSBT Potential Donor Audit</i> )	✓	100%
<b>CANCER</b>		
Bowel cancer ( <i>National Bowel Cancer Audit Programme</i> ) <sup>[1]</sup>	✓	0%
Head and neck cancer ( <i>National Head and Neck Cancer Audit</i> ) <sup>[2]</sup>	✓	76%
Lung cancer ( <i>National Lung Cancer Audit</i> ) <sup>[3]</sup>	✓	72%
Oesophago-gastric cancer ( <i>National Oesophago-Gastric Cancer Audit</i> )	✓	75%
<b>HEART</b>		
Acute coronary syndrome or Acute myocardial infarction ( <i>MINAP</i> )	✓	100%
Adult cardiac surgery ( <i>NICOR Adult Cardiac Surgery Audit</i> )	N/A	N/A
Cardiac arrhythmia ( <i>NICOR Cardiac Rhythm Management National Audit</i> )	✓	100%
Congenital heart disease ( <i>NICOR Congenital Heart Disease Audit</i> )	N/A	N/A
Coronary angioplasty ( <i>NICOR National Audit of PCI Procedures</i> )	✓	100%
Heart failure ( <i>NICOR National Heart Failure Audit</i> ) <sup>[4]</sup>	✓	0%
Cardiac arrest ( <i>ICNARC National Cardiac Arrest Audit</i> ) <sup>[5]</sup>	✓	70-90%
National Vascular Registry ( <i>National Vascular Database</i> )		
• Abdominal aortic aneurysm	✓	100%
• Infra-inguinal bypass	✓	76%
• Major amputation	✓	100%
Pulmonary hypertension ( <i>Pulmonary Hypertension Audit</i> )	N/A	N/A
<b>LONG-TERM CONDITIONS</b>		
Adult asthma ( <i>British Thoracic Society</i> )	✓	97%
Bronchiectasis ( <i>British Thoracic Society</i> )	✓	100%

<b>National clinical audits and registries</b>	<b>MFT</b>	<b>% cases submitted</b>
Diabetes (adult) ( <i>National Diabetes Audit</i> )		
• Core Audit	✓	0%
• National Diabetes Inpatient Audit (NaDIA)	✓	100%
Diabetes (paediatric) ( <i>National Paediatric Diabetes Audit</i> )	✓	100%
Inflammatory bowel disease ( <i>UK IBD Audit</i> ) <sup>[6]</sup>	✓	Ongoing
Pain ( <i>National Pain Audit</i> ) <sup>[7]</sup>	✓	100%
Renal replacement therapy ( <i>Renal Registry</i> )	N/A	N/A
Renal transplantation ( <i>NHSBT UK Transplant Registry</i> )	N/A	N/A
<b>MENTAL HEALTH</b>		
National audit of psychological therapies ( <i>NAPT</i> )	N/A	N/A
Prescribing Observatory for Mental Health ( <i>POMH</i> )	N/A	N/A
<b>OLDER PEOPLE</b>		
Carotid interventions ( <i>UK Carotid Endarterectomy Audit</i> )	✓	100%
Fractured neck of femur ( <i>College of Emergency Medicine</i> )	✓	100%
Hip fracture ( <i>National Hip Fracture Database</i> )	✓	100%
Dementia ( <i>National Audit of Dementia</i> )	✓	100%
Parkinson's disease ( <i>National Parkinson's Audit</i> ) <sup>[8]</sup>	✓	N/A (12-13)
Stroke ( <i>Sentinel Stroke National Audit Programme - SSNAP</i> )	✓	73%
<b>WOMEN'S AND CHILDREN'S HEALTH</b>		
Childhood epilepsy ( <i>Epilepsy12 audit</i> )	✓	Ongoing
Neonatal intensive and special care ( <i>NNAP</i> )	✓	100%
Paediatric asthma ( <i>British Thoracic Society</i> )	✓	100%
Paediatric fever ( <i>College of Emergency Medicine</i> )	✓	100%
Paediatric intensive care ( <i>PICANet</i> )	N/A	N/A
Paediatric pneumonia ( <i>British Thoracic Society</i> )	✓	0%

**Key to abbreviations:**

MFT, Medway NHS Foundation Trust; N/A, not applicable. ICNARC, Intensive Care National Audit & Research Centre; MINAP, Myocardial Infarction National Audit Programme; NHSBT, NHS Blood & Transplant; NICOR, National Institute for Cardiovascular Outcomes Research; NNAP, National Neonatal Audit Programme; PCI, Percutaneous Coronary Intervention; PICANet, Paediatric Intensive Care Audit Network

**Notes:**

<sup>[1]</sup> National Bowel Cancer Audit Programme: Continuous data collection is under way, but there was no upload of local data onto the central system in 2012/13.

<sup>[2]</sup> National Head and Neck Cancer Audit: Case submission is by network. This is the most recent case ascertainment rate for the Kent & Medway Cancer Network (KMCN), published by the Health Quality Improvement Partnership (HQIP).

<sup>[3]</sup> National Lung Cancer Audit: Trust case ascertainment rate provided by the Health & Social Care Information Centre (HSCIC). However, the Lung Cancer Team at Medway believes that all eligible cases were entered into the audit. The Trust participates as part of the KMCN, and as other Trusts in the network had case ascertainment rates between 107% and 126%, expected cases may have been wrongly attributed to the Trust.

<sup>[4]</sup> National Heart Failure Audit: ***Planning is under way to allow the Trust to start participating in this audit in 2013/14; shared employment of specialist nurses to support the audit is being explored with the NHS Medway Clinical Commissioning Group. The Trust already participates in the Enhancing Quality Heart Failure Programme.***

<sup>[5]</sup> National Cardiac Arrest Audit: Data was required to be completed for Quarters 1 to 3 by the end of March 2013; the Trust entered 96 cases for this period. Although the number of emergency calls is logged by the Trust, these include non-cardiac emergencies and cannot be used to judge case submission rate. An estimate of participation rate is therefore given.

<sup>[6]</sup> UK IBD Audit: The Trust is currently participating in the data collection for the clinical audit phase of the 4<sup>th</sup> round of the national audit. Trust participation in the biological therapies part of the audit will commence in 2013/14.

<sup>[7]</sup> National Pain Audit: Patient questionnaires were given to those attending the Chronic Pain Clinic as required by the audit. However, the Trust's participation has been omitted from the national report; this is being followed up by the clinical lead.

<sup>[8]</sup> National Parkinson's Audit: Data submission required every 2 years; Trust submitted data in 2011/12 and plans to submit data again in 2013/14.

**(b) Table 4: National patient reported outcome measures**

PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires given to patients before and after selected procedures (see [www.hscic.gov.uk/proms](http://www.hscic.gov.uk/proms)). The information provided here is the most up-to-date available (published February 2013) and covers operations carried out between April and September 2012; at this point it is provisional only.

National Patient Reported Outcome Measures (PROMs) Programme	MFT	Response rate	
		Pre-operative questionnaire	Post-operative questionnaire
Elective surgery – hip replacement	✓	81.9%	85.0%
Elective surgery – knee replacement	✓	84.7%	81.7
Elective surgery – groin hernia	✓	50.3%	69.3%
Elective surgery – varicose vein	✓	44.0%	80.6

**(c) Table 5 : National confidential enquiries**

<b>National Confidential Enquiries and Clinical Outcome Review Programmes</b>	<b>MFT</b>	<b>% cases submitted</b>
Alcohol-related liver disease ( <i>NCEPOD</i> )	✓	100%
Subarachnoid haemorrhage ( <i>NCEPOD</i> )	✓	100%
Tracheostomy care ( <i>NCEPOD</i> )	✓	Ongoing
Asthma deaths ( <i>National Review of Asthma Deaths</i> )	✓	100%
Suicide and homicide by people with mental illness ( <i>NCISH</i> )	N/A	N/A
Child health programme (CHR-UK)	✓	100%
Maternal, infant and newborn programme (MBRRACE-UK) <sup>[1]</sup>	✓	N/A (12-13)

**Key to abbreviations:**

MFT, Medway NHS Foundation Trust; N/A, not applicable. CHR-UK, Child Health Reviews – UK; MBRRACE-UK, Mothers and Babies Reducing Risk through Audits and Confidential Enquiries – UK; N/A; not applicable; NCEPOD, National Confidential Enquiry into Patient Outcome and Death; NCISH, National Confidential Inquiry into Suicide and Homicide by people with mental illness.

**Notes:**

<sup>[1]</sup> Maternal, infant and newborn programme (MBRRACE-UK). MBRRACE was launched in March 2013, but online data entry did not become available until April 2013 due to technical delays.

**National Clinical Audits: Actions planned or taken to improve quality of healthcare**

**British Thoracic Society (BTS) Community-Acquired Pneumonia (CAP)**

- A champion for respiratory disease has been identified within the Emergency Department
- Teaching activities have been carried out for both doctors and nurses in the Emergency Department and there is increased awareness of the need to highlight CAP patients at triage
- A Trust pneumonia proforma has been drawn up
- There will be continued focus on quality of care of patients with CAP through the Enhancing Quality (EQ) programme
- The EQ pneumonia lead and EQ specialist nurse will continue to educate staff and promote the use of the CURB-65 severity score for CAP
- An audit is planned of patient flow from the Emergency Department and GPs through to the Acute Medical Unit (AMU), with a view to improving flow so that more patients are seen in “daylight” hours

**British Thoracic Society (BTS): Non-Invasive Ventilation**

- A domiciliary ventilation service has been introduced, so patients can remain under the care of the Trust’s respiratory team while at home
- The respiratory team is working with the ambulance service to optimise saturation levels and oxygen on admission

- The Trust is taking part in the pilot phase of the BTS chronic obstructive pulmonary disease (COPD) care bundle initiative. More than 50 percent of patients requiring NIV suffer from COPD, so this should have a positive impact on their care and clinical outcomes
- There will be continued training and education for clinical staff in the use of NIV therapy

### **Carotid endarterectomy**

- Delays due to lack of theatre time have been resolved
- The internal pathway has been reviewed to ensure there are no built-in delays
- Concerns about delays in the primary care pathway are to be raised with NHS Medway

### **Epilepsy12**

- Training of paediatric staff to improve first seizure documentation is planned
- Steps will be taken to improve awareness among paediatricians of epilepsy syndrome diagnosis and contraindications to EEG (electroencephalography)
- It is hoped to appoint an epilepsy specialist paediatric nurse

### **Intensive Care National Audit & Research Centre (ICNARC) Case Mix Programme**

- ICNARC reports continue to show that Medway's Critical Care Units are performing well, in spite of caring for a higher number of very sick patients compared with other trusts in the region
- No changes are needed, but the Trust will continue to monitor performance and benchmark the service using ICNARC

### **National Comparative Audit of Blood Transfusion: Blood transfusion sample collection and labelling**

- Mandatory training and competency assessment is in place for all those taking pre-transfusion blood samples
- The Electronic Clinical Transfusion Management System, BloodTrack, is being rolled out across the Trust. This will ensure that sample labels are produced containing accurate and legible patient information
- It is planned to produce compliance reports for each area taking samples on the hospital site and to educate staff where necessary to improve performance
- The feasibility of producing an information leaflet for all new doctors to the Trust outlining their blood transfusion responsibilities will be explored
- The transfusion practitioner has been monitoring rejected antenatal samples taken in the community, and providing feedback to relevant members of staff. A photograph of the request

form and sample tube showing the error is sent to clarify the nature of the shortcoming and help stop it happening again

- The transfusion practitioner is liaising with community colleagues to deliver training on sample acceptance criteria to district nurses employed by Medway PCT

#### **National Diabetes Inpatient Audit (NaDIA)**

- The decision on renewal of funding for a Think Glucose nurse awaits agreement of the area community diabetes plan
- Patients are choosing to stay with their consultant rather than being discharged back to primary care. This issue is to be addressed by NHS Medway Clinical Commissioning Group
- Resourcing for diabetes care will be added to the commissioning agenda for 2013/14
- The diabetes specialist midwives will participate in the 2013/14 National Pregnancy in Diabetes audit (NPID)
- A local audit is currently in progress on management of urgent acute diabetic foot problems

#### **National Head and Neck Cancer Audit**

- Current staffing levels are to be reviewed in the light of national standards
- Issues needing to be addressed at network level have been communicated to the Kent & Medway Cancer Network
- An audit of biopsy to reporting times at Medway is currently under way

#### **National Hip Fracture Database (NHFD)**

- The Trust has continued to develop its service in 2012, with the successful establishment of a four bedded enhanced care bed unit. This is monitored by two highly experienced and dedicated senior nurses, who provide exemplary care for these inpatients
- Continued and increasing emphasis is to be placed on provision of elderly care physician input in the initial and ongoing management of patients. Currently a locum geriatric consultant is in post, and the process is under way to appoint a substantive full-time orthogeriatrician
- Trauma list capacity will be reviewed, with the aim of improving throughput and access to theatre

#### **National Joint Registry (NJR)**

- Consent rates (patients' permission granted for the NJR to include and use their personal data) and compliance (number of cases submitted to the NJR) will continue to be monitored and the processes reviewed

- The variety of different implants used for hip and knee replacements has been reduced to the bare minimum following the recommendation of the previous report that the type of implants in use should be rationalised
- The number of joint replacement implant types being used within the department will continue to be monitored

### **National Neonatal Audit Programme (NNAP)**

- The Oliver Fisher Neonatal Unit (OFNU) has been recognised by NNAP as one of the top performing Trusts in the country
- Steps are being taken to improve admission temperatures in very pre-term babies. It is planned to:
  - Optimise environmental temperature in delivery areas, particularly theatres, and monitor continuously
  - Re-introduce posters for midwives and education on how to use thermal wraps
  - Present audit findings to obstetricians in joint meetings to highlight risk
  - Review processes in best-practising units in UK
- It is hoped to increase breast-feeding rates on discharge. A local study is currently under way to aid understanding of the effect of gestation, first feed and feed progression on the final feeding outcome, as well as the nursing contribution to initiating breastfeeding

### **National Pain Audit**

- An improved 'medicine map' is being used, which should reduce waiting times for patients with chronic back pain
- The Trust has been working closely with Dartford & Gravesham Trust with regard to joint use of a psychologist to overcome the problem of shortage of these specialists

### **National Paediatric Diabetes Audit**

- Investment in the service has been made, with further planned, to bring provision in line with the Best Practice Tariff (BPT). Improvements have included the appointment of an additional Paediatric Diabetes Specialist Nurse, psychology input, more paediatric dietetic time, and more outpatient clinic slots. Children are contacted by the team more frequently between clinic visits.
- In the coming year it is planned to continue to invest in the service to obtain the BPT; this should lead to improvements in outcomes

### **National Sentinel Audit of Stroke (SINAP/SSNAP)**

- Medway NHS Foundation Trust and Medway Community Healthcare stroke specialist team work together to provide a specialist coordinated service for patients from Medway and Swale
- It is planned to re-establish the Acute Stroke Strategic Group to develop a detailed action plan based on recommendations made to the Board. These include:
  - Joint review of the hyper acute stroke pathway
  - Review of staffing levels across medical, nursing and therapy disciplines
  - Review of stroke consultant activity, with a view to providing seven day stroke consultant ward round cover
  - To consider introducing four protected 'red beds' to allow direct admission to the Acute Stroke Unit 24 hours a day, seven days a week

### **Patient-Reported Outcome Measures (PROMs)**

- It is planned to continue to review results and to develop a system of disseminating, monitoring and acting on consultant level information

### **Potential Donor Audit**

- The Trust took part in NHS Blood & Transplant's "Pass it On" campaign during National Transplant Week – the campaign calls for more people to sign up to the Organ Donor Register and to make their wishes known to relatives
- The Trust manned a publicity stand at the 2012 British Transplant Games, hosted for the first time in Medway, providing a reminder of the importance of organ donation and how lives can be improved dramatically – 600 athletes who had benefitted from a transplant competed
- The specialist nurse for organ donation was on the panel of experts taking part in the Trust's members' event: "End of Life Care – one chance to get it right"
- Links have been improved with clinical staff involved with end of life care
- Publicity screensavers were set up on hospital computers

### **UK Inflammatory Bowel Disease (IBD)**

- Guidelines on the management of severe ulcerative colitis have been placed on the intranet for easy access by doctors and nurses
- Actions planned are to:
  - Increase the number of patients admitted under a gastroenterology specialist and to improve efficiency of transfer of IBD patients to the gastroenterology wards
  - To provide nurse specialist review for all IBD inpatients, with improved smoking cessation advice

- To increase dietician review; this has been raised via the Nutrition Steering Group
- To review guidelines on stool samples for C. difficile toxin and update to include IBD

### **Local Clinical Audits: Actions planned or taken to improve quality of healthcare**

The Trust Clinical Audit Programme for 2012/13 included around 190 local audits, with results and recommendations of many of these being presented and discussed at dedicated directorate and departmental audit meetings. Over 60 local audits were reported to the Board this year. Actions taken or planned following a selection of these are given below.

**Acute upper gastrointestinal (GI) bleed management and endoscopy service.** *This audit was the winner of the Trust-wide Clinical Audit Competition in 2012. It showed the need for faster access to endoscopy for patients with acute upper GI bleeding.*

- The referral form has been revised and incorporates the Glasgow-Blatchford bleeding score, which reflects the probability that the patient will need medical intervention. This highlights urgent cases so that they can be given priority
- GI bleed slots on the endoscopy list have been changed to make them more available to the medical teams
- Staffing levels have been reviewed; the possibility of an on-call bleed rota is being considered
- It is hoped to introduce an electronic booking system for endoscopy; a pilot system is currently being trialled elsewhere in the Trust

**Anaemia in revision hip arthroplasty.** *Pre-operative anaemia was identified in many of the patients undergoing this procedure; in some, haemoglobin levels dropped further during the course of the operation.*

- Steps will be taken to resolve pre-operative anaemia
- During the procedure, a cell-saver machine will be used wherever possible (this allows patients' own blood to be cleaned, filtered and restored to them, without the necessity of a donor blood transfusion)
- High-dependency care will be recommended for all patients

**Antimicrobial prescribing on all 25 adult wards in Medway Maritime Hospital (re-audit).**

*Audits are carried out biannually. The latest found prescribing to be clinically appropriate and guideline-compliant. However, documentation of stop/review dates and clinical indication needed improvement.*

- A 48-hour antimicrobial review improvement plan is to be developed

- The principal antimicrobial pharmacist will continue active promotion of antimicrobial prescribing guidelines and prudent prescribing policy

**Ectopic pregnancy management (re-audit).** This audit demonstrated good compliance with Royal College of Obstetricians guidelines on medical management of ectopic pregnancy. Significant cost savings were achieved with reduced bed occupancy. A second audit of surgical management demonstrated an increased use of laparoscopy as the surgical technique of choice. This has the advantage for the patient of involving a smaller incision and shorter recovery time than the alternative.

- Current medical and surgical practice will continue
- The views of patients receiving medical management will be sought at re-audit in 2014
- Laparoscopic surgery simulation training is currently under consideration

**Medicines prescribed but not given in orthopaedics (re-audit).** This re-audit found significant improvements in medicines adherence.

- A list of 'critical medications' is now available on all drug trolleys to ensure these medications are never missed
- Staff have been instructed to give vital medicines, even when patients are fasting for surgery
- There is improved liaison with pharmacy, reducing out-of-stock medications
- Educational sessions for doctors and nurses have taken place regarding the importance of avoiding missed medications

**MRI report turnaround for inpatients (re-audit).** The first round of this audit resulted in changes being made to allocation of reporting and staff were given advice on how to proceed in the absence of a specialist radiologist. The re-audit showed significant improvements in numbers of scans reported within 24 hours. Further actions:

- MRI radiographers now have a list of radiologist specialties to improve work allocation
- There is a nominated member of staff whose responsibility it is to ensure that all ward reports are allocated on the same day
- Staff have been advised to consider using the Medica teleradiology service if a Trust radiologist is not available within 24 hours

**Neonatal record-keeping.** Clinical record-keeping achieved a high standard; results were emailed to doctors and nurses to highlight key learning points and the following actions taken to improve identification and folder organisation:

- Patient identification labels in the Neonatal Unit (NNU) have been standardised and incorporate both the NHS number and hospital number, as well as the NNU number

- A new supply of stickers has been obtained to show year of treatment on the case-notes folder
- Organisation of neonatal documents within the case-notes has been brought into line with filing of clinical records from other directorates

**Pain in children presenting to the Emergency Department.** This local audit addressed the national priority of timely treatment of children in pain.

- An ongoing training programme for Emergency Department nurses now allows them to prescribe simple analgesia at navigation (preliminary assessment)
- The navigation sheet has been modified to prompt recording of pain scores whenever analgesia is considered

*Other planned actions include:*

- Promoting the use of pain scoring through teaching, posters, etc
- Exploring whether a stock of simple analgesia could be kept safely in the navigation room
- Making documentation a priority in the Emergency Department governance strategy for the year

**Prevention of delirium in patients on medical and elderly wards.** This study by physiotherapists showed good compliance with the recommendation that moving patients between wards should be avoided when there is risk of delirium. More patients needed to mobilise within 24 hours of admission.

- A simple flow chart has been developed as a tool to help identify risk factors for delirium. This is now in use within physiotherapy
- Teaching on delirium has been made part of the physiotherapy in-service training programme
- The Bed Occupancy System (BOS) within all medical and elderly care wards is now being used by physiotherapy as a means of communication within the multidisciplinary team to identify patients' mobility levels and discharge plans, and to highlight any issues that may arise

**Quality of portable imaging on the Special Care Baby Unit (SCBU).** High-quality images were sometimes not achieved because of suboptimal positioning of infants.

- This was discussed with neonatal nursing staff, who were very willing to hold infants at the time of scanning to help position them appropriately
- Quality criteria for the technique have been drawn up
- It was highlighted that, where possible, clinicians should review the image before the radiographer leaves the SCBU

**Quality outcome measures following anaesthesia.** Outcomes reviewed were post-operative temperature, pain scores, and nausea and vomiting

- Operating department practitioners have been advised to ensure fluid warmers are used for all patients
- It is planned to trial Inditherm warming mattresses for appropriate procedures, as recommended by NICE
- Future audits of these quality outcome measures will use SAFERsleep®, a newly installed, automated system that provides accurate time-related anaesthetic records

**Renal colic: imaging of patients with renal colic in the Emergency Department.** This audit found that performing x-ray KUB (kidneys, ureters and bladder) in the ED before CT KUB provided no additional information but unnecessarily lengthened the time to diagnosis.

- Patients are now referred to urology without any x-rays, which reduces unnecessary time being spent in the Emergency Department
- A possible alternative under consideration is for direct referral for CT KUB by emergency physicians, to allow definitive investigation to be completed in the Emergency Department and so reduce hospital admissions

**Two year developmental follow-up of infants born at less than 30 weeks gestation and/or weighing less than 1500 g at birth.** When a baby is born very prematurely, it is important to monitor developmental progress. Two year follow-up will be a national priority in 2013/14.

- Repeat appointments will continue to be offered to parents/carers who do not bring their children to follow-up appointments
- It is hoped to increase community neurodevelopmental slots
- A network solution will be explored for babies moving out of the Trust's catchment area

**Ward preparation for inpatients undergoing interventional radiological procedures (audit and re-audit).** Incomplete or incorrect ward preparation causes delays or even cancellations of procedures. After the first cycle of the audit, the following actions were taken:

- A communication pack was sent to 20 wards. This included a covering letter to the senior sister, the audit report, and laminated procedure checklists
- Ward preparation checklists were added to the interventional radiology intranet

A re-audit demonstrated significant improvements. Further actions are now planned:

- Interventional radiology nurses will contact the ward the day before the procedure and make a follow-up phone call to the ward on the day of procedure
- In an emergency, interventional radiology nurses will complete the checklist by phone

**Weekend handover standards on medical wards (audit and re-audit).** Each medical team writes handover forms for its patients, to brief the weekend team. Forms should be used to document jobs and patient reviews. Actions taken following the first cycle of the audit:

- The handover form was revised. Instead of two forms, there is now a single form for both house officers and registrars. The form is more user friendly, with tick-box options
- Day of task is now specified to make it easier for the weekend team to keep track of jobs

A re-audit showed marked improvement in use of the handover form, with more adequate clinical information and fewer poorly defined tasks. Recommendations from this round were:

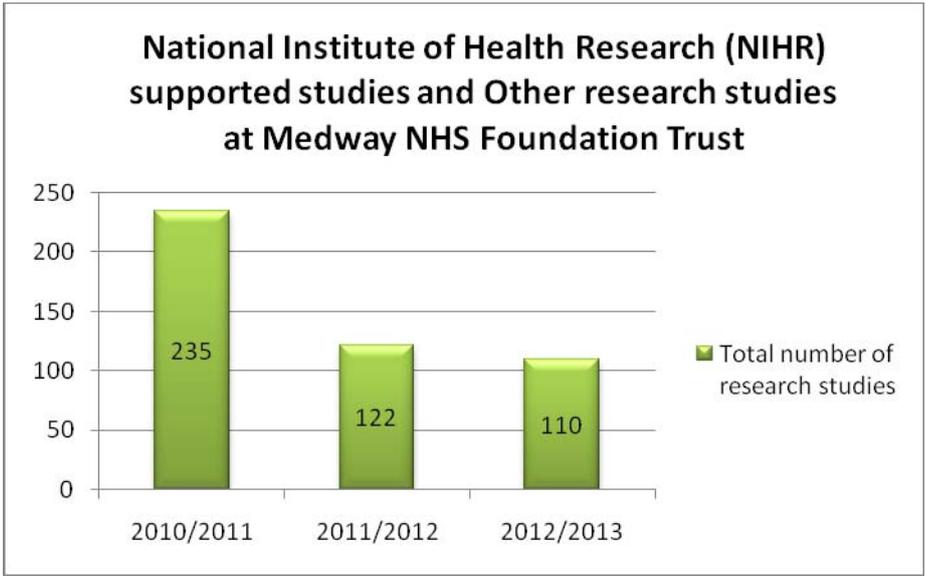
- The medical registrar should review the jobs at the beginning of each shift to identify any need for adjustments of workload within the team
- HOs and medical registrars covering the wards should meet at the beginning and end of the weekend shift to make sure every job is accounted for

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

Between 1 April 2011 and 1 March 2013, of the population who received NHS services provided or sub-contracted by Medway NHS Foundation Trust, 1,119 patients were recruited in to research studies approved by a research ethics committee.

Active participation in research contributes to successful patient outcomes, allowing clinicians to stay abreast of the latest treatment possibilities. Medway NHS Foundation Trust therefore remains committed to improving the quality of care for patients and wider healthcare services through active participation in clinical research.

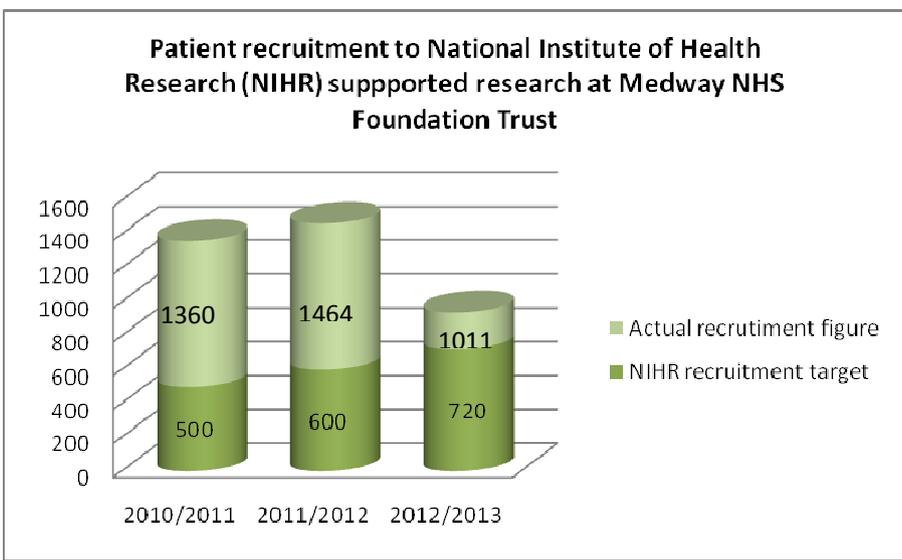
**Figure 1** compares, by year, the number of research studies conducted between 2010 and 2013. For the period 1 April 2012 to 1 March 2013, Medway NHS Foundation Trust took part in 54 National Institute of Health Research (NIHR) supported studies, including 34 cancer specialty studies and an additional 22 non-NIHR studies including staff undertaking MSc final year dissertations and questionnaire studies.



The Trust has continued to demonstrate a strong commitment to clinical research by contributing to publications for the *American Society of Haematology* and journal of *Critical Care Medicine* between 2012 and 2013.

Medway NHS Foundation Trust continues to actively participate in research supported by the National Institute for Health Research (NIHR) by setting annual NIHR recruitment targets to improve year-on-year patient involvement in clinical trials. For the period of 2012 to 2013 the Trust exceeded its annual target of 720 by an additional 219 patient recruits to date.

**Figure 2** represents the number of participants, by year, recruited into an NIHR supported research study since 1 April 2010 to 1 March 2013.



Continual growth in research activity indicates our commitment to work in successful partnership to provide flexible, first class healthcare to local people and our desire to improve patient outcomes and experience across the NHS. The Trust has exceeded recruitment targets set by the NIHR for three consecutive years.

In the past year, investigators involved in cancer and intensive care studies at Medway Maritime Hospital, have projected that the outcomes of their research will have a positive effect on mortality rates.

For example, cancer trials investigators are projecting that nine out of thirty-four cancer trials have contributed to a reduction in mortality rates, however this cannot be proven until trials are completed. For critical care research, investigators intend to use the primary outcome measures of the CALORIES and proMiSE studies to similarly improve the relative rates of mortality. Follow up of these trials will continue for a significant number of years. An example of the intent/rationale of two cancer studies and two critical care studies is shown in Table 6:

**Table 6**

Study Acronym	Rationale
<b>6v12</b>	'6 vs 12' cycles (standard cycle of treatment is 12 weeks); could the reduction in cycles reduce toxicity related deaths?
<b>TEAMM</b>	Could the use of prophylactic antibiotics to prevent early development of infections and potential septicaemia in myeloma cancer patients reduce mortality?
<b>proMiSE</b>	This study considers the benefit of early, goal-directed resuscitation compared to usual resuscitation in critically ill patients with severe sepsis or septic shock.
<b>CALORIES</b>	Is a research study which aims to find out the best way of providing early nutrition to patients in critical care.

Our engagement with clinical research demonstrates the Trust's commitment to testing and offering the latest medical treatments and techniques. One such study is looking at the position of women with epidural during the late stages of labour (BUMPS). This research expects to discover whether an upright or laying down position during labour will help women have a straightforward birth, to avoid the need for a forceps or suction birth. At this time ten women have taken part in this study.

**Table 7** shows the number of research projects by medical speciality being undertaken at Medway NHS Foundation Trust since 1 April 2012 to present that Medway NHS Foundation Trust patients have taken part in.

<b>Number of studies by medical speciality</b>	<b>2012-2013</b>
<b>Neurology</b>	<b>6</b>
<b>Anaesthesia</b>	<b>2</b>
<b>Haematology and cancer</b>	<b>34</b>
<b>Neonatology/foetal</b>	<b>5</b>
<b>Respiratory</b>	<b>6</b>
<b>Gynaecology and urology</b>	<b>4</b>
<b>Nuclear medicine</b>	<b>1</b>
<b>Critical care</b>	<b>3</b>
<b>Rheumatology</b>	<b>5</b>
<b>Paediatrics</b>	<b>2</b>
<b>Dermatology</b>	<b>2</b>
<b>Trauma and orthopaedic surgery</b>	<b>2</b>
<b>GUM</b>	<b>1</b>
<b>Diabetes and endocrinology</b>	<b>6</b>
<b>Gastroenterology</b>	<b>5</b>
<b>Cardiology</b>	<b>2</b>
<b>Obstetrics</b>	<b>2</b>
<b>Renal</b>	<b>1</b>
<b>Stroke</b>	<b>6</b>
<b>Other*</b>	<b>14</b>
<i>* studies outside of clinical speciality for example educational studies or research into overall patient experience.</i>	

Between the 1 April 2012 and 1 March 2013 it is estimated that there have been approximately 150 clinical staff participating in research that has been approved by a research ethics committee across the Trust. These members of staff have been participating in some of the 25 medical specialties listed above.

### **The Commissioning for Quality and Innovation (CQUIN)**

A proportion of the Trust's income in 2012/13 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. Details of the agreed goals for 2012/13, and for the next 12 month period, are available electronically at [www.medway.nhs.uk](http://www.medway.nhs.uk)

The CQUIN framework has been the foundation of discussions about quality of service between the Trust and the two main commissioners. A number of CQUIN targets are determined nationally

and are a response to known areas requiring improvement within patient safety and patient experience. The framework has enabled a dialogue to develop between the organisations about what is important to the local population. 2.5 percent (£4,703,000) of the Trust's 2012/13 projected income is dependent on the Trust achieving the CQUIN targets, which are composed of national, regional and local targets.

**Table 8: CQUIN Achievements 2012/13**

Description	Achievement
% of all adult inpatients who have had a VTE risk assessment on admission to hospital	Achieved
Patient Survey results relating to "responsiveness to personal needs"	Achieved
Safety Thermometer data submission	Achieved
Dementia screening, risk assessment and referral	Achieved
Improvement targets within the Enhancing Quality and Enhanced Recover Programmes	Mostly Achieved
% of patients at risk of VTE prescribed the appropriate prophylaxis	Achieved
Ward dashboard and improvement targets relating to safe workforce	Achieved
Achievement of High Impact Innovations	Achieved
Improvement targets for patients with long-term conditions	Partially Achieved

Seven of the nine areas for improvement achieved their target during 2012/13. These achievements have impacted on the Trust by:

- ✓ Enhancing patient safety by:
  - Ensuring patients are identified for risk of blood clots on admission
  - Ensuring those patients found at risk of developing a VTE are prescribed the correct prophylaxis
  - Ensuring 100% submission on data on all patients one day a month within a Safety Thermometer audit looking at harm caused by falls, pressure ulcers, VTE assessment and urinary tract infections with an indwelling urinary catheter.
- ✓ Improved patient experience through:
  - Enhanced responsiveness to patient needs
  - Ensuring for three consecutive months that patients over 75yrs who are admitted or who are living with dementia are identified, screened and referred appropriately for specialist review
- ✓ Enhanced clinical effectiveness by:
  - Achieving high impact innovation with introduction of oesophageal dopplers monitoring hydration under anaesthesia
  - Mostly achieving targets within Enhanced Quality and Enhanced Recovery programmes particularly with the hips and knees pathway

- Partially achieved improvement targets for patients with long-term conditions

In the areas that did not achieve fully, MFT will continue to monitor and report within the directorate quality governance performance structure, in order to continue to strive for best practice and best experience for patients on these pathways.

Where we did not achieve for patients with long-term conditions, a plan has been devised to concentrate on the discharge process in an attempt to reduce length of stay.

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

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

The CQC has not taken enforcement action against the Trust during 2012/2013. The Trust has participated in special reviews or investigations by the CQC relating to the following areas during 2012/13. The CQC carried out a planned compliance review of all four of the Trust's registered locations in August and September 2012. The CQC reported that all of the Trust's locations were compliant with the CQC essential standards of quality and safety.

### **Data Quality**

The Trust has well-established information governance and data quality groups. The information governance group is chaired by the executive director of governance and risk and the data quality group by the head of financial planning. 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.

The Trust developed a data quality policy formally sets out 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 and the group continues to meet on a quarterly basis and has an agreed work plan.

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

- Clinical coding
- Data checks
- Other data quality checks

## Clinical coding

With the introduction of a new encoder, ICD10 fourth edition introduction and accommodation/staffing issues, comprehensive audits were carried out at less than the 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 9 – Clinical coding audits**

Month	Specialty
March 2012	Elderly care including deceased
April 2012	Gynaecology
June 2012 – internal ad hoc audits	AAAs, c.diff and falls to fracture
November 2012	Colorectal
December 2012	Spinal surgery

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 September 2012 and concentrated on the quality of coding for general medicine patients.

Finally, there was a CQC alert on septicaemia which required considerable input from clinical coding.

Individual results:

**Table 10: Elderly care including deceased**

FCEs Audited	Primary diagnosis correct	Secondary diagnosis correct	Primary procedures correct	Secondary procedures correct	Episodes changing HRG
71	94%	91%	100%	100%	5.63%

**Table 11: Gynaecology**

FCEs Audited	Primary diagnosis correct	Secondary diagnosis correct	Primary procedures correct	Secondary procedures correct	Episodes changing HRG
30	83%	92%	93%	88%	20%

**Table 12: Colorectal**

FCEs Audited	Primary diagnosis correct	Secondary diagnosis correct	Primary procedures correct	Secondary procedures correct	Episodes changing HRG
55	87%	81%	93%	84%	18%

**Table 13: Spinal**

FCEs Audited	Primary diagnosis correct	Secondary diagnosis correct	Primary procedures correct	Secondary procedures correct	Episodes changing HRG
25	92%	80%	80%	80%	4%

**Table 14: General medicine (IG toolkit)**

FCEs Audited	Primary diagnosis correct	Secondary diagnosis correct	Primary procedures correct	Secondary procedures correct	Episodes changing HRG
200	91%	88%	96%	95%	8.5%

The Trust was subject to the Payment by Results clinical coding audit during the reporting period (November 2012) by the Audit Commission and the error rates which has not yet been reported in a published audit for that period for diagnoses and treatment coding (clinical coding) were:

**Table 15: Error rates for diagnoses and treatment coding**

Year	Primary diagnosis correct	Secondary diagnosis correct	Primary procedures correct	Secondary procedures correct	Episodes changing HRG
2012/13	90%	98%	92%	91.8%	5%

The services reviewed within the sample included:

- HRG sub-chapters CZ, CZ21V, FZ/VA. This included ENT procedures and general surgery – 90 sets of notes.
- Random selection of FCEs from deceased patients – 30 sets of notes.

The vast majority of the errors were around documentation on hypertrophy of tonsils with adenoids. It was also found that a fifth digit was not required in the musculoskeletal coding when the area or areas affected is not specific. Feedback has been given to all staff.

There was positive feedback on the way deceased notes were coded.

The non-coding issues included:

- Inaccuracy of the EDN
- Filing within the case notes – not in chronological order
- Title of operation did not coincide with the procedure undertaken.

There is regular monthly auditing on SUS data, correcting anomalies before second inclusion. This includes poorly coded primary diagnosis, ungrouped HRGs etc. Further work has been undertaken as a result of an outside agency presenting on changes in HRGs and the coded data. Workshops

on maternity, surgical and paediatrics were given by the company and work streams to be initiated for further training to be given to clinicians on clinical coding and how this affects mortality (HSMR) and payment (HRG).

During 2012/13 as well as continuing with a clinical coding audit programme, a clinical coding training programme continued to further develop the clinical coders in their roles. All clinical coders are up-to-date with refresher course training.

**Table 16: Clinical coding training 2012/13**

<b>Course/workshop</b>	<b>Month</b>	<b>No of coders</b>
Bespoke gynaecology workshop (one day)	October/November 2012	13
Refresher workshop (four days)	December 2012/January 2013	6

Assessment tests were introduced as part of the appraisal process. Clinical coders are expected to achieve at least 85 percent accuracy.

Two further clinical coders attained the accredited clinical coding qualification bringing the total number of qualified clinical coders to ten. Three further clinical coders are preparing to take the examination in September 2013.

The system of 'peer review' of data will be reviewed in spring 2012 to ascertain the value of continuing the process beyond 2011/12.

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 and peer reviews**

Although no formal internal audits (IA) were undertaken by the Trust in 2012/2013, 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 in the past, 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 '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 2012/13 are:

- Cancelled operations
- Four hour target in the Emergency Department
- Single sex breaches

The peer review process involves an audit of the data included in the Trust's 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 and 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.

- **Other Data Quality Checks**

**Hospital Standardised Mortality Ratio (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 cases alerted for review are then forwarded to the clinical director in each directorate for report back to the medical director to see if anything could have been done to prevent the death. In December 2012 the Trust set up the Mortality Working Party, a multi-agency group to support us in an increased focus on improving patient safety and reducing our HSMR. The working party is independently chaired by the director of public health for Medway. Its membership is constituted of clinical leads, executive leads and non - executive leads of the Trust, our neighbouring acute trust, CCGs and NHS England's area team. The crude, unadjusted mortality rate has been stable or even fallen slightly over a long period of time.

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. 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 appointed an end of life care matron.

The HSMR is reported to the Trust Board via the Patient Safety Committee and the Quality Committee. During 2011/2012 the new Summary Hospital-level Mortality Indicator (SHMI) was introduced nationally. The SHMI gives an indication of whether the actual number of deaths that occurred within 30 days of discharge from the hospital were higher or lower than expected when compared to the national figure. The Trust's SHMI was 114.48 for the year 2011/2012, and 112.64 for period covering between July 2011 and June 2012 which is the latest published data. SHMI will continue to be published in parallel with HSMR. The Trust was part of the Keogh Review which took place recently. The Trust is currently awaiting feedback from the review. More information is presented within the annual governance statement within this Annual Report.

**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 and Investment Committee.

**'Un-recorded 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 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 in many areas the Trust is performing to a higher level than our peers.

**Table 17: CHKS benchmarking data**

DATA QUALITY INDICATOR	Apr 2012 to Feb 2013	
	TRUST RATE	NATIONAL RATE
Data Quality Index	96.9	95.3
Blank primary diagnosis	0.08%	1.02%
Unacceptable primary diagnosis	0.02%	0.05%
Diagnosis non-specific	14.24%	20.34%
Sign and symptom as a primary diagnosis	11.00%	11.73%
Sign and symptom as a primary diagnosis: Episode 1	11.22%	11.76%
Sign and symptom as a primary diagnosis: Episode 2	10.09%	12.98%
Admitting diagnosis emergency for elective admission	0.83%	1.23 %
Coded Finished Consultant Episodes (FCEs) with Palliative care code Z515	0.74%	0.69%
Deaths with Palliative care code Z515	15.87%	14.50%
Coded FCEs with end of life care code Z518	0.54%	0.47%
Deaths with end of life care code Z518	33.99%	23.75%
Date conflicts	0.01%	0.13%
HRG U Groups	0.00%	0.02%
Average diagnosis per coded episode	4.3	4.2

Source- CHKS

## **NHS Number and general medical practice code validity**

- **NHS Number**

The Trust submitted records during April 2012 - January 2013 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:

- 99.4% for admitted patient care
- 99.4% for outpatient care
- 97.0% for Emergency Department 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:

- 100% for admitted patient care
- 100% for outpatient care
- 99.8% for Emergency Department care

## **Information Governance Toolkit (IGT)**

Medway NHS Foundation Trust's information governance assessment report overall score for April 2012 to March 2013 was 80 percent and was graded satisfactory.

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 80 percent compares favorably with other trusts in the SHA. The Trust declared a score of level two or above in all the standards, meaning that it falls into the category of satisfactory performance (satisfactory performance is represented by a score of two or above in all standards).

## **Core Indicators for 2012/13**

A proposed change to the reporting requirements for 2012 /13 followed advice from the National Quality Board as to how Quality Accounts can be strengthened by increased understanding of comparative performance. The indicators that are relevant to Medway NHS Foundation Trust and performance against these are tabled below:

## INDICATORS FOR QUALITY ACCOUNTS 2012/13

### DOMAIN 1 : PREVENTING PEOPLE FROM DYING PREMATURELY

SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR				
Period	Medway FT	National Ave.	Highest Value	Lowest Value
Apr 2011 - Mar 2012	1.1448	1.0000	1.2475	0.7102
Jul 2011 - Jun 2012	1.1264	1.0000	1.2559	0.7108

The Trust considers that this data is, as described as worse than the national average and is a Trust priority to improve in 2013/14.

The Trust intends to work collaboratively with the all stakeholders to implement improvement and since December 2012 has set up a 'Mortality Working Party' chaired by the director of public health for Medway to improve the quality of its services. As one of the 14 hospitals under review by NHS England it is expected that recommendations will indicate further ways forward for improvement.

The table below relating to palliative care coding remains near the national average. Continued work in this area will further improve the hospital level indicator.

PATIENT DEATHS WITH PALLIATIVE CARE CODED				
Period	Medway FT	National Ave.	Highest Value	Lowest Value
Apr 2011 - Mar 2012	18.0%	17.9%	44.2%	0.0%
Jul 2011 - Jun 2012	18.8%	18.4%	46.3%	0.3%

### DOMAIN 3 : HELPING PEOPLE TO RECOVER FROM EPISODES OF ILL HEALTH OR FOLLOWING INJURY

The latest PROMS data published is from April 2011 to March 2012. The Trust's adjusted average health gain scores during this period are:

PATIENT REPORTED OUTCOME MEASURES (PROMS)				
Procedure	Medway FT	National Ave.	Highest Value	Lowest Value
Hip Replacement	0.438	0.416	0.532	0.306
Knee Replacement	0.290	0.302	0.385	0.180
Groin Hernia	0.114	0.087	0.143	-0.002
Varicose Vein	*	0.094	0.167	0.047

\* No modelled score calculated due to small number of results.

The Trust considers that the PROMS data for hip replacement and groin hernia are better than the national average, and knee replacement results are slightly lower than the national average. There was a low number of returns for varicose veins and therefore, these are not comparable.

The Trust has taken the action to improve PROMS and the quality of its services, by establishing a new surgical patient enhancement team. This is aimed at all stable surgical patients who still require surgical treatment but can receive this treatment at home. This should help improve the patient experience.

<b>RE-ADMISSIONS WITHIN 28 DAYS - AGED 0 TO 14 YEARS</b>		
<b>Period</b>	<b>Medway FT</b>	<b>National Ave.</b>
2012 - 13	10.2%	N/A
2011-12	10.4%	9.6%

<b>RE-ADMISSIONS WITHIN 28 DAYS - AGED 15 YEARS OR OVER</b>		
<b>Period</b>	<b>Medway FT</b>	<b>National Ave.</b>
2012-13	11.6%	N/A
2011-12	7.3%	7.1%

Note: 2011-12 figures were taken from CHKS which had no exclusions applied. In order to comply with Monitor's definition, the 2012-13 rates were recalculated to exclude Maternity and cancer patients

The Trust considers that this data is slightly above the national average although there is no comparable accurate evidence available to date.

The Trust is undertaking further work to identify unexpected re-admissions rather than planned readmissions which are common in all our specialties. We are also reviewing the discharge policy to ensure future complicity. This remains a clinical quality target.

#### **DOMAIN 4 : ENSURING THAT PEOPLE HAVE A POSITIVE EXPERIENCE OF CARE**

<b>NATIONAL INPATIENT SURVEY - RESPONSIVENESS TO PERSONAL NEEDS OF PATIENTS</b>	
<b>Period</b>	<b>Medway FT</b>
2012	6.42
2011	6.23

The scores above comprise of the average of five questions within the national inpatient survey.

The individual scores for each of the questions are shown below:

<b>NATIONAL INPATIENT SURVEY RESULTS</b>				
<b>Question</b>	<b>2011 Score</b>	<b>2012 Score</b>	<b>Highest Value 2012</b>	<b>Lowest Value 2012</b>
Patient was involved in decisions about care and treatment	6.5	6.9	8.7	6.3
Patient found someone on hospital staff to talk about worries and fears	5.1	5.4	7.8	4.2
Patient given enough privacy when discussing condition or treatment	8.0	8.2	9.3	7.8
Patient was told about medication side effects	4.0	4.1	7.5	3.4
Patient was told who to contact if worried about condition or treatment after leaving the hospital	7.6	7.6	9.5	6.6

The Trust considers that this data is below the national average due to poor patient perception.

The Trust is undertaking further work to identify areas for further improvement to increase patient satisfaction and enhance perception. An action plan has highlighted areas of concern which will be shared with our commissioners for consultation and recommendation.

<b>NATIONAL STAFF SURVEY - RECOMMEND THE TRUST AS A PROVIDER OF CARE TO FAMILY OR FRIENDS</b>				
Period	Medway FT	National Ave.	Highest Value	Lowest Value
2012	57%	63%	94%	35%
2011	54%	60%	96%	22%

The Trust considers that this data is below average. The Trust chief executive has also promoted staff engagement through chief executive open sessions/Board briefings 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. This includes a number of focus groups for staff to help the Trust develop its approach to addressing areas for improvement.

#### **DOMAIN 5 : TREATING AND CARING FOR PEOPLE IN A SAFE ENVIRONMENT AND PROTECTING THEM FROM AVOIDABLE HARM**

<b>VTE RISK ASSESSMENT</b>				
Period	Medway FT	National Ave.	Highest Value	Lowest Value
Apr 2012 - Feb 2013	95.7%	93.9%	100.0%	76.1%
2011-12	90.5%	89.1%	100.0%	23.4%

<b>C. DIFFICILE INCIDENCE RATE (PER 100,000 BED DAYS)</b>				
Period	Medway FT	National Ave.	Highest Value	Lowest Value
2012-13	8.0	*	*	*
2011-12	19.7	21.8	51.6	0.0

<b>PATIENT SAFETY INCIDENTS REPORTED</b>				
Period	Medway FT	Ave. for Medium Acute Hospitals	Highest Value	Lowest Value
2012-13	4.49	6.87	14.44	3.11
2011-12	5.14	6.68	13.01	2.91

<b>PATIENT SAFETY INCIDENTS REPORTED THAT RESULTED IN SEVERE HARM OR DEATH</b>				
Period	Medway FT	Ave. for Medium Acute Hospitals	Highest Value	Lowest Value
2012-13	1.2%	0.8%	3.6%	0.0%
2011-12	0.9%	0.7%	3.0%	0.0%

\*Final publication figures for C difficile will not be available for the period April 2012 – March 2013, from the Health Protection Agency until 11 July 2013. This means that final figures remain unavailable for this report.

The Trust considers that this data shows that the Trust has achieved better results than the national average with the exception of patient safety incidents which resulted in severe harm or death.

## Part 3 – Other information

This part of the Quality Report looks back on last year's information and priorities regarding quality of services, explaining both what has been achieved and where improvements are needed. It will also showcase areas of good practice in relation to patient safety, patient experience and clinical effectiveness and give an explanation of other areas of service that are specific to this organisation and have been a local focus over the past year.

### **Looking back at our priorities in 2012/13 these were:**

#### **Why these priorities were chosen**

Each priority from 2012/13 is given a short introduction on why it was originally chosen and an explanation where the target has not been achieved. Table 18 demonstrates how the Trust performed against target by year end, with an additional column to demonstrate actions that will be taken forward in 2013/14.

### **Patient safety**

#### **Improve the care of patients at risk of developing blood clots**

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-embolisms (VTE). All inpatients should be assessed for their risk of developing such clots so that the appropriate preventative treatment or prophylaxis can be implemented which should result in fewer complications for the patients. Although the Trust had made good progress in the previous year, it was felt that in order to ensure a culture of sustained practice it was best to maintain this as a priority for 2012/13.

#### **Reduce the number of omitted medication doses**

A reduction in the number of omitted medication doses has become a patient safety issue in recent years. It is a complex area to improve, as it is linked to training and competence of staff, and we continue to work on it. As sepsis has been highlighted as a factor within the HSMR and mortality figures, Antibiotics will be monitored for speed of administration and rates of omission in 2013/14.

**Increase the percentage of patients who have `harm free` care within four areas: falls, pressure ulcers, blood clots and infection with an in-dwelling urinary catheter.**

Following a huge improvement in the reduction of pressure ulcers in 2010/11 and a priority concentrating on falls in 2011/12, this priority was chosen as it allowed a continued observation of sustained good practice for pressure ulcers and a continued emphasis on reducing falls. The measurement that was set and improvement achieved are set out below.

**Patient experience**

- Improve the outpatient experience
- Survey results, patient feedback, complaints and ever increasing referrals to PALS all indicated that this was an experience that needed to be improved
- Increase the number of patients who say they had the opportunity for them or their family to speak to a doctor when needed

This was one of the Trust's worst scores in the national patient survey results and our local surveys.

Immediate changes such as offering families patient led visiting times allowed for greater opportunity to see a doctor as well as offering relatives clinics', although the latter has not been as successful as we would have hoped.

**Increase the number of patients who say they receive enough help with their meals and rate the quality of food as good**

Previous feedback on patient surveys both nationally and locally highlighted quality of food as poor. Not receiving enough help with their meals was also an area for improvement.

New menus have been introduced with better choices available to patients. A new supplier is being considered and assistance with meals by trained volunteers has been introduced.

**Clinical effectiveness**

**Increase health promotion regarding alcohol misuse**

This was one of the criteria that the governors in particular felt may make a difference to the number of admissions in Emergency Department. It was also an area of concern as the ward which held many of the patients with alcohol abuse had had a number of difficult cases involving the need for a statutory Deprivation of Liberty. It was felt that this area in particular could be an area to focus on, this year within the health promotion arena.

### Improve the diagnosis and referral for patients with dementia.

Care of the patient living with dementia is high on the agenda both nationally and locally. A commissioning for quality and innovation (CQUIN) had been set for the coming year and the Trust had just commenced looking at how we could improve our services for this patient group.

### Improve the discharge process for patients

In the previous year the number of 'transfer of care' concerns rose and complaints continued to be heard regarding the discharge process for our patients, including possible inappropriate discharge at night and unreasonable delays. It was felt this could be a priority that with improvement could make a marked difference for our patients.

**Table 19: Quality priority achievements – looking back to 2012/13**

Category	Priority	What we will monitor	Where were April 2012	Target expected 2012 - 13	YTD
Patient safety	Improve the care of patients at risk of developing blood clots	Percentage of patients who are assessed on admission	92% for assessment on admission	95%	96%
		Percentage of patients prescribed the appropriate prophylaxis	Not measured	Take baseline in Quarter (Qtr) 1 and increase by 10%	94% From Qtr 1 baseline of 86%
	Reduce the number of omitted medication doses	Actual number of omitted doses on a monthly spot check audit	5.32 mean number per ward	Reduction of 10%	5.2 mean number per ward
	Increase the percentage of patients who have 'harm free' care within 4 areas: falls, pressures ulcers, blood clots and	Monthly spot check of every inpatient on one day	89%	Increase to and sustain at >90%	92%

	infection with an in-dwelling urinary catheter				
<b>Patient experience</b>	Improve the outpatient experience	Contacts with PALS	850	Reduce by 10%	1055
		Number of cancelled and changed appointments	14%	Reduce by 25%	13%
	Increase the number of patients that say they had the opportunity for them or their family to speak to a doctor when needed	National survey	5.4 (red)	Increase to amber	N/A as not in survey this year
		Local survey	Not measured	Take baseline In Qtr 1 and agree target	Not achieved
	Increase number of patients who say they receive enough help with their meals and rate the quality of food as good	National survey	6.5 & 4.2	Increase to 7.0 and 5.0	6.7 and 4.0
		Local survey	Qtr. 4 - 56 & 85	Increase to 88	59 and 95
<b>Clinical effectiveness</b>	Increase health promotion regarding alcohol misuse	Increase number of referrals to community service	Not currently measured	Assess baseline numbers in Qtr 1	Not achieved (issues with pathway to community service)
		Look for promotional literature when under - going the '15 step challenge'	Not currently measured	All areas to have alcohol misuse education material	Not measured
	Improve the diagnosis and referral for patients with dementia	Number of patients screened on admission Number of patients assessed	Target not achieved by peer acute hospitals within Kent	Assess baseline numbers in Qtr 1 and agree	90% achieved for 3 consecutive months in all 3 areas of FAIR assessment

		Number of patients referred		targets	
Improve the discharge process for patients	Transfer of care concerns	153 past seven months (21.8 per month)		Reduce by 10%.	223
	Discharge at night	0.6% of total		<1% of total	0.23%
	Delays to discharge from national survey	6.6 on national survey		To be amber rated in national survey	Red (5.2)
	Told how to take medications on discharge	National survey 7.6		To be amber rated in National Survey	Amber (8.4)
	Readmissions	Admission within 30 days following elective surgery = 3.48% and following emergency = 10.65%		To achieve as peer	Elective 3.9 against peer 3.7 Emergency 10.8 against peer 10.8

CLINICAL QUALITY TARGETS																					
Target / Indicator	Description	Green	Amber	Red	2012/13 Plan	YTD Latest Mth	YTD Actual	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13		
Infection Control	C Diff reduction (stretch target)	<= Plan		> Plan	26	26	16	3	1	0	1	1	1	1	0	1	2	3	2		
	Incident rate of C Diff (per 10,000 bed days)						0.80	1.64	0.56	0.00	0.62	0.62	0.63	0.59	0.00	0.62	1.19	1.98	1.17		
	MRSA reduction	<= Plan		> Plan	2	2	1	0	0	1	0	0	0	0	0	0	0	0	0		
Clinical Staff	Incident rate of MRSA (per 10,000 bed days)						0.05	0.00	0.00	0.58	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
	Nutrition	>= 95%	90-94%	< 90%	95%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
	Falls with injury per 1,000 admissions	<= 5	5.1-7	> 7	5	5	4.91	5.45	4.09	5.90	5.36	5.12	4.85	4.77	4.35	5.24	3.70	4.04	6.23		
	Observations	>= 90%	85-89.9%	< 85%	90%	90%	98.3%	97.1%	98.5%	98.7%	97.7%	98.7%	98.6%	98.2%	99.0%	98.0%	98.9%	98.4%	97.9%		
	Single sex breaches	0	1-4	5	0	0	70	20	8	0	6	0	6	0	6	8	4	4	8		
	Hand hygiene audits	>= 95%	92-94%	< 92%	95%	95%	98.4%	97.1%	99.1%	99.4%	98.1%	97.2%	95.0%	98.0%	98.8%	100.0%	99.4%	98.5%	99.6%		
	Nurses not wearing correct uniform	<= 10 per month	11-14 per month	>= 15 per month	120	120	6	0	0	1	1	0	0	1	1	1	1	1	0	0	
	Child safeguarding training at Level 1	>= 95%	90-94.9%	< 90%	95%	95%	81.6%	88.5%	88.8%	80.7%	90.1%	90.1%	71.5%	71.5%	81.5%	81.6%	81.5%	79.4%	77.9%		
	Adult safeguarding training at Level 2	>= 95%	90-94.9%	< 90%	95%	95%	83.1%	89.0%	89.8%	87.2%	87.2%	87.1%	79.2%	79.2%	80.8%	81.6%	80.8%	79.1%	78.9%		
	Enhanced CRB check	100%	95-99.9%	< 95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
	Child & adult protection plan	>= 95%	90-94.9%	< 90%	95%	95%	88.7%	91.5%	97.7%	92.7%	92.1%	81.8%	88.1%	63.3%	87.2%	100.0%	100.0%	100.0%	88.9%		
	Discharge letters within 24 hours	100%	95-99.9%	< 95%	100%	100%	94.5%	94.8%	95.8%	94.9%	95.2%	94.1%	94.6%	96.0%	95.0%	95.1%	95.9%	91.1%	91.3%		
	Wristband errors (wards only)	<= 6 per month	7-9 per month	>= 10 per month	72	72	114	7	4	3	11	2	8	2	10	5	21	21	20		
	Operational Metrics	Average length of stay (excludes DC) - FCE						3.15	3.46	3.29	3.37	3.06	3.14	2.84	3.14	2.95	3.06	3.24	3.15	3.10	
Average length of stay (range) - FCE							0 to 27.00	0.80 to 20.00	0 to 16.07	0 to 15.29	0 to 14.00	0 to 22.00	0 to 16.64	0 to 18.77	0.80 to 27.00	0 to 12.05	0 to 18.68	0 to 20.83	0 to 14.22		
Number of incidents (patients only)							5,183	438	453	470	435	526	436	458	482	564	476	445			
Number of new SUIs		0-2 per month	3-6 per month	> 6 per month	24	24	58	4	4	5	3	3	2	8	6	3	7	8	5		
Number of Never events		0		>= 1	0	0	3	0	0	0	0	0	0	0	2	0	0	1	0		
Utilisation - Trust		<= 90%	91-94%	>= 95%	90%	90%	90.87%	99.72%	95.04%	93.93%	85.42%	85.91%	87.79%	89.98%	89.56%	87.30%	91.41%	91.62%	92.97%		
Utilisation - Adult beds only		<= 90%	91-94%	>= 95%	90%	90%	95.23%	104.71%	99.53%	97.96%	88.04%	89.19%	91.30%	92.82%	93.58%	92.64%	97.05%	97.11%	99.20%		
Number of permanent beds - adult		TBC	TBC	TBC	513	513	502	508	508	508	508	508	502	502	486	486	486	486	786		
Number of permanent beds - child		51-57	35-50	< 35	51-57	51-57	55	55	55	55	55	55	55	55	55	59	59	59	59		
Re-admission rates within 24 hours		<= 1%	1.01-1.49%	>= 1.5%	1%	1%	0.94%	0.95%	0.91%	0.87%	0.92%	0.81%	1.09%	1.10%	1.13%	0.99%	0.88%	0.72%	N/A		
Additional bed days used following re-admission (24 hours)							1,714	264	176	133	184	77	224	138	164	135	123	96	N/A		
Re-admission rate within 72 hours							1.96%	2.14%	1.83%	1.77%	2.11%	2.06%	1.94%	2.02%	2.27%	2.21%	1.75%	1.44%	N/A		
Re-admission rates within 28 days		< 6.7%	6.7-7.9%	>= 8%	7%	7%	7.43%	8.29%	7.38%	7.44%	8.03%	7.91%	7.42%	7.92%	8.17%	8.39%	6.83%	3.81%	N/A		
Additional bed days used following re-admission (28 days)							14,379	1,761	1,453	1,165	1,442	1,657	1,248	1,364	1,337	1,425	1,100	427	N/A		
HSMR - Dr Foster (as published each month)		<= 100	101-109	>= 110	100	100		107.5	102.8	91.8	104.7	98.1	104.9	80.1	88.8	101.8	107.6	N/A	N/A		
HSMR - Dr Foster (updated figures)		<= 100	101-109	>= 110	100	100	104.7	123.0	119.5	95.5	109.8	101.7	105.1	85.1	92.7	105.7	107.6	N/A	N/A		
Mortality rate RAMI 2012 - CHKS - trust index (peer rate)					100	100	73	81 (81)	77 (72)	74 (79)	68 (79)	63 (79)	71 (84)	55 (79)	69 (86)	76 (84)	80 (78)	87 (75)	N/A		
Bed days lost due to delayed discharge	<= 600 per month	601-699 per month	>= 700 per month	7,200	7,200	3,111	297	333	279	343	428	297	269	253	84	201	139	188			
Complications for medical and surgical care						2.06%	1.99%	1.90%	1.49%	2.03%	2.35%	1.89%	2.07%	2.26%	2.26%	1.89%	2.59%	N/A			

CLINICAL QUALITY TARGETS (continued)

Target / Indicator	Description	Green	Amber	Red	2012/13			YTD												
					Plan	Plan	Actual	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	
Complaints	Number of complaints received	<= 40 per month	41-59 per month	>= 60 per month	480	480	569	39	55	54	55	36	45	47	44	33	46	43	72	
	Complaints ratio to contacts	<= 0.16%	0.17-0.23%	>= 0.24%	0.16%	0.16%	1 to 671 (0.15%)	1 to 729 (0.14%)	1 to 622 (0.16%)	1 to 555 (0.18%)	1 to 612 (0.16%)	1 to 861 (0.12%)	1 to 693 (0.14%)	1 to 748 (0.13%)	1 to 786 (0.13%)	1 to 850 (0.12%)	1 to 733 (0.14%)	1 to 724 (0.14%)	1 to 429 (0.23%)	
Cancer 2 Week Wait	All cancers	>= 93%	90-92%	< 90%	93%	93%	96%	99%	98%	95%	93%	94%	95%	97%	96%	97%	97%	96%	N/A	
	Symptomatic breast	>= 93%	90-92%	< 90%	93%	93%	94%	93%	94%	93%	94%	94%	100%	100%	100%	100%	100%	83%	N/A	
Cancer 31-Day	First treatment - all	>= 96%	93-95%	< 93%	96%	96%	96%	96%	97%	97%	98%	97%	97%	96%	97%	92%	98%	N/A	N/A	
	Subsequent treatment - Surgery	>= 94%	91-93%	< 91%	94%	94%	98%	100%	96%	96%	96%	100%	100%	100%	96%	97%	96%	100%	N/A	
	Subsequent treatment - Anti Cancer Drug	>= 98%	95-97%	< 95%	98%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	N/A	
Cancer 62-Day	GP referral	>= 85%	82-84%	< 82%	85%	85%	91%	96%	95%	88%	95%	91%	95%	89%	92%	92%	92%	76%	N/A	
	National screening service	>= 90%	87-89%	< 87%	90%	90%	98%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	91%	N/A	
	Consultant upgrade						90%	100%	100%	100%	100%	100%	80%	89%	90%	75%	100%	83%	N/A	
A&E Access	Trust only	>= 98%		< 98%	98%	98%	94.00%	89.49%	95.01%	96.54%	98.01%	96.09%	96.54%	95.99%	94.42%	94.75%	93.86%	90.16%	85.39%	
Cancelled Ops	Cancelled operations	<= 0.8%	0.9-1.5%	> 1.5%	0.8%	0.8%	0.93%	1.05%	0.78%	0.69%	0.89%	0.90%	0.93%	0.92%	0.95%	0.39%	1.13%	0.97%	1.51%	
Cardiac Access	Seen within 2 weeks for Rapid Access Chest Pain	>= 98%	95-97%	< 95%	98%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Workforce	Staff in post - WTE *				3455	3455	3,613	3,609	3,562	3,587	3,583	3,619	3,571	3,617	3,674	3,666	3,589	3,671		
	Paybill - in £ millions **				144.6	121.1	137.7	12.5	12.4	12.5	12.4	12.4	12.3	12.6	12.6	12.6	12.8	12.7	N/A	
	Statutory & Mandatory training *						82.83%	85.27%	84.96%	83.92%	83.98%	82.63%	84.04%	84.04%	81.90%	82.01%	81.90%	81.55%	77.74%	
	Bank staff - cost in £000's **				4425	4083	4,670	482	428	423	446	401	394	435	451	384	392	434		
	Banks staff - % Total paybill **						9.0%	10.1%	9.0%	8.8%	9.4%	8.6%	8.7%	9.1%	9.5%	8.1%	8.2%	9.0%	N/A	
	Nursing agency - WTE ***				17.1	14.4	134.15	11.22	6.75	6.99	6.69	6.04	7.84	12.86	20.85	18.53	10.99	25.39		
	Nursing agency - % Nursing paybill **						1.5%	1.4%	0.7%	0.9%	0.6%	0.6%	0.6%	2.0%	1.9%	2.4%	2.2%	3.3%	N/A	
	Medical agency - WTE ***				33.6	28.0	234.26	17.02	14.48	16.53	21.78	20.04	20.22	20.23	27.19	25.24	26.59	24.94		
	Medical agency - % Medical paybill **						8.4%	7.2%	6.7%	9.7%	7.8%	7.1%	8.2%	8.0%	8.8%	9.0%	9.5%	10.1%	N/A	
	Vacancies over 3 months **						0.53%	0.79%	0.86%	0.28%	0.29%	0.25%	0.50%	0.55%	0.61%	0.58%	0.60%	0.51%	0.64%	
	Sickness absence - nursing **	<= 3.3%	3.4-4.0%	>= 4.1%	3.3%	3.3%	2.96%	3.24%	3.41%	2.60%	2.45%	2.68%	2.94%	1.94%	3.52%	3.51%	3.84%	2.63%	2.64%	
	Stability **						88%	89%	89%	89%	89%	87%	88%	89%	88%	88%	90%	88%	87%	
	FCE per nurse **						4.66	4.39	4.85	4.61	4.76	4.71	4.48	4.78	4.83	4.52	4.82	4.53	4.61	
	Nursing staff / bed ratio **						2.72	2.70	2.70	2.68	2.68	2.70	2.72	2.73	2.79	2.76	2.73	2.71	2.75	
T&D spend (non-MPET) - £000's **				468		467	45	45	31	44	65	32	55	41	26	35	48			
RIDDOR score **						20	0	2	1	3	0	3	1	3	1	4	2			

Notes: \* YTD figure relates to latest month  
 \*\* YTD figure relates to actual from April 2012 to date  
 \*\*\* YTD figure relates to monthly average

## Patient surveys

The Trust participates in all the adult national surveys, these include:

- Inpatient surveys
- Outpatient surveys
- Emergency Department surveys
- Maternity surveys
- Cancer surveys

A sample of patients is asked what they thought about different aspect of their care and treatment. This information is then given a score based on the responses given by patients. The Trust also conducts its own local surveys on a quarterly basis to obtain patient feedback.

The 2012 national inpatient survey results were published by the Care Quality Commission on 16 April 2013.

The benchmarking report highlights red as being worse than other trusts, amber the same as other trusts and green is better than other trusts.

Positive aspects of the patient experience included:

- Overall 73% rated care 7+ out of 10
- Overall treated with respect and dignity 71%
- Doctors – always had confidence and trust 73%
- Hospital – room/ward was very/fairly clean 95%
- Hospital – toilets and bathrooms were very/fairly clean 91%.
- Care – always enough privacy when being examined or treated 86%.
- 

Most patients are highly appreciative of the care they receive. However, there is always room for improving the patient experience. The results do show improvement on last year's survey although areas of patient concern highlighted that improvements were needed in the following areas:

- Discharge process
- Hospital food
- Patients wanted to be more involved in decisions
- There was not always enough emotional support from hospital staff
- Not told how to expect to feel after an operation or procedure
- Did not receive any information explaining how to complain

Patients' perceptions and experiences are influenced by the quality of their care and treatment, staff attitude and how they are communicated with. In order to exceed patients' expectations we need to continually monitor, measure and review patient feedback so that we can learn and improve.

## Part 4 – Annex

### Statement from Medway Clinical Commissioning Group

**Our Ref:**

**Your Ref:**

29 May 2013

Susan Osborne  
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Medway NHS Foundation Trust  
Windmill Road  
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Dear Susan

### Statement from NHS Medway Clinical Commissioning Group

In response to the draft Medway NHS Foundation Trust (MFT) Quality Account submitted to NHS Medway Clinical Commissioning Group (MCCG) please find detailed below the MCCG statement in accordance with the National Health Service (Quality Accounts) Amendment Regulations 2012.

NHS MCCG welcomes the 2012/13 draft Quality Account submitted by Medway NHS Foundation Trust and can confirm that the CCG has reviewed it against all the Department of Health reporting requirements and as far as can be determined the commentary and data presented are an accurate and honest reflection of progress made in improved service delivery and patient outcomes and it does meet all national reporting requirements.

MCCG acknowledges that the data presented provides helpful coverage of strong progress made in many areas of service improvement, in particular MFT have continued to deliver a strong performance in relation to infection prevention and control with very low levels of incidence reported across the year. The hospital continues to deliver an excellent record on the prevention of Hospital Acquired Pressure Ulcers and congratulations are offered to the Tissue Viability Team for achieving their second consecutive Journal of Wound Care Pressure Care Award.

The Hospital Standardised Mortality Ratio remains a significant concern for MCCG, but acknowledges the on-going work throughout the year that has taken place between the two organisations and the

CCG will continue to work with MFT in the year to come including responding positively to the outcome of the Keogh Rapid response review.

Patients falls whilst they are in hospital continues to be an area for improvement and the CCG welcomes that this remains a priority for the Trust and will become a key performance improvement initiative as part of the Commissioning for Quality and Innovation measures.

The 2012 Inpatient Survey demonstrates some consistent high scores and improvements in key areas in the quality of care experienced by patients; however it does highlight areas that are of concern to our patients particularly in relation to the quality of food, some questions relating to communication and delays in discharge.

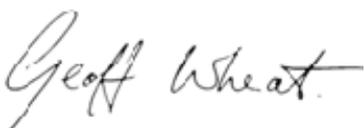
The MCCG acknowledges and supports the priorities for 2013/14 detailed within the Quality Account around Patient Safety, Clinical Effectiveness and Patient Experience.

NHS MCCG look forward to continuing to work closely with the nursing and medical Directors and colleagues at all levels within the Trust to assure the quality of local services and ensure the culture of continuous improvement is present in all areas of the Trust.

Yours sincerely



**Chief Clinical Officer**  
Medway Clinical Commissioning Group



**Geoffrey Wheat**  
**Chief Nurse**  
North Kent Clinical Commissioning Group's

## Statement from Local Healthwatch Group

28<sup>th</sup> May 2013

### Healthwatch Medway Response to Medway NHS Foundation Trust Quality Account – 2012/ 2013

Dear Sir/ Madam,

Healthwatch Medway would like to thank Medway NHS Foundation Trust for the opportunity to comment on their Quality Account for 2012/2013.

Healthwatch Medway was commissioned in April 2013 and to date has focused on ensuring transfer of the LINK legacy and service mobilisation. For this reason, whilst Healthwatch Medway notes the content of the Quality Account, comment has been limited, as follows:

#### **1. Is the Quality Account clearly presented for patients and public?**

The Quality Account provides a comprehensive account of the Trust's position and plans moving forward.

A more reader friendly and accessible version of the report would be welcomed, using insights and techniques developed by such bodies as the Plain English Foundation, or the DH Guidance for people who commission or produce Easy Read information 2010. This would facilitate reasonable adjustment in line with the Equality Act, and promote accessibility and inclusion.

#### **2. Priorities for 2012/13**

Medway LINK undertook the scrutineer role during 2012/2013 and thus Healthwatch Medway has declined to comment on priorities in year. The Medway LINK legacy documents are publicly available via their website, and particular note is made of the 'Medway Maritime Hospital A&E Questionnaire Project', as follows;  
*Project Objectives*

*The objective of the project was to obtain feedback from A&E patients on what helped them choose Medway A&E for their treatment, if they had tried somewhere else first, and to find out if they knew about and what they thought about alternative services. The data collected would help the MCG/PCT plan the allocation of funding and manage clinical resources more effectively particularly during the winter peak, and more effectively target patient information.*  
*Summary*

*The original plan was to carryout approximately 20 visits. Twenty-two were eventually achieved, and 233 questionnaires were returned. The sample size was sufficient to extract useful information. The difficulty in getting a GP appointment did seem to be the biggest issue encountered. Those who couldn't or didn't think they could get a GP appointment soon enough came to over 30%. This difficulty is recognised nationally as a problem. Also, of those who answered the question, only 39% thought it was an emergency that couldn't be dealt with elsewhere.*

#### *Conclusion*

*Sufficient data to make an assessment was collected. The assumptions expressed with reference to the difficulty in getting a GP appointment were confirmed. The assumption that some overseas patients don't know how the NHS works and use A&E as the first port of call as opposed to a GP surgery was dispelled, as was a suspicion that more patients were coming from the Maidstone area. Other subjects that concerned patients were waiting times, insufficient engagement by staff with service users, dignity & privacy issues and cleanliness. Project Lead Alan West November 2012*

### **3. Priorities for 2013 / 14**

The introductory statement from the Chief Executive acknowledges the Trust is one of fourteen identified for review in 2013/2014, due to its performance in relation to mortality. Timely dissemination of the findings of this review will be welcomed. In addition, the need to implement the recommendations of the Francis Report, in year is noted. The Trust's priorities for 2013/2014 are also noted and supported; in particular, the focus on improving patient experience within outpatients and emergency medicine, and improving the discharge experience of patients and their carers.

On behalf of Healthwatch Medway  
Bridget Bygrave  
Operations Manager

## **Statement from Health and Adult Social Care Overview and Scrutiny**

### Quality Account

I am writing to thank you for inviting the Health and Adult Social Care Overview and Scrutiny Committee to comment on your Quality Accounts.

As the Quality Accounts are often received outside of the business cycle for the Committee the Assistant Director, Adult Social Care and the Assistant Director, Customer First, Leisure, Democracy and Culture have a delegated authority, along with the Chairman and spokespersons of the Committee to respond.

Set out below is the response on behalf of the Committee:

The Health and Adult Social Care Overview and Scrutiny Committee has been officially consulted by Medway NHS Foundation Trust over the past year on a number of issues in particular the Trust has actively engaged with the Committee on the proposed merger with Darent Valley Hospital, the Dr Foster mortality report, and the physiotherapy and phlebotomy services. The Committee will be receiving regular updates on the mortality figures following on from the action plan devised by the review group set up to monitor the figures.

Having checked the Quality Account the Committee would be interested to know more about the following over the next year: The steps the Trust are taking to improve the outpatient experience bearing in mind the results of the National Inpatient Survey, which indicated this as one of the Trust's worst scores. This also seemed to be reflected in the low score in patients being told about medication side effects Reductions in the number of omitted medication doses Steps being taken to increase the number of patients who had the opportunity for them or their family to talk to a doctor when they needed to Information around the sharp increase in some of the complaints (dermatology) for instance and the increase in complaints around poor discharge arrangements

Kind regards

Rosie Gunstone

Democratic Services Officer on behalf of the  
Health and Adult Social Care Overview and Scrutiny Committee

### **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 2012/2013.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2012 – June 2013
  - Papers relating to quality reported to the Board over the period April 2012 to June 2013
  - Feedback from the commissioners dated (due back 24 May 2013)

- Feedback from governors dated 16 January 2013
  - Feedback from LINKs (Healthwatch) dated (due back 24 May 2013)
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31 May 2013.
  - The latest national patient survey 24 April 2013.
  - The latest national staff survey was in 28<sup>th</sup> February 2013.
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 11/05/2012.
  - CQC quality and risk profiles dated 31<sup>st</sup> March 2013
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered.
  - The performance information reported in the Quality Report is reliable and accurate.
  - There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
  - The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, 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](http://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](http://www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

Signed: D Harker, Chair

Date: 29 May 2013

Signed: M Devlin, Chief Executive

Date: 29 May 2013

## 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**

The Clinical Executive Group (CEG), consisting of clinical directors and executive directors meets monthly 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 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 2012/13

Denise Harker	Non-executive director and chairman
Graham Clayden	Non-executive director
Adrian Horwood	Non-executive director and deputy chairman
Martin Jamieson	Non-executive director
Jan Stephens	Non-executive director
John Sands	Non-executive director
Colin Wilby	Non-executive director
Andy Brown	Interim director of human resources
Mark Devlin	Chief executive
Patrick Johnson	Director of operations/deputy chief executive
<sup>1</sup> Cheryl Lee	Director of human resources (currently on secondment)
<sup>3</sup> Alastair Marshall	Interim director of finance
<sup>4</sup> Jacqueline McKenna	Director of nursing
<sup>3</sup> David Meikle	Director of finance
<sup>2</sup> Jeremy Moon	Director of finance (currently on secondment)
<sup>4</sup> Susan Osborne	Interim director of nursing
<sup>5</sup> Jason Seez	Director of governance and strategy
Gray Smith-Laing	Medical director

1. Cheryl Lee, substantive director of human resources was seconded to the transition team, who are working towards the integration of Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust, on 1 April 2011.
2. Jeremy Moon, substantive director of finance was seconded to the transition team, who are working towards the integration of Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust, on 1 April 2011 up until 9 April 2013.
3. Alastair Marshall was interim director of finance until 7 September 2012, Steve Orpin from 8 September to 16 September and David Meikle commenced as director of finance from 17 September 2012.
4. Jacqueline McKenna was director of nursing until 31 March 2013 and replaced by Susan Osborne as interim director of nursing from 1 April 2013.
5. Jason Seez was appointed as director of governance and strategy on 11 March 2013.

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 five Board away days during the year in order to consider strategy, integration and development issues; one away day was held with the integrated board.

### **Denise Harker**

#### **(Trust Chair and Non-executive director)**

Denise qualified as a chartered management accountant in 1977 and worked in a multinational manufacturing company before embarking on a career in broadcasting. She worked for TVS as controller of finance in Southampton and Maidstone and then as chief financial officer starting up the new ITV joint venture, London News Network. She became managing director of LNN in 1997 until 2004.

Denise was a non-executive director and chairman of audit committee of the Met Office until 2010 and joined Maidstone and Tunbridge Wells NHS Trust as a non-executive director and chairman of audit committee in 2008. She was appointed chairman of Medway Primary Care Trust in 2010 and moved to the role of chairman of Sussex Primary Care Trust cluster in 2011. Denise has recently completed her term of office as a governor of Ravensbourne College and a trustee of the Rory Peck Trust.

Denise returned to Medway as chairman of the Trust in April 2012.

**Appointment:** 1 April 2012.

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

### **Graham Clayden**

#### **(Non-executive director)**

Graham was 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 is a current member of NICE Evidence Resources Reference Panel.

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 advisor to the Institute of Directors' Board of Examiners.

**Appointment:** 1 April 2007

**Membership of committees:** Nominations and Remuneration Committee, Quality Committee, Integrated Audit Committee, Workforce 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 Chatham Maritime Estates (an estate management company) as a trustee and non-executive director and is also part of the leadership team of the Salvation Army in Chatham. Adrian also works with the Kent, Surrey and Sussex (KSS) Deanery and the London Deanery as a lay advisor on matters relating to recruitment to various specialities on a national and local basis. He is also a Lay member on the KSS School of Surgery Board.

**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. Over the past 16 years he 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. He then joined Country Land and Business Association as director general.

Martin was recently appointed as chief executive at Rayner Intraocular Lenses. Rayner has an unparalleled history of uninterrupted manufacture of acrylic implants for cataract surgery for over sixty years. With the help of worldwide charity organisations, Rayner's intraocular lenses have restored sight to hundreds of thousands in the developing world.

**Appointment:** 22 December 2010

**Membership of committees:** Performance and Investment Committee and Nominations and Remuneration Committee.

## **Jan Stephens**

### **(Non-executive director)**

Jan joined Kent Police in 1975 and served for around 36 years as a police cadet, police officer and then as a police manager until November 2011. She first worked in the Medway towns in 1988 returning twice in the 90s and finally in 2006 when she was appointed as Medway's area commander (chief superintendent) before retiring in 2008. Jan has also served in Swale as chief inspector of operations and then area commander between 2001 and 2003. Her policing career was varied including senior management roles covering uniform operations, crime investigations and partnership working.

After retiring as a police officer Jan was appointed as the policy and governance manager for Kent Police which included liaison with Kent Police Authority and coordination of the force's policies.

Jan has lived in Medway since 1988 and is a trustee of Medway Youth Trust (a charity delivering employment and career guidance services together with other development opportunities for young people). She is director of a local residents' management company.

**Appointment:** 1 August 2011

**Membership of committees:** Nomination and Remuneration Committee, Quality Committee, Workforce Committee (chair) and non-executive lead for security.

## **John Sands**

### **(Non-executive director)**

John's business background is in social housing in the local authority and voluntary sectors. Until his retirement John was chief executive of mhs homes group, a major Medway business. His particular interest in the Trust is the development of a brilliant patient experience.

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 non-executive roles, including appointments with Kent Probation, the RICS and the Office of the Independent Adjudicator for Higher Education. He was also chair of the independent remuneration panel for Tonbridge and Malling Borough Council, Sevenoaks District Council and Tunbridge Wells Borough Council from 2007 to 2013.

Colin is also the senior independent non-executive director for the Board of Directors.

**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 before moving to the Royal Brompton and Harefield NHS Trust, and then North West London Hospitals. He was appointed director of human resources at

Dartford and Gravesham NHS Trust in 2008 and since June 2010 Andy has been seconded from Dartford as interim director of human resources.

### **Mark Devlin**

#### **(Chief executive)**

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 achieved his first board level position in 2001 as deputy chief executive of North West London Hospitals. Before joining Medway NHS Foundation Trust in 2010 he had been the chief executive of Dartford and Gravesham NHS Trust from 2005.

### **Patrick Johnson**

#### **(Director of operations/deputy chief executive)**

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 seven 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/integration director)**

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. Cheryl was seconded to the transition team on 1 April 2011. The transition team are working towards the integration of Medway NHS Foundation Trust and Dartford and Gravesham Trust. 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 had been the director of nursing at Medway NHS Foundation 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.

**David Meikle**

**(Director of Finance)**

David joined the NHS as a national finance trainee and following qualification, joined the private sector working as a consultant for KPMG and Coopers & Lybrand for a number of years. He returned to the NHS and has worked as a finance director in a number of trusts across England and Scotland.

**Jeremy Moon**

**(Director of finance/integration director)**

Jeremy trained as a chartered accountant with Touche Ross and 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. Jeremy was seconded to the transition team on 1 April 2011. The transition team are working towards the integration of Medway NHS Foundation Trust and Dartford and Gravesham Trust.

**Susan Osborne**

**(Interim director of nursing from 1 April 2013)**

Susan trained as a registered nurse at University College Hospital, London in the early 70s and also completed her midwifery training at Queen Charlottes Hospital for Women, London. She specialised in intensive care unit and medical nursing and then developed her career in general and nurse management. Susan has held senior managerial positions in the NHS which include chief executive director, achieving NHS trust status for the Royal London Homoeopathic Hospital, director of nursing for Luton and Dunstable Hospital NHS Trust and at St Mary's Hospital NHS Trust which became the first Academic Health Sciences Centre in England following merger with Hammersmith and Charing Cross Hospitals and Imperial College. Susan was also seconded as chief nurse to NHS East of England for one year. In addition, Susan worked for Connecting for Health for two years, one day a week as a joint lead for nurses and midwives on the National Programme for Information Technology

(NPfIT). Susan now works as an independent management and nursing consultant undertaking interim director of nursing, quality governance roles and reviewing services within the NHS. She was awarded a CBE for her contribution to nursing in 2005.

### **Jason Seez**

#### **(Director of governance and strategy from 11 March 2013)**

Jason joined Medway NHS Foundation Trust in March 2013 from Barts Health NHS Trust, where he was associate director of strategic development.

Jason has significant NHS experience having worked in both leading London teaching hospitals and district general hospitals in the home counties. Jason was also the mergers and acquisitions lead for NHS London in 2010/11.

Jason's focus and skills lie in strategic business planning and project management, with a clear understanding of the need to work across both organisational and professional barriers to succeed.

### **Gray Smith-Laing**

#### **(Medical director)**

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 the Medway NHS 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, Martin Jamieson disclosed his new appointment to Rayner, which could conflict with his appointment as a non-executive director. This potential conflict is managed by the Trust Board. No other 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](http://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 2012/13**

<b>Member</b>	<b>Total</b>
Andy Brown	12/12
Graham Clayden	11/12
Mark Devlin	10/12
Denise Harker	12/12
Adrian Horwood	10/12
Martin Jamieson	10/12
Patrick Johnson	12/12
Alastair Marshall	5/5
Jacqueline McKenna	11/12
David Meikle	7/7
John Sands	12/12
Jason Seez	1/1
Gray Smith-Laing	12/12
Jan Stephens	10/12
Colin Wilby	12/12

## Committees of the Board

### Integrated Audit Committee

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

The Integrated Audit Committee (IAC), which consists of not less than three non-executive directors of the Trust is required to meet at least three times a year 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. Seven meetings were scheduled in order to provide adequate assurance to the Board.

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 attend 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 work of the Board's Performance and Investment Committee
- The compilation of the Trust's annual accounts
- The preparation of the Trust's Annual Report
- The preparation of the annual governance statement
- 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 since 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 Committee

<b>Members</b>	<b>Committee role</b>	<b>Attendance</b>
John Sands (Non-executive director)	Chairman	11 out of 12
Graham Clayden (Non-executive director)	Member	11 out of 12
Jan Stephens (Non-executive director)	Member	11 out of 12
Mark Devlin (Executive director)	Member	8 out of 12
Patrick Johnson (Executive director)	Member	8 out of 12
Jacqueline McKenna (Executive director)	Member	8 out of 12
Gray Smith-Laing (Executive director)	Member	11 out of 12

The Quality Committee, which consists of no less than three non-executive directors of the Trust and four executive directors, meets on a monthly basis. It is also regularly attended by the head of governance and risk, director of infection, prevention and control and the chairman of the Patient Safety Committee.

The Quality Committee ensures an integrated and co-ordinated approach to the management and development of the quality metrics (patient safety, patient experience and clinical effectiveness) at a corporate level, it leads on the development and monitoring of quality systems within the Trust to ensure that quality is a key component of all activities within the Trust and assures compliance with regulatory requirements and best practice with patient safety, patient experience and clinical effectiveness. The committee regularly receives and gives guidance or actions on:

- Reports on serious incidents
- Infection control report

The Quality Committee provides a report to the Board of Directors after every meeting on its activities which includes reports on infection control.

#### **Performance and Investment Committee**

<b>Members</b>	<b>Committee role</b>	<b>Attendance</b>
Colin Wilby (Non-executive director)	Chairman	12 out of 12
Adrian Horwood (Non-executive director)	Member	10 out of 12
Martin Jamieson (Non-executive director)	Member	9 out of 12
Mark Devlin (Chief executive)	Member	10 out of 12
Patrick Johnson (Director of operations/deputy chief executive)	Member	9 out of 12
Alastair Marshall (Interim director of finance)	Member	4 out of 5
David Meikle (Director of finance)	Member	5 out of 7

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.

During the year, the Performance and Investment Committee fully reviewed its terms of reference to more accurately reflect its role. It has regularly received and challenged the financial summaries, trends in service line reporting, the Transforming Performance programme, performance report, aged debts and has been fully involved in the budget setting process. It was also provided with an update on the progress of the patient level

information costing systems. The committee has also continued to challenge both support services and specialities on their strategic activities and forecasting.

### **Workforce Committee**

<b>Members</b>	<b>Committee role</b>	<b>Attendance</b>
Jan Stephens (Non-executive director)	Chair	10 out of 10
Graham Clayden (Non-executive director)	Member	9 out of 10
John Sands (Non-executive director)	Member	8 out of 10
Andy Brown (Interim Director of Human Resources)	Member	10 out of 10
Patrick Johnson (Executive director)	Member	6 out of 10
Jacqueline McKenna (Executive director)	Member	3 out of 10

The Workforce Committee was established in-year to oversee the development and implementation of an effective organisational development and workforce strategy. It also has a responsibility to provide assurance to the Board that the appropriate structures, processes and systems are in place to ensure an effective capable workforce to meet the Trust's current and future needs.

The Workforce Committee works to develop a systematic approach to the management of change and to establish ways to attract and retain a high performing workforce. It reviewed the workforce strategy before it progressed to the Trust Board. It ensures there are robust performance processes in place for the effective management of the workforce to ensure the Trust meets its priorities. The Workforce Committee works to drive a positive culture of continuous improvement and high staff engagement and monitors the implementation and of workforce strategies as well as educational plans and performance.

The Workforce Committee provides a report to the Board of Directors after every meeting on its activities which includes reports workforce data and outcomes for the Trust.

## Remuneration report

The following sections of the remuneration report are subject to external audit.

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 comprises all non-executive directors of the Trust and is chaired by the chairman. The chief executive and interim director of human resources will normally attend the meeting to provide an update to the Committee. The Committee 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.

### Nominations and Remuneration Committee

Members	Committee role	Attendance
Denise Harker (Chairman)	Chair	6 out of 6
Graham Clayden (Non-executive director)	Member	4 out of 6
John Sands (Non-executive director)	Member	5 out of 6
Jan Stephens (Non-executive director)	Member	5 out of 6
Adrian Horwood (Non-executive director)	Member	5 out of 6
Colin Wilby (Non-executive director)	Member	5 out of 6
Martin Jamieson (Non-executive director)	Member	1 out of 6

The Trust appointed three new substantive executive directors in 2012/13. With the exception of one director who received a performance bonus, all directors are paid a basic annual salary only. The Nominations and Remuneration Committee reviews salaries each year. In 2012/13 the committee decided that no inflationary pay award was appropriate. This is in line with overall increases in the NHS and that director salaries were within benchmarked salary ranges.

When new appointments are made the salary is determined by reference to Foundation Trust Network (FTN) benchmarking of chief executive and executive director salaries, current market rates and internal relativities with executive directors/senior managers. This may involve consideration of advice from external advisors, including executive search and selection consultants.

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

The Trust has been actively pursuing integration with Dartford and Gravesham NHS Trust, and will consider the implications for substantive appointments. This includes the advertisement of posts as designate director for the integrated organisation where appropriate.

Executive directors hold substantive contracts with six-month notice periods. This does not affect the right of the Trust to terminate the contract without notice by reason of the conduct of the executive director. Depending on the circumstances of the early termination the Trust would, if the termination were due to redundancy, apply redundancy terms under Section 16 of the Agenda for Change terms and conditions of service or consider severance settlements in accordance with current Department of Health and Monitor requirements and guidance. Any compensation would need to be approved by the Trust's Nominations and Remuneration Committee.

Signed: M Devlin, Chief Executive

Date: 29 May 2013

The following sections of the remuneration report are subject to external audit.

## Salary and pension entitlements of senior managers

### a) Remuneration

Name and title	2012/13			2011/12		
	Salary	Other Remuneration	Benefits in kind	Salary	Other Remuneration	Benefits in kind
	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100
Mrs D Harker, Chair	40-45					
Mr V Hull, Chair	-	-	-	40-45	-	-
Mr G Clayden, 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	-	-	-	0-5	-	-
Mr J Sands, Non-executive Director	10-15	-	-	10-15	-	-
Mr M Jamieson, Non-executive Director	10-15	-	-	10-15	-	-
Ms J Stephens, Non-executive Director	10-15	-	-	5-10	-	-
Mr M Devlin, Chief Executive	150-155	-	-	150-155	-	-
Mr P Johnson, Director of Operations and Deputy CEO	130-135	-	-	130-135	-	-
Mr D Meikle, Director of Finance	70-75			-	-	-
Mr S Orpin, Interim Director of Finance	-	-	-	95-100	-	-
Dr G Smith-Laing, Medical Director	25-30	150-155	-	25-30	150-155	-
Ms J McKenna, Director of Nursing	100-105	-	-	100-105	-	-
<b>Band of Highest Paid Director's Total Remuneration (£'000)</b>		150-155			150-155	
<b>Median Total Remuneration (£'000)</b>		22,676			22,676	
<b>Ratio</b>		6.8			6.8	

#### Notes:

For the purposes of the remuneration report, senior managers are defined as those with voting rights at a Trust Board meeting.

Mr S Orpin filled the role of interim director of finance between 1 April 2011 and 31 March 2012, and returned to the role of deputy director of finance on 1 April 2012.

Mr A Marshall filled the role of interim director of finance between 1 April 2012 and 7 September 2012, he was employed by PricewaterhouseCoopers. Salary costs of £124,800 for the period were recharged to the Trust by PricewaterhouseCoopers.

Mr A Brown provided services as an interim director of human resources throughout the financial year he is employed by Dartford and Gravesham NHS Trust. Salary costs of £111,257 for this period (including pension and employers' costs) were recharged to the Trust by Dartford and Gravesham NHS Trust (2011/12 £71,490)

As part of the Review of Tax Arrangements of Public Sector Appointees, published by the chief secretary to the Treasury on 23 May 2012, departments and their arms length bodies were required to publish information relating to the number of off payroll engagements costing over £58,200 per annum, that were in place on 31 January 2012. Public sector organisations are now required, as part of their annual report, to present two sets of data as follows:

1. The number of 'off payroll' engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012.
2. The number of new 'off-payroll' engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and for more than six months.

The relevant details for Medway NHS Foundation Trust are as follows:

<b>Table 1: For off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012</b>	
No. In place on 31 January 2012	11
Of which:	
No. that have since come onto the organisation's payroll	0
Of which:	
No. that have since been re-negotiated/re-engaged to include to include contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
Number that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the (department) to seek assurance as to their tax obligations	9
Number that have come to an end	2
<b>Total</b>	<b>11</b>

The existing contracts for engagements, either directly or via a personal services company, already include contractual clauses that place the liability for taxation and national insurance upon the contractor. All continuing contracts are being reviewed in order to re-assess employment status or alternatively identify any necessary contract revisions.

With regard to all new 'off-payroll' engagements arising between the 23 August 2012 and 31 March 2013, for more than £220 per day and for a period of more than six months, it should be noted that only one individual is currently in post. The standard contract clauses, for this type of engagement, do place responsibility for taxation and national insurance upon the

contractor. The contracts for any new engagements arising in the future will also be subject to continuing review in order to re-assess compliance and employment status.

## 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 2012  (bands of £2500) £000	Cash Equivalent Transfer Value at 31 March 2012  £000	Cash Equivalent Transfer Value at 31 March 2011  £000	Real Increase in Cash Equivalent Transfer  £000
Mr M Devlin, Chief Executive	5-7.5	165-167.5	671	595	45
Mr P Johnson, Director of Operations and Deputy CEO	0-2.5	7.5-10	134	101	28
Mr D Meikle, Director of Finance	0-2.5	175-177.5	888	-	15
Ms J McKenna, Director of Nursing	(0-2.5)	125-127.5	570	532	10

- a) The information in the above table has been provided by the NHS Pensions Agency.  
b) Dr G Smith-Laing, medical director has taken his pension and as such no benefit is recorded above.

The directors and governors receive reimbursement of travel and incidental expenses incurred as a result of their duties to the Trust, during 2012/13 the directors received expenses of £9,669.14 and the governors £1,025.66.

## 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 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 appointed by the partner organisations. A full breakdown of the Council of Governors is detailed later in the report.

### 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 and specifically representing one particular class in their own membership community. The public governors each represent a constituency. The Medway constituency has nine public governors; Swale constituency has four public governors; 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: nursing and midwifery; allied health professionals, medical and dental; non-clinical; and management. Stakeholder governors are appointed by their organisation to sit on the Council and link back to their organisation.

### **Role of Governor**

Governors are required to attend regular meetings of the Council of Governors – normally seven a year which includes the Annual Members' Meeting.

The governors have some specific statutory requirements to fulfil 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
- Receive feedback on chairman and non-executive director annual appraisals
- Hold the Board to account
- Represent constituent members
- Consider the foundation trust's forward plans and advise the Board of Directors on these.

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 of Governors

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

**Membership Engagement Group:** 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; review any issues brought to the Working Group's attention that relate to the members and membership, including complaints from members about membership and adjudicating on any application for disqualification from membership.

**Finance and Performance Working Group:** 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; to hold the Board's Performance and Investment Committee and the Integrated Audit Committee to account.

**Non-executive director Nominations and Remuneration Committee:** 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.

**Quality Working Group:** To receive quarterly reports from the Board's Quality Committee on the work around patient safety, patient experience and other aspects of quality including the Trust's Quality Accounts; to scrutinise the decisions made, or actions taken, in connection with the Quality Committee; make recommendations to the Council of Governors arising from the outcome of the scrutiny process.

## 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 separate 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 governor positions are vacated for election or 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**

Governors were first 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 2012/13, the Council of Governors consisted of the following:

Elected representatives for Medway (nine):

- Syed Ahamed
- Vivien Bouttell
- Renee Coussens
- Pamela Gibbon (re-elected in June 2012)
- Gillian Hammond (elected in June 2012)
- Margaret Ratcliffe
- Ann Richmond
- Ann Smart (elected in June 2012)
- Lee Tribe
- 

Elected representatives for Swale (four):

- Kelly Collins (elected November 2012 but did not take up the seat)
- Sarah Drury
- Christine Kite
- Ruth Jenner (re-elected in June 2012)
- VACANT

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

- Richard Tripp

Elected staff representatives (five):

- Trish Marchant (management class)
- Viv Parker (non clinical) (elected June 2012)
- Rosemary Toyne (medical and dental class)
- Inmaculada Diaz-Alonso (nursing and midwifery) (elected November 2012)
- John McLaughlin (allied health professions)

Nominated representatives from partner organisations (seven):

- Alison Burchell, NHS Medway
- Adrian Crowther, Kent County Council
- Councillor Jane Etheridge, Medway Council
- Peter Milburn, Christ Church University (retired February 2013, seat current vacant)
- Andrew Scott-Clark, NHS Eastern and Coastal Kent
- John Spence, League of Friends
- VACANT - Chamber of Commerce (seat has been vacant since January 2011 following the liquidation of the Organisation)

Appointed / Nominated	Name	Constituency	Term of office
<b>Appointed 2007</b>			
June 2007	Michael Burch	Medway(resigned 2010)	3 years
June 2007	Pam Gibbon	Medway	2 years
June 2007	Angela Jenkins	Medway	1 year
June 2007	Dai Liyanage	Medway (resigned 2008)	1 year
June 2007	Maggie Luck	Medway (resigned 2009)	2 years
June 2007	Ann Richmond	Medway	1 year
June 2007	Sheila Shepherd	Medway	2 years
June 2007	Lee Tribe	Medway	3 years
June 2007	Michael Ward	Medway (resigned 2008)	1 year
June 2007	Colin Allison	Swale (resigned 2009)	2 years
June 2007	Victoria Allison	Swale (resigned 2009)	3 years
June 2007	Lachlan Berntsen	Swale (resigned 2009)	3 years
June 2007	John Gibbons	Swale	2 years
June 2007	Serena Gilbert	Rest of England and Wales (resigned 2010)	3 years
June 2007	Paula Bell	Staff: Allied health professionals (resigned 2009)	2 years
June 2007	Marian Cogger	Staff: Non clinical	1 year
June 2007	Sharon Small	Staff: Nursing and midwifery (resigned 2009)	2 years
June 2007	Rosemary Toye	Staff: Medical and dental Class	3 years
June 2007	Geraldine Mott	Staff: Management class (resigned 2010)	3 years
<b>Appointed 2008</b>			
June 2008	Ann Richmond	Medway (re-elected)	3 years
June 2008	Angela Jenkins	Medway (re-elected, resigned 2011)	3 years
June 2008	Renee Coussens	Medway	3 years
June 2008	Margaret Ratcliffe	Medway	3 years
June 2008	Marian Cogger	Staff: Non clinical (resigned Sept 2008)	3 years
November 2008	Eric Ambrose	Staff: Non clinical (resigned 2010)	3 years
<b>Appointed 2009</b>			
June 2009	Nigel Cartlidge	Medway	3 years
June 2009	John Gibbons	Swale (re-elected, resigned Oct 2009)	3 years
June 2009	Ruth Jenner	Swale	3 years
June 2009	John Mount	Swale (resigned 2011)	3 years

June 2009	Sheila Shepherd	Medway (re-elected, resigned 2012)	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 (resigned 2012)	3 years
<b>Appointed 2010</b>			
June 2010	Vivien Bouttell	Medway	3 years
June 2010	Ronald Clayton	Swale (resigned Sept 2010)	3 years
June 2010	Stephen Funnell	Staff: Non clinical (resigned 2012)	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	2 ½ years
December 2010	Christine Kite	Swale	2 ½ years
December 2010	John McLaughlin	Staff: Allied health professionals	2 ½ years
<b>Appointed 2011</b>			
June 2011	Syed Ahamed	Medway	3 years
June 2011	Renee Coussens	Medway (re-elected)	3 years
June 2011	Margaret Ratcliffe	Medway (re-elected)	3 years
June 2011	Ann Richmond	Medway (re-elected)	3 years
September 2011	John Skelton	Swale (appointed from previous Swale governor election results)	9 months
<b>Appointed 2012</b>			
June 2012	Pam Gibbon	Medway (re-elected)	3 years
June 2012	Gillian Hammond	Medway	3 years
June 2012	Ruth Jenner	Swale (re-elected)	3 years
June 2012	Viv Parker	Staff: Non clinical	3 years
June 2012	Ann Smart	Medway	3 years
November 2012	Kelly Collins	Swale (elected but did not take up the seat)	0 years
November 2012	Inmaculada Diaz-Alonso	Staff: Nursing and midwifery	2 ½ years
<b>Nominated</b>			
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
June 2008 June 2011	Andrew Scott-Clark	NHS Eastern & Coastal Kent	3 years
Jan 2011	Vacant	Chamber of Commerce	3 years
April 2011	Peter Milburn	Universities (retired Feb 2013)	3 years
September 2011	Alison Burchell	NHS Medway	3 years

## Attendance at Council of Governors meetings 1 April 2012/31 March 2013

Attendee	Attendance
Denise Harker (Chairman)	9 out of 9
Syed Ahamed	8 out of 9
Vivien Bouttell	7 out of 9
Alison Burchell (including attendance on her behalf by her representative Dr Peter Green)	4 out of 9
Nigel Cartlidge	2 out of 2
Kelly Collins	0 out of 0
Renee Coussens	7 out of 9
Adrian Crowther	8 out of 9
Inmaculada Diaz-Alonso	1 out of 3
Sarah Drury	4 out of 9
Councillor Jane Etheridge	8 out of 9
Stephen Funnell	0 out of 1
Pamela Gibbon	5 out of 9
Gillian Hammond	5 out of 7
Ruth Jenner	8 out of 9
Christine Kite	6 out of 9
Trish Marchant	6 out of 9
Peter Milburn	3 out of 8
John McLaughlin	3 out of 9
Viv Parker	6 out of 7
Margaret Ratcliffe	9 out of 9
Ann Richmond	8 out of 9
Nancy Sayer	1 out of 2
Andrew Scott Clark	6 out of 9
Sheila Shepherd	2 out of 2
John Skelton	2 out of 2
Ann Smart	6 out of 7
John Spence	4 out of 9
Lee Tribe	6 out of 9
Rosemary Toyne	9 out of 9
Richard Tripp	6 out of 9

A register of governor's interests is held at the Trust's offices. Information regarding governor's interests and whether they have undertaken any material transactions with Medway NHS Foundation Trust can be obtained by contacting the governor and membership lead, Postgraduate Centre, Medway NHS Foundation Trust, Windmill Road, Gillingham, Kent, ME7 5NY, or email [members@medway.nhs.uk](mailto:members@medway.nhs.uk)

### Membership

The membership strategy outlines the Trust's vision 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 the needs of the local community to the Trust.

Monitor (the Trust's independent regulating body) requires the membership base to be representative of the local community. The Trust works hard at ensuring that its members reflect the socio economic breakdown of its population and are able to present a voice from the community.

In order to ensure the members reflect the socio economic breakdown, the Trust has calculated the age, gender and ethnic breakdown of the population it serves into percentages and the aim is to reflect those percentage breakdowns across the public membership.

The governor and membership lead regularly runs reports via the database software to determine which areas are under represented and require further recruitment drives.

As the Trust has exceeded its target membership total of 10,500, the main focus within the membership strategy is now on membership engagement.

### **Membership recruitment**

During 2012/13, the Membership Engagement Group planned several opportunities for recruiting new members.

A simple and cost effective method of face-to-face recruitment was orchestrated by the governor and membership lead. Methods included participation at University Fresher's' and Refreshers' Fairs, a presentation to college health and social care students and a mini recruitment drive in the Swale area. An advertisement on the Trust's website encouraging visitors to become members has also proved to be a successful exercise, producing on average eight new members per week. Each month staff who leave the Trust are also encouraged to remain members, with most opting to continue their support.

In the last 12 months a total of 1,294 public members were recruited. 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 is monitored by the Membership Engagement Group.

### **Engagement between members and governors**

The governors are always looking for ways to engage with their members and a programme of eight members' events are being scheduled for 2013.

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. Approximately 2,500 members have registered an email address in order to receive e-bulletins.

The Trust's website continues to be developed to ensure communication flows 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's intranet site enables staff and governors to access the site away from the Trust's premises and thus provides them with much more information.

Engagement between governors and members is an evolving and ongoing feature for the Trust and governors are continually looking at ways to improve 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 also held its fourth Annual Members Meeting as a foundation trust in September 2012; this was an extremely successful event held again at the St George's Centre, Chatham Maritime and the governors were fully involved in the success of this event.

## Membership base

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

Constituency	Total
Medway	7,112
Swale	2,029
Rest of England and Wales	2,256
<b>Membership Total</b>	<b>11,397</b>

**Statement setting out the steps that 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 directors understand and are aware of views expressed by governors and members.

The Council of Governors is chaired by the chairman of the Trust 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 Governors meetings and working groups on a regular basis to provide updates as and when requested by the governors.

The Council of Governors has undertaken scrutiny of a variety of subjects during the year 2012/13, including:

- Proposed integration with Dartford and Gravesham Trust
- Care of the elderly at Medway Maritime Hospital
- Hospital Standardised Mortality Ratio (HSMR)
- The Trust's performance against the Annual Plan
- The Trust's performance against the Quality Accounts
- Progress towards resolving the financial breach imposed by Monitor

The non-executive directors have an open invitation to attend the Council of Governors meetings and have attended regularly – the non-executive directors which chair the

Performance and Investment Committee, the Integrated Audit Committee and the Quality Committee regularly attend the Finance and Performance and Quality Working Group meetings to answer questions on the performance of the committees. The Trust chairman chairs the governors' Non-executive directors' Nominations and Remuneration Committee which is also attended by the senior independent director. One non-executive director attends the Membership Engagement Group to offer support and advice.

**Non-executive director attendance at Council of Governors meetings (including the annual members' meeting) 1 April 2012/31 March 2013**

<b>Attendee</b>	<b>Attendance</b>
Denise Harker	9 out of 9
Graham Clayden	4 out of 9
Adrian Horwood	6 out of 9
Martin Jamieson	0 out of 9
John Sands	5 out of 9
Jan Stephens	7 out of 9
Colin Wilby	8 out of 9

**Non-executive director attendance at Governors' Working Group/Committee meetings 1 April 2012/31 March 2013**

<b>Attendee</b>	<b>Attendance</b>
Denise Harker	3 out of 3
Adrian Horwood	3 out of 4
John Sands	3 out of 3
Jan Stephens	4 out of 5
Colin Wilby	7 out of 7

Governors are also invited to take part in various Trust task and finish groups and committees in order to communicate the views and concerns of their members.

Regular departmental visits take place at least four times a month and one governor accompanies one executive director and one non-executive director. The purpose of these visits is to develop a picture of a department or ward in terms of patient experience, staff experience and patient safety.

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 annual appraisal. The senior governor also has an open invitation to attend Board meetings, which she regularly attends together with one other nominated governor.

There is a specific item on the Board agenda to allow the senior governor to raise questions and concerns directly to the Board. Governors also keep a log of any queries raised with executive directors outside of their scheduled meetings and this log is presented each month at the Board meetings in order to update the Board of the types of concerns being reported.

The senior governor reports back at each Council of Governors meeting on the Board's performance.

Governors are informed as soon as possible by email of any significant concerns or developments, which are then followed up with progress reports at Council of Governors' 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.

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 to Membership Office, Postgraduate Centre, Medway NHS Foundation Trust, Windmill Road, Gillingham, Kent, ME7 5NY, by email to **members@medway.nhs.uk** or via the website at **www.medway.nhs.uk**

## Code of governance compliance

The Trust's Board of Directors support and agree with the principles set out in the 'NHS Foundation Trust Code of Governance', first published by Monitor in 2006 and updated in March 2010.

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 2012/13 year, the Trust has been compliant with the code with the exception of the following:

### **D.2 – Performance evaluation**

The chairman and executive directors have received appraisals in-year, however the non-executive director appraisal policy is currently being developed. The governors nominations and remunerations committee has discussed this and created an action for the company secretary to complete a policy and process.

# Annual governance statement

## **Scope of responsibility**

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

## **The purpose of the system of internal control**

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of 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 2013 and up to the date of approval of the Annual Report and accounts.

## **Capacity to handle risk**

### **Leadership**

The governance and risk infrastructure introduced in 2011/12 has continued to strengthen and support the work of the Board.

The overall responsibility for the management of risk lies with the chief executive as accounting officer. The Board of Directors, collectively and individually, ensure that robust systems of internal control and management are in place. Responsibility for leading the management of risk throughout the Trust has been delegated to the director of finance (for financial risk), to the medical and nursing directors (for clinical risk) and the director of governance and strategy (for corporate risks) at Board level.

The director of governance and strategy has also been identified as the senior information risk owner (SIRO) to fulfil the requirements to have an executive director responsible for managing information governance (IG) and associated risks at Board level.

The Trust Board gains assurance from the bi-monthly scrutiny of the board assurance framework and corporate risk register; it also receives reports from the Integrated Audit Committee and Quality Committee, both of which are chaired by non-executive directors. The clinical and executive group is chaired by the chief executive; the Board receives a report from him, which includes the activities of this group. These committees also receive assurance by way of reports from internal and external auditors, executives and minutes and reports from sub-committees including: infection prevention and control, health and safety, information governance, patient safety and patient experience.

The Board established a Workforce Committee in 2012/13. It reports directly to the Board and provides assurance to the Board that the appropriate structures, processes, and systems are in place to ensure an effective capable workforce to meet the Trust's current and future needs. It also ensures that the organisational development and workforce strategy and associated plans are aligned and focussed on meeting the needs of the clinical strategy.

The head of governance and risk receives a monthly report from the directorate governance leads (who are senior nurses and doctors) on their performance against the Care Quality Commission's 'Essential Standards of Quality' and also receives a signed compliance declaration. On a quarterly basis, this information is reviewed and signed off by the governance lead and the directorate's management team. A governance panel, consisting of the executive director leads for each of the CQC standards, supported by the head of governance and risk, meets on a quarterly basis and challenges each directorate team on the evidence supporting their declaration.

In 2012/13 the Trust was fully compliant with the registration requirements of the Care Quality Commission.

### **How staff are trained or equipped to manage risk**

Board and senior managers throughout the Trust receive annual risk awareness training and this year the focus has been on health and safety awareness for executives. Additional training has also been cascaded throughout the Trust via the directorate governance leads on the use of risk registers and an e-learning risk management module has been developed and introduced

Risks to data security are managed by providing annual information governance 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 and these are reviewed and updated. All known incidents are logged and reported to the Information

Governance Committee. A quarterly briefing is provided to the Board outlining recent incidents, work undertaken by the committee and progress against the Information Governance Toolkit.

## **The risk and control framework**

### **Governance structure and risk management**

The Trust's risk management strategy, which is available to all staff on the Trust's intranet site, outlines the Trust's overall processes for managing risk, corporate and directorate responsibilities for risk and the Trust's risk identification, evaluation and control system, as well as the risk management process. This was last approved by the Board in January 2011 and is being reviewed by the Integrated Audit Committee in April 2013 for approval by the Board at its May 2013 meeting.

All directorate risk registers for the Trust are now centralised electronically on DATIX. This is supported by monthly risk reviews led by the clinical and executive group.

The Integrated Audit Committee performs the key role of reviewing and monitoring the systems of internal control. It also receives regular reports on the work and findings of the external and internal auditors as well as from the local counter fraud specialist. Following each meeting a chair's report is provided to the Board of Directors. An Annual Report is also presented to the Board.

In July 2011, the Trust carried out a baseline self-assessment against the Quality Governance Framework. In accordance with Monitor's request for this work to be reviewed externally, the Trust commissioned the University Hospitals Southampton NHS Foundation Trust to conduct a peer review. This was completed in early April 2012 and Quality Committee informed of this.

### **Incident reporting**

The Trust's e-based reporting system, DATIX web, is now embedded across all wards and departments of the Trust so that incidents can be reported and input at source and data can be interrogated through ward, team and locality processes. This encourages local ownership and accountability for incident management.

The Trust continues to apply the principles and strategies developed by the National Patient Safety Agency (NPSA) and uses root cause analysis as a tool for undertaking structured investigations into serious incidents.

The Trust has a 'being open' policy which ensures that patients, carers and visitors are involved in discussion following an incident. The chief executive also holds open door sessions on a monthly basis which allows staff free access to report and discuss concerns.

### **Risk appetite**

The Trust recognises that it is impossible to deliver its services and achieve positive outcomes for its stakeholders in a completely risk-free context. Indeed, most actions that result in benefit will involve some form of risk. The Trust does however take these risks in a controlled manner, thus reducing its exposure to a level deemed acceptable from time to time by the Board and, by extension, external inspectors, regulators and relevant legislation.

### **How risks are identified**

Risks are identified from a number of sources including directorate meetings, performance reports, serious incidents, claims and reports from external organisations, internal management reviews, complaints and external audits, risk assessments and internal auditors' reports.

The Trust's corporate risk register incorporates finance and clinical risks. The highest scoring major risks are discussed at monthly meetings of the Clinical and Executive Group. Recommendations are then made to the Board. The significant clinical risks on the risk register throughout 2012/13 have been in relation to patient falls, infection control (MRSA bacteraemia), missed and delayed medications, failure to detect that a patient is deteriorating and delayed/ no action being taken to escalate this and bed capacity issues whereby patients may at times be nursed 'out-of-specialty'. During the year these have been managed and actions put in place to mitigate serious harm being caused. If significant harm to a patient does occur then this is recorded as a serious incident and is fully investigated through a root cause analysis with remedial actions implemented based on the findings.

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 RAG rated to reflect the level of risks to the organisation.

The Trust is designated with NHS Litigation Authority Risk Management Standards for Acute Trusts and maternity Clinical Negligence Scheme for Trusts at level two. Level two is described as having adequate policies and processes for managing risk and put into practice. The Trust also received a reduction in its NHSLA contribution as a result of having a low rate of claims recently.

## **Management of data security risks**

There were no serious incidents related to loss of data in 2012/13.

The Information Governance Committee (IGC) oversees and monitors data security risks and information governance risks are included in the corporate risk register. Minutes of the IGC are provided to the clinical and executive group on a regular basis. This year the Trust achieved an overall score of 80 percent and achievement of at least level two on all standards in the Department for Health's Information Governance Toolkit.

Attainment of the standards set out in the Information Governance Toolkit issued by 'Connecting for Health' is monitored by the IGC. The Board approved the 2012/13 Toolkit declaration at its March meeting and no departure from these standards is anticipated

Data protection incidents have increased slightly and 103 incidents have been reported within the Trust during 2012/13. None was recorded as a 'serious incident'.

## **Stakeholder involvement**

The Trust's 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. Those participating in departmental visits submit observation forms, which are fed back to the department and, if necessary, feedback is also provided to the Quality Committee. The Trust has continued with the 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 attended LINKs patient experience working groups for Medway and Swale before this group was disbanded. The Trust's complaints system has also identified areas and actions have been taken as a result of these.

## **Equality impact assessments**

The Trust has published a 'Corporate Equality Impact Assessment Programme'. The programme identifies priority impact assessments 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 and fairness steering group, through its monitoring of the Single Equality Scheme action plan.

The equality and fairness steering group, which reports to the Clinical Executive Group, scrutinises annual diversity monitoring reports and takes remedial action where necessary. The group ensures the Trust meets its legal duties and makes a positive contribution to the equality, diversity and human rights agenda. The Trust has enhanced workforce reports and

developed patient reports covering access to services, how patients experience services and complaints assessed against the protected characteristics to comply 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.

### **NHS Pension Scheme**

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.

### **Equality, diversity and human rights**

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

### **Carbon reduction delivery plans**

The Trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and adaptation reporting requirements are complied with.

### **Review of economy, efficiency and effectiveness of the use of resources**

The Trust achieves economy, efficient and effectiveness by internally employing a range of accountability and control mechanisms and also obtains independent, external assurances. To ensure that resources are used economically, efficiently and effectively across clinical services the Trust carries out regular monitoring of clinical indicators on quality and safety.

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

The Integrated Audit Committee agrees the work plan and monitors the work undertaken by the external and internal auditors, the 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. The committee continued with its programme of presentations during 2012/2013 on areas in which it was seeking assurances or further information on particular areas. These included complaints and PALS, the bed occupancy system and appointments and cancellations.

A non-executive director chairs the Performance and Investment Committee which provides independent and objective assurance to the Board that there are robust and integrated mechanisms in place on all areas of finance, performance and investment and to ensure that the Trust is compliant with its statutory and regulatory requirements.

The Board of Directors receives both performance and finance reports at each Board meeting, along with reports from each of its committees.

### **Annual Quality Report**

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) 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 formulation of the Quality Accounts has been led by the director of nursing with the full support of the Board and the Council of Governors. This work has involved discussion and consultation with the Board, staff, patients, and governors.

To support this work, and to assure the Board that appropriate controls are in place to ensure accuracy of data, the Quality Account is reviewed throughout the year to monitor progress being made on the Trust's priorities for improvement.

The Trust established a Clinical Quality Performance Committee, chaired by the director of nursing, which reviews on a monthly basis the clinical quality indicators, including the metrics in the Quality Account, and reports to the Quality Committee, a sub-committee of the Board on an exception basis, with a full report at the end of the financial year.

A quality performance indicator dashboard has been produced so that quality measures are seen together rather than dispersed in the operational performance dashboard.

The Quality Account, which is coordinated by the director of nursing, has input from professionals who lead on different issues, for example, clinical audit and paediatrics. This

allows directors to take an objective view of the data being submitted. The Quality Account will have been subject to review throughout the year via the Quality Committee.

The Quality Account 2012/13 is a comprehensive document and focussed on identifying and promoting quality issues. This is seen as the central document for the priorities for improvement in the quality of the Trust's services.

Comments and advice have been sought from clinicians, the Board, governors, members of the public, NHS Medway, Medway LINKs and Medway Council's Overview and Scrutiny Committee on the Quality Account. This has ensured that the Quality Account provides a balanced view of quality performance.

### **Review of effectiveness**

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit, the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report included in this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Integrated Audit Committee, the Performance and Investment Committee and the Quality Committee and plan to address weaknesses and ensure continuous improvement of the system is in place.

The main operational elements of the systems of internal control and governance to ensure that the Trust optimises the use of all resources 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 and the comprehensive system of budgetary control. The clinical and executive directors meet monthly to review operational performance and control.

The Board Assurance Framework sets out the principal risks to the delivery of the Trust's strategic objectives and key priorities. This is updated regularly to ensure it covers all areas on which the Board should be seeking assurance.

The executive director with responsibility for a strategic objective is also responsible for managing and monitoring the associated risks. The Board Assurance Framework, which is presented to the Board every two months, alternating with the corporate risk register,

identifies the key controls and assurances available in relation to the achievement of the Trust's objectives.

A non-executive director chairs the Quality Committee, which ensures an integrated and coordinated approach to the management and development of quality, patient experience and patient safety at a corporate level in the Trust. As part of this role, the Quality Committee receives the results of the national clinical audits and these are presented by the relevant directorate clinical audit lead.

The Trust also has an Audit Leads Committee, which reports to the Quality Committee, that has been established to coordinate clinical audit within the Trust and to oversee progress towards the annual clinical audit plan and is chaired by the Trust clinical audit lead.

The Trust appointed a full-time director of governance and risk in 2011 who was responsible for governance and compliance matters and this has improved the Trust's overall performance in all areas of compliance. In 2012/13 the Trust developed the role further and appointed a new director of governance and strategy. This role continues to ensure governance and risk matters are managed well and incorporated into the need for strategic development in the Trust.

My review is also informed by the following mechanisms.

- Review and challenge from non-executive directors within committees and at the Board and the 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 executive directors
- Review and challenge at the governance panel on the Care Quality Commission's 'Essential Standards of Quality and Safety'
- Review of Trust's performance against the Quality Governance Framework
- External review bodies, e.g. Care Quality Commission
- Discussions with Monitor and responses to Monitor to the quarterly Board declaration process
- 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 Quality Committee's regular review of the Quality Accounts
- 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 primary care trusts, 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

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.

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

- Two yearly review of the risk management strategy by the Board
- Ongoing 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 verify that a system of risk management is in place.

### **Monitor conditions**

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, the Trust was placed in significant breach of its terms of authorisation and this still remains the case.

As a result of this, Monitor decided that the Trust was 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. The Trust has therefore remained red rated for governance risk and will do so until Monitor is assured that the Trust is returning to full and sustainable compliance with its authorisation.

The Trust reached a Monitor risk rating of three for quarter two and sustained this achievement for the rest of the year and to the end of the subsequent quarter.

In the final six weeks of 2012/13, the Trust, like many other trusts in the country, experienced high levels of demand through its Emergency Department and unscheduled

admissions. As a result, it incurred increased levels of spend, in both pay (especially agency spend) and non-pay (clinical supplies and drugs). This meant that it finished the year with a deficit of £1.78m, some £780k greater than the Annual Plan. The conditions over this period also resulted in failure to achieve the four hour Emergency Department waiting time for the quarter and the year overall. The Trust is actively reviewing its emergency and urgent care pathways in the first half of 2013/14 to ensure sufficient capacity, flexibility and resilience going forward.

The Trust remains committed to returning to a sustainable financial footing such that a Monitor financial risk rating of three is delivered in financial year 2013/14.

### **Keogh Review**

The Trust approach to patient safety has been entirely focused on reducing harm and avoidable deaths. Our results demonstrate improvement in key elements of our patient safety metrics. We do, however, recognise that our HSMR has not improved correspondingly and in October 2012 made the decision to set up the Mortality Working Party, a multi-agency group to support the Trust in an increased focus on improving patient safety and reducing HSMRs. The Working Party is independently chaired by the director of public health for Medway and this work has been supported internally by actively engaging with staff utilising the Listening into Action programme, of which the Trust is a national pioneer.

On 6 February, the Prime Minister announced that he had asked Professor Sir Bruce Keogh to review the quality of care and treatment provided by those NHS trusts and NHS foundation trusts that are outliers on mortality indicators. Fourteen hospital trusts will be investigated as part of this review on the basis that they have been outliers for the last two consecutive years on the Summary Hospital-Level Mortality Indicator or the Hospital Standardised Mortality Ratio (HSMR). Medway NHS Foundation Trust has been identified as one of these hospitals. The Trust will be participating in the review and working with the review panel to improve outcomes.

### **Integration with Dartford & Gravesham NHS Trust**

Medway Foundation Trust has been working closely with Dartford & Gravesham NHS Trust to integrate and form the North Kent Hospitals NHS Foundation Trust. As a result of the NHS England review, it was decided in February 2013 by the Medway Foundation Trust Board to pause the Monitor assessment process for integration. In the meantime the designate board meets and collaborative work continues wherever possible. Office functions, such as some within the finance directorates, and some clinical services are working together to create and exploit possible synergies.

**Conclusion**

The Trust has a robust system of internal control that supports its aims and objectives, whilst safeguarding patients and the public as well as public funds and departmental assets. We have taken steps to mitigate and resolve issues that have arisen in year and continue to work towards successful assurance outcomes. The Trust continues to report regularly to Monitor.

Signed: M Devlin, Chief Executive

Date: 30 May 2013

## **Independent Auditor's Report to the Board of Governors of Medway NHS Foundation Trust on the 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 Medway NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

### **Scope and subject matter**

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

1. number of clostridium difficile infections
2. 28 day readmission rates.

We refer to these national priority indicators collectively as the "indicators".

### **Respective responsibilities of the Directors and auditors**

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by 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 Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the list below; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

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 became aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the list of documents below:

- Board minutes for the period April 2012 to May 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to May 2013;
- Feedback from the Commissioners dated 29 May 2013;
- Feedback from local Healthwatch organisations dated 28 May 2013;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- The latest national patient survey dated February 2012 for outpatients and April 2013 for inpatients;
- The latest national staff survey dated 2012;
- Care Quality Commission quality and risk profiles dated May 2013; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2013.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Medway NHS Foundation Trust as a body, to assist the Council 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 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and 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 Audit or Reviews of Historical Financial Information” issued by the International Auditing and Assurance Standards Board (“ISAE 3000”). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; 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**

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

## **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 2013:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the list above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

**Leigh Lloyd-Thomas** (Senior statutory auditor)

for and on behalf of BDO LLP

London, UK

29 May 2013

# Annual accounts 2012/13

## 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 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 Medway NHS Foundation Trust and to enable him to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting officer is also responsible for safeguarding the assets of Medway 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: 29 May 2013

## **Independent auditor's 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 2013 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

This report is made solely to the Board of Governors of Medway NHS Foundation Trust, as a body, in accordance with paragraph 5.2 of Audit Code for NHS Foundation Trusts. Our audit work has been undertaken so that we might state to the Board of Governors of Medway NHS Foundation Trust 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 NHS 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 the Chief Executive's Responsibilities as the Accounting Officer, the Accounting Officer is responsible for the preparation of the financial statements which give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law 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 Medway NHS 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 affairs of Medway NHS Foundation Trust's affairs as at 31 March 2013 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with NHS Foundation Trust Annual Reporting Manual 2012/13; and
- have been prepared in accordance with the National Health Service Act 2006.

## **Opinion on other matters on which we are required to report**

In our opinion:

- the part of the directors' remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13; and
- the information given in the Directors' report for the financial year for which the financial statements are prepared is consistent with the financial statements.

## **Matters on which we report by exception**

Medway NHS Foundation Trust has a general duty under paragraph 63 of Chapter 5 of the National Service Act 2006 to exercise the functions of the 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 Medway NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

On 27 April 2011 Monitor issued a notice to Medway NHS 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 have been unable to satisfy ourselves that Medway NHS Foundation Trust made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in respect of the following other matters which the Audit Code for NHS Foundation Trusts requires us to report to you if we have been unable to satisfy ourselves that:

- proper practices have been observed in the compilation of the financial statements; or
- the annual governance statement meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with other information that is forthcoming from the audit; or
- the quality report has been prepared in accordance with the detailed guidance issued by Monitor.

## **Qualified certificate**

We certify that we have completed the audit of the financial statements 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 except that, as noted above, we have been unable to satisfy ourselves that Medway NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

**Leigh Lloyd-Thomas** (Senior statutory auditor)

for and on behalf of BDO LLP

London, UK

29 May 2013

**STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED  
31 March 2013**

	NOTE	2012/13 £000	2011/12 £000
<b>Revenue</b>			
Revenue from patient care activities	3	212,074	202,910
Other operating revenue	4	25,304	24,495
Operating expenses	5	<u>(234,356)</u>	<u>(223,410)</u>
<b>Operating surplus</b>		<b>3,022</b>	<b>3,995</b>
<b>Finance costs</b>			
Finance income	11	109	31
Finance expenses - financial liabilities	12	(92)	(128)
Finance expenses - unwinding of discount on provisions	24	(22)	(22)
PDC Dividends payable		<u>(4,797)</u>	<u>(4,848)</u>
<b>Net finance costs</b>		<u><b>(4,802)</b></u>	<u><b>(4,967)</b></u>
<b>Operating deficit prior to impairment</b>		<b>(1,780)</b>	<b>(972)</b>
Impairment Losses - Property plant and equipment		(413)	(46)
Impairment Reversals - Property plant and equipment		<u>248</u>	<u>451</u>
<b>Deficit for the year</b>		<u><b>(1,945)</b></u>	<u><b>(567)</b></u>
<b>Other comprehensive income</b>			
Revaluation gains and (impairment losses) property, plant and equipment		<u>92</u>	<u>1,700</u>
<b>Total comprehensive income / (expenditure) for the year</b>		<u><b>(1,853)</b></u>	<u><b>1,133</b></u>

The notes on pages 136 to 165 form part of these accounts.

All operating activities are from continuing operations.

**STATEMENT OF FINANCIAL POSITION AS AT  
31 March 2013**

		31 March 2013 £000	31 March 2012 £000
<b>Non Current Assets</b>	<b>NOTE</b>		
Property, plant and equipment	13.1	<u>145,581</u>	<u>147,906</u>
<b>Total non current assets</b>		<b>145,581</b>	<b>147,906</b>
<b>Current Assets</b>			
Inventories	14.1	5,592	5,460
Trade and other receivables	15	15,377	11,296
Other current assets	18	6	52
Cash and cash equivalents	25	<u>7,111</u>	<u>1,898</u>
<b>Total current assets</b>		<b>28,086</b>	<b>18,706</b>
<b>Current liabilities</b>			
Trade and other payables	19	(27,003)	(19,023)
Borrowings	21	(1,234)	(1,157)
Provisions	24	(172)	(151)
Other liabilities	20	<u>(36)</u>	<u>(66)</u>
<b>Total current liabilities</b>		<b>(28,445)</b>	<b>(20,397)</b>
<b>Total assets less current liabilities</b>		<b>145,222</b>	<b>146,215</b>
<b>Non current liabilities</b>			
Borrowings	21	(3,295)	(2,693)
Provisions	24	<u>(838)</u>	<u>(855)</u>
<b>Total non current liabilities</b>		<b>(4,133)</b>	<b>(3,548)</b>
<b>Total assets employed</b>		<u><b>141,089</b></u>	<u><b>142,667</b></u>
<b>Financed by:</b>			
<b>Taxpayers' equity</b>			
Public dividend capital		109,423	109,148
Revaluation reserve		31,655	32,038
Income and expenditure reserve		11	1,481
<b>Total taxpayers' equity</b>		<u><b>141,089</b></u>	<u><b>142,667</b></u>

The financial statements were approved and authorised for issue by the Board on 28<sup>th</sup> May 2013 and signed on its behalf by the Chief Executive and Director of Finance.

Signed: M Devlin, Chief Executive

Date: 29 May 2013

Signed: D Meikle, Director of Finance

Date: 29 May 2013

## STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000	<b>Total £000</b>
At 1 April 2012	109,148	32,038	1,481	<b>142,667</b>
Deficit for the year	-	-	(1,945)	<b>(1,945)</b>
Revaluation gains and impairment losses property, plant and equipment	-	92	-	<b>92</b>
Public Dividend Capital received	275	-	-	<b>275</b>
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	-	(475)	475	<b>0</b>
Taxpayers' equity as at 31 March 2013	<u><b>109,423</b></u>	<u><b>31,655</b></u>	<u><b>11</b></u>	<u><b>141,089</b></u>
At 1 April 2011	109,104	31,223	1,163	<b>141,490</b>
Deficit for the year	-	-	(567)	<b>(567)</b>
Revaluation gains and impairment losses property, plant and equipment	-	1,700	-	<b>1,700</b>
Public Dividend Capital received	44	-	-	<b>44</b>
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	-	(885)	885	<b>0</b>
Taxpayers' equity as at 31 March 2012	<u><b>109,148</b></u>	<u><b>32,038</b></u>	<u><b>1,481</b></u>	<u><b>142,667</b></u>

**STATEMENT OF CASH FLOWS FOR THE YEAR ENDED  
31 March 2013**

	NOTE	2012/13 £000	2011/12 £000
<b>Cash flows from operating activities</b>			
Operating surplus from continuing operations		2,857	4,400
<b>Non-cash income and expense</b>			
Depreciation and amortisation		8,439	8,608
Impairments		165	(405)
(Gain)/Loss on Disposal		(10)	(39)
Non-cash donations/grants credited to income		(198)	0
Dividends accrued and not paid or received		117	0
(Increase) /Decrease in Trade and Other Receivables		(4,081)	2,130
(Increase) / decrease in other assets		0	70
(Increase) / decrease in Inventories		(132)	(675)
Increase / (Decrease) in Trade and other Payables		7,980	(2,130)
Increase / (decrease) in other liabilities		0	(45)
Increase / (decrease) in Provisions		(3)	(16)
<b>Net cash generated from operations</b>		<b>15,134</b>	<b>11,898</b>
<b>Cash flows from investing activities</b>			
Interest received		109	31
Payments to acquire Property, Plant and Equipment		(5,818)	(5,885)
Receipts from sales of Property, Plant and Equipment		10	353
<b>Net cash used in investing activities</b>		<b>(5,699)</b>	<b>(5,501)</b>
<b>Cash flows from financing activities</b>			
Public dividend capital received		275	44
Loans received	21	1,680	232
Loans repaid	21	(80)	(58)
Capital element of finance lease rental payments		(1,091)	(1,059)
Interest paid		(2)	(27)
Interest element of finance leases		(90)	(101)
PDC Dividend paid		(4,914)	(4,875)
<b>Net cash used in financial activities</b>		<b>(4,222)</b>	<b>(5,844)</b>
<b>Increase / (decrease) in cash and cash equivalents</b>		<b>5,213</b>	<b>553</b>
<b>Cash and Cash equivalents at 1 April</b>		<b>1,898</b>	<b>1,345</b>
<b>Cash and Cash equivalents at 31 March</b>	<b>26</b>	<b>7,111</b>	<b>1,898</b>

## NOTES TO THE ACCOUNTS

### 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 2012/13* 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, inventories, certain financial assets and financial liabilities, and the other financial asset relating to the 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 contracts with commissioners in respect of healthcare services 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 accrual was those patients who were occupying a Trust bed on 31st March 2013 but were not discharged until the following 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 2012/13 and 2013/14 financial years, based on the distribution of length of stay.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

#### 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.

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 2013 as at the valuation date of 31 March 2013.

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 that date are 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 are 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 *NHS Foundation Trust Annual Reporting Manual*, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent 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.:
  - o management are committed to a plan to sell the asset;
  - o an active programme has begun to find a buyer and complete the sale;
  - o the asset is being actively marketed at a reasonable price;
  - o the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
  - o the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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

### **1.5 Donated, government grant and other grant funded assets**

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

### **1.6 Revenue government and other grants**

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

## **1.7 Inventories**

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using average cost of pharmacy stock and latest prices for all other stock which 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 2.45% (2011/12: 2.8%) 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 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 27, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

## **1.9 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](http://www.pensions.nhsbsa.nhs.uk). The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. 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.

All other financial assets and financial liabilities are recognised when the Trust becomes party to the contractual provisions of the instrument.

## **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 commencement of the lease. 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, to achieve a constant rate of finance over the life of the lease, 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 payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balance 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 the trust not been bearing its 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 and as deferred income in liabilities, valued at fair value. As the Trust makes emissions a provision is recognised. The provision is settled on surrender of the allowances. The other financial asset, provision and deferred income amount 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 requires consolidation as a subsidiary entity. 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 the period ending 31 March 2013.

## **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.

IFRS 9 Financial Instruments  
IFRS 10 Consolidated Financial Statements  
IFRS 11 Joint Arrangements  
IFRS 12 Disclosure of Interests in Other Entities  
IFRS 13 Fair Value Measurement  
IAS 12 Income Taxes amendment  
IAS 1 Presentation of financial statements, on other comprehensive income (OCI)  
IAS 27 Separate Financial Statements  
IAS 28 Associates and joint ventures  
IAS 19 Employee Benefits  
IAS 32 Financial Instruments – Presentation  
IFRS 7 Financial Instruments - Disclosure

## **1.21 Restructuring costs**

In accordance with IAS 37 the Trust has disclosed an element of the redundancy costs as restructuring. These amounts relates to the cessation of the activities of an entire department or the removal of a management function.

## **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 PCT's shown below amounted to £210,439,000. (2011/12 £201,367,000) 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 analysis.

## Operating segments 2012/13

	A&E and Adult Medicine £000	Children and Women's Services £000	Surgery and Anaesthetics £000	Central £000	Total £000
Income	78,417	47,173	76,902	15,204	217,696
Expenditure	<u>(63,447)</u>	<u>(42,411)</u>	<u>(70,244)</u>	<u>(14,769)</u>	<u>(190,871)</u>
Contribution	14,970	4,762	6,658	435	26,825

### Reconciliation to accounts

	Directorates £000	Under 10% £000	Total £000
Income	217,696	19,930	237,626
Expenditure	<u>(190,871)</u>	<u>(35,459)</u>	<u>(226,330)</u>
Contribution	26,825	(15,529)	11,296
			Depreciation (8,439)
			Finance expenses (114)
			Finance income 109
			PDC dividend <u>(4,797)</u>
			<u>Operating deficit (1,945)</u>

## Operating segments 2011/12

	A&E and Adult Medicine £000	Children and Women's Services £000	Surgery and Anaesthetics £000	Central £000	Total £000
Income	76,462	46,257	74,422	8,444	205,585
Expenditure	<u>(60,894)</u>	<u>(40,905)</u>	<u>(67,583)</u>	<u>(13,753)</u>	<u>(183,135)</u>
Contribution	15,568	5,352	6,839	(5,309)	22,450

### Reconciliation to accounts

	Directorates £000	Under 10% £000	Total £000
Income	205,585	22,271	227,856
Expenditure	<u>(183,135)</u>	<u>(31,713)</u>	<u>(214,848)</u>
Contribution	22,450	(9,442)	13,008
			Depreciation (8,608)
			Finance expenses (150)
			Finance income 31
			PDC dividend <u>(4,848)</u>
			<u>Operating deficit (567)</u>

### 3. Income from Activities

#### 3.1 Income from Activities (by classification)

	2012/13	2011/12
	£000	£000
Elective income	39,594	36,596
Non elective income	70,483	69,474
Outpatient income	43,297	41,952
A & E income	7,631	7,353
Other NHS clinical income	49,434	46,072
Private patient income	615	292
Other non-protected clinical income		
- Injury cost recovery (including Road Traffic Act Income)	1,020	1,171
	<u>212,074</u>	<u>202,910</u>

#### Other NHS clinical income includes

	2012/13	2011/12
	£000	£000
Direct Access	9,349	9,533
NICU	6,790	6,962
ICU	5,482	5,645
High Cost Drugs	8,062	6,581
	<u>29,683</u>	<u>28,721</u>

#### 3.2 Income from Activities (by type)

	2012/13	2011/12
	£000	£000
Primary Care Trusts	210,439	201,367
NHS Foundation Trusts	0	44
NHS Trusts	0	36
Non NHS:		
- Private patients	369	158
- Overseas patients (non-reciprocal)	246	134
- Injury cost recovery (including Road Traffic Act Income)	1,020	1,171
	<u>212,074</u>	<u>202,910</u>

Injury Cost Recovery income is subject to a provision for doubtful debts of 12.6% (10.5% 2011/12) to reflect expected rates of collection.

The statutory limitation on private patient income in section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. Therefore financial statements disclosures that were provided previously are no longer required.

### 4 Other Operating Income

	2012/13	2011/12
	£000	£000
Research and development	763	378
Education and training	6,189	5,645
Charitable and other contributions to expenditure	453	412
Non-patient care services to other bodies	7,343	8,313
Reversal of Impairment	248	451
Other income	10,546	9,684
Profit on disposal of property, plant and equipment	10	63
	<u>25,552</u>	<u>24,946</u>

## Other Income includes

	2012/13	2011/12
	£000	£000
Car parking	1,448	1,317
Staff accommodation	481	390
Creche	344	349
Catering	799	662
	<u>3,072</u>	<u>2,718</u>

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

## 5 Operating Expenses (by type)

### Operating expenses comprise

	2012/13	2011/12
	£000	£000
Services from other NHS Trusts	6,180	5,835
Services from PCTs	118	133
Services from non NHS bodies	511	1,397
Services from Foundation Trusts	289	717
Non-executive Directors' costs	135	132
Executive Directors' costs	908	718
Staff costs	149,443	146,268
Supplies and services - clinical	39,466	35,736
Supplies and services - general	2,875	2,397
Consultancy services	1,682	2,018
Establishment	2,438	2,046
Transport	250	176
Premises	7,797	7,150
Increase in bad debt provision	77	88
Depreciation	8,439	8,608
Fixed asset impairments and reversals	413	46
Loss on disposal	0	24
Statutory audit fee	76	73
Other auditor remuneration	2	0
Clinical negligence	5,374	5,067
Redundancy	0	545
Restructuring	1,705	543
Other	6,591	3,739
	<u>234,769</u>	<u>223,456</u>

The Trust incurred £76,000 (2011/12 £73,000) in audit services fees in relation to the statutory audit of the Trust to 31 March 2013, which included the fees for auditing the Trust's Quality Report for 2012/13. In addition to the above, other auditor remuneration (audit related assurance services) comprised £1,700 paid in respect of the auditor's involvement in providing information to other advisers to support the Trust's proposed merger with Dartford and Gravesham NHS Trust.

The impairment loss in 2012/13 of £413,000 (2011/12 £46,000) and Impairment Reversal of £248,000 (2011/12 £451,000) 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

	<b>2012/13</b>	2011/12
	<b>£000</b>	£000
Minimum lease payments	<u>434</u>	<u>434</u>
	<b>434</b>	<b>434</b>

#### Total future minimum lease payments

#### Total future minimum lease payments

			<b>31 March</b>	31 March
			<b>2013</b>	2012
	Buildings	Other	<b>Total</b>	Total
Payable:	£000	£000	<b>£000</b>	£000
Not later than one year	132	277	<b>409</b>	434
Between one and five years	<u>228</u>	<u>378</u>	<b>606</b>	<u>1,041</u>
<b>Total</b>	<u>360</u>	<u>655</u>	<b>1,015</b>	<u>1,475</u>

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 £41,294 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

	<b>£000</b>	£000
Amounts included within other interest payable arising from claims made under this legislation	<b>1</b>	1

## 8 Employee expenses and numbers

### 8.1 Employee expenses

	<b>Total</b>	<b>2012/13 Permanently Employed</b>	<b>Other</b>	<b>Total</b>	<b>2011/12 Permanently Employed</b>	<b>Other</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
Salaries and wages	127,805	114,288	13,517	124,033	112,213	11,820
Social Security Costs	9,814	9,625	189	10,038	9,582	456
Employer contributions to NHS Pension Scheme	12,732	12,658	74	12,915	12,573	342
Termination benefits	1,401	1,401	0	1,088	1,088	0
	<b>151,752</b>	<b>137,972</b>	<b>13,780</b>	<b>148,074</b>	<b>135,456</b>	<b>12,618</b>

This analysis excludes non-executive director costs of £135,000 (2011/12 £132,000)

### 8.2 Directors' Remuneration and Other Benefits

	<b>2012/13 £000</b>	<b>2011/12 £000</b>
Directors Remuneration	922	693
Social Security Costs	56	80
Employer contributions to NHS Pension scheme	65	77
Total Remuneration	<b>1,043</b>	<b>850</b>

5 directors (2011/12 6) are accruing pension benefits under the NHS Pension Scheme (Defined benefits)

### 8.3 Average number of persons employed

	<b>Total</b>	<b>2012/13 Permanently Employed</b>	<b>Other</b>	<b>Total</b>	<b>2011/12 Permanently Employed</b>	<b>Other</b>
	<b>Number</b>	<b>Number</b>	<b>Number</b>	<b>Number</b>	<b>Number</b>	<b>Number</b>
Medical and dental Administration and estates	476	453	23	450	426	24
Healthcare assistants and other support staff	1,088	989	99	1,104	1,007	97
Nursing, midwifery and health visiting staff	542	542	0	541	541	0
Nursing, midwifery and health visiting learners	1,195	1,035	160	1,253	1,036	217
Scientific, therapeutic and technical staff	19	19	0	19	19	0
	288	266	22	282	265	17
Total	<b>3,608</b>	<b>3,304</b>	<b>304</b>	<b>3,649</b>	<b>3,294</b>	<b>355</b>

## 8.4 Staff Sickness

	2012/13	2011/12
	Number	Number
Days lost (long-term)	29,777	20,755
Days lost (short term)	21,925	17,834
<b>Total days lost</b>	<b>51,702</b>	<b>38,589</b>
<b>Total Staff Years</b>	<b>3,304</b>	<b>3,321</b>
Average working days lost	15.6	11.6
Total staff employed in period (headcount)	3,880	3,848
Total staff employed in period with no absence (headcount)	1,157	1,418
<b>Percentage staff with no sick leave</b>	<b>30%</b>	<b>37%</b>

## 8.5 Reporting of other compensation schemes - exit packages

2012/13						
	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages
Exit package cost band	Number	£000s	Number	£000s	Number	£000s
<£10,000	2	15	16	67	18	82
£10,001 - £25,000	4	82	4	57	8	139
£25,001 - 50,000	3	130	1	36	4	166
£50,001 - £100,000	2	158	0	0	2	158
£100,001 - £150,000	1	134	0	0	1	134
£150,001 - £200,000	4	682	0	0	4	682
>£200,001	0	0	0	0	0	0
<b>Total</b>	<b>16</b>	<b>1,201</b>	<b>21</b>	<b>160</b>	<b>37</b>	<b>1,361</b>

2011/12						
	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages
Exit package cost band	Number	£000s	Number	£000s	Number	£000s
<£10,000	7	38	0	0	7	38
£10,001 - £25,000	10	182	0	0	10	182
£25,001 - 50,000	6	193	0	0	6	193
£50,001 - £100,000	2	139	0	0	2	139
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	2	320	0	0	2	320
>£200,001	1	216	0	0	1	216
<b>Total</b>	<b>28</b>	<b>1,088</b>	<b>0</b>	<b>0</b>	<b>28</b>	<b>1,088</b>

There have been no (2011/12 0) departures where special payments have been made.

## 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](http://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.

This 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.

The last formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. The notional deficit of the scheme was calculated at £3.3 billion by the Government Actuary, and concluded that the scheme continues to operate on a sound financial basis. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision. Employer and employee contribution rates are currently being determined under the new scheme design. Employers currently pay contributions at 14% of pensionable pay and employees contributions are on a tiered scale from 5% to 8.5% depending on total earnings.

### b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2013, is based on detailed membership data as at 31 March 2010 updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

### c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained: The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

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

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011/12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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.

### 10 Retirements due to ill-health

During 2012/13 there was 3 (2011/12, 1) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £247,274 (2011/12, £36,529). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

### 11 Finance income

	2012/13 £000	2011/12 £000
Interest on bank accounts	109	31
	<u>109</u>	<u>31</u>

### 12 Finance costs – interest expense

	2012/13 £000	2011/12 £000
Finance leases	90	101
Working Capital Facility	0	26
Other	2	1
	<u>92</u>	<u>128</u>

### 13. Property, plant and equipment

#### 13.1 Property, plant and equipment 2012/13

	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 2012	20,370	106,805	6,086	1,372	35,518	485	10,112	10,218	190,966
Additions - purchased	0	21	0	4,250	1,128	0	275	2	5,676
Additions - donated	0	27	0	42	247	0	17	7	340
Additions - leased	0	0	0	0	145	0	26	0	171
Impairments	0	(354)	(1)	0	0	0	0	0	(355)
Reclassifications	0	2,245	147	(2,806)	130	0	266	18	0
Revaluation	30	(4,061)	27	0	0	0	0	0	(4,004)
Disposals	0	0	0	0	(496)	0	0	0	(496)
<b>Cost or Valuation at 31 March 2013</b>	<b>20,400</b>	<b>104,683</b>	<b>6,259</b>	<b>2,858</b>	<b>36,672</b>	<b>485</b>	<b>10,696</b>	<b>10,245</b>	<b>192,298</b>
Depreciation at 1 April 2012	0	207	56	0	26,893	475	6,400	9,029	43,060
Provided during the year	0	4,173	230	0	2,605	2	1,168	261	8,439
Impairments	0	413	0	0	0	0	0	0	413
Reversal of impairments	0	(248)	0	0	0	0	0	0	(248)
Revaluation	0	(4,261)	(190)	0	0	0	0	0	(4,451)
Disposals	0	0	0	0	(496)	0	0	0	(496)
<b>Depreciation at 31 March 2013</b>	<b>0</b>	<b>284</b>	<b>96</b>	<b>0</b>	<b>29,002</b>	<b>477</b>	<b>7,568</b>	<b>9,290</b>	<b>46,717</b>
<b>Net book value</b>									
- Owned at 1 April 2012	20,370	105,493	6,030	1,372	4,729	0	2,928	1,155	142,077
- Finance lease at 1 April 2012	0	0	0	0	2,881	0	777	0	3,658
- Government Granted at 1 April 2012	0	0	0	0	60	0	0	0	60
- Donated at 1 April 2012	0	1,105	0	0	955	10	7	34	2,111
<b>- Total at 1 April 2012</b>	<b>20,370</b>	<b>106,598</b>	<b>6,030</b>	<b>1,372</b>	<b>8,625</b>	<b>10</b>	<b>3,712</b>	<b>1,189</b>	<b>147,906</b>
- Owned at 31 March 2013	20,400	103,317	6,123	2,816	4,667	0	2,488	922	140,733
- Finance lease at 31 March 2013	0	0	0	0	2,074	0	622	0	2,696
- Government Granted at 31 March 2013	0	0	0	0	0	0	0	0	0
- Donated at 31 March 2013	0	1,082	40	42	929	8	18	33	2,152
<b>- Total at 31 March 2013</b>	<b>20,400</b>	<b>104,399</b>	<b>6,163</b>	<b>2,858</b>	<b>7,670</b>	<b>8</b>	<b>3,128</b>	<b>955</b>	<b>145,581</b>

### 13.2 Analysis of property, plant and equipment 31 March 2013

#### Net book value

Protected assets at 31 March 2013	20,185	104,399	0	0	0	0	0	0	124,584
Unprotected assets at 31 March 2013	215	0	6,163	2,858	7,670	8	3,128	955	20,997
	<b>20,400</b>	<b>104,399</b>	<b>6,163</b>	<b>2,858</b>	<b>7,670</b>	<b>8</b>	<b>3,128</b>	<b>955</b>	<b>145,581</b>

### 13.3 Property, plant and equipment 2011/12

	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 2011	20,435	105,281	6,081	1,570	37,000	475	8,704	10,126	189,672
Additions - purchased	0	0	0	4,826	3,172	0	929	0	8,927
Additions - donated	0	0	0	0	251	10	3	14	278
Additions - government granted	0	0	0	0	60	0	0	0	60
Impairments	(5)	(121)	(50)	0	0	0	0	0	(176)
Reclassifications	0	3,795	94	(5,024)	350	0	617	168	0
Revaluation	0	(1,918)	(39)	0	0	0	0	0	(1,957)
Disposals	(60)	(232)	0	0	(5,315)	0	(141)	(90)	(5,838)
<b>Cost or Valuation at 31 March 2012</b>	<b>20,370</b>	<b>106,805</b>	<b>6,086</b>	<b>1,372</b>	<b>35,518</b>	<b>485</b>	<b>10,112</b>	<b>10,218</b>	<b>190,966</b>
Depreciation at 1 April 2011	0	130	34	0	29,246	472	5,470	8,862	44,214
Provided during the year	0	4,109	239	0	2,930	3	1,070	257	8,608
Impairments	0	32	7	0	7	0	0	0	46
Reversal of impairments	0	(439)	(12)	0	0	0	0	0	(451)
Revaluation	0	(3,621)	(212)	0	0	0	0	0	(3,833)
Disposals	0	(4)	0	0	(5,290)	0	(140)	(90)	(5,524)
<b>Depreciation at 31 March 2012</b>	<b>0</b>	<b>207</b>	<b>56</b>	<b>0</b>	<b>26,893</b>	<b>475</b>	<b>6,400</b>	<b>9,029</b>	<b>43,060</b>

### 13.4 Analysis of property, plant and equipment 31 March 2012

#### Net book value

Protected assets at 31 March 2012	20,155	106,598	0	0	0	0	0	0	126,753
Unprotected assets at 31 March 2012	215	0	6,030	1,372	8,625	10	3,712	1,189	21,153
	<b>20,370</b>	<b>106,598</b>	<b>6,030</b>	<b>1,372</b>	<b>8,625</b>	<b>10</b>	<b>3,712</b>	<b>1,189</b>	<b>147,906</b>

### 13.4 Property, plant and equipment (contd)

Of the totals at 31 March 2013, 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	£50,746
Medway League of Friends	£201,299
Oliver Fisher Special Care Baby Unit	£45,846
The Dinwoodie Settlement	£42,160

### 13.5 Impairments

	2012/13	2011/12
	£000	£000
<b>Property, plant and Equipment</b>		
Loss or damage from normal operations	0	14
Changes in market price	768	208
Reversal of impairments	(248)	(451)
<b>TOTAL</b>	<b>520</b>	<b>(229)</b>

### 13.6 Economic lives and valuations

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

During the year the land, buildings and dwellings were valued by the Valuation Office Agency on a Modern Equivalent Asset basis.

## 14 Inventories

### 14.1 Inventories

	31 March 2013	31 March 2012
	£000	£000
Drugs	1,370	1,193
Consumables	4,222	4,267
<b>TOTAL</b>	<b>5,592</b>	<b>5,460</b>

### 14.2 Inventories recognised in expenses

	2012/13	2011/12
	£000	£000
Inventories recognised as an expense in the year	(38,208)	(34,248)
	<b>(38,208)</b>	<b>(34,248)</b>

## 15 Trade receivables and other receivables

	31 March 2013 £000	31 March 2012 £000
<b>Current:</b>		
NHS receivables	9,394	6,466
Provision for impaired receivables	(426)	(349)
Prepayments, accrued income and deferred expenditure	1,231	885
PDC dividend receivable	128	11
Other receivables	5,050	4,283
<b>TOTAL</b>	<b>15,377</b>	<b>11,296</b>

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.

## 16 Provision for impairment of receivables

	31 March 2013 £000	31 March 2012 £000
Balance at 1 April	349	281
Increase in provision	77	88
Amount utilised	0	(20)
Balance at 31 March	<b>426</b>	<b>349</b>

This principally relates to a provision for doubtful debts of 12.6% (2011/12 10.5%) for Road Traffic Act income.

## 17 Analysis of receivables past due impaired and non-impaired

	31 March 2013 £000	31 March 2012 £000
<b>Ageing of past due impaired receivables</b>		
Over 180 days	426	349
	<b>426</b>	<b>349</b>
<b>Ageing of past due non-impaired receivables</b>		
0 - 30 days	961	755
30-60 Days	382	105
60-90 days	221	141
90- 180 days	572	435
over 180 days	1,013	1,413
	<b>3,149</b>	<b>2,849</b>

## 18 Other Current Assets

	31 March 2013 £000	31 March 2012 £000
EU Emissions Trading Scheme	6	52
<b>TOTAL</b>	<u>6</u>	<u>52</u>

## 19 Trade and other payables

	31 March 2013 £000	31 March 2012 £000
<b>Current</b>		
NHS payables	4,573	3,206
Non - NHS trade payables - revenue	12,683	10,149
Non - NHS trade payables - capital	3,348	1,709
Social security costs	1,403	1,481
Other payables	304	250
PDC Payable	0	0
Accruals	4,692	2,228
<b>TOTAL</b>	<u>27,003</u>	<u>19,023</u>

NHS payables include;

- £1,699,266 outstanding pensions contributions at 31 March 2013 (31 March 2012 £1,593,352).

## 20 Other liabilities

	31 March 2013 £000	31 March 2012 £000
<b>Current</b>		
Deferred Income	36	66
<b>TOTAL</b>	<u>36</u>	<u>66</u>

## 21 Borrowings

	31 March 2013 £000	31 March 2012 £000
<b>Current</b>		
Other loans	40	80
Obligations under finance leases	965	1,077
Foundation Trust Financing Facility	229	0
	<u>1,234</u>	<u>1,157</u>
<b>Non Current</b>		
Other loans	218	178
Obligations under finance leases	1,705	2,515
Foundation Trust Financing Facility	1,372	0
	<u>3,295</u>	<u>2,693</u>

## 22 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 £33.7 million at 31 March 2013. The Trust has actually borrowed £4,529,732 (£3,850,145 at 31 March 2012). This borrowing relates primarily to finance leases and £258,291 in respect to non-interest bearing loans.

The Trust has a £17.0 million approved working capital facility. At the end of the financial year there was no draw down against the working capital facility (£0 at 31 March 2012).

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

Financial Ratio	Actual Ratio March 2013	Approved PBL Ratio March 2013	Actual Ratio March 2012	Approved PBL Ratio March 2012
Minimum Dividend Cover	2.7x	>1x	2.0x	>1x
Minimum Interest Cover	103x	>3x	122x	>3x
Minimum Debt Service Cover	12x	>2x	18x	>2x
Maximum Debt Service to Revenue	<1%	<2.5%	<1%	<2.5%

## 23 Finance lease obligations

### Amounts payable under finance leases

	Minimum Lease Payments		Present value of minimum lease payments	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Within one year	965	1,077	965	1,077
Between one and five years	1,820	2,720	1,705	2,515
Less future finance charges	(115)	(205)	0	0
Present value of minimum lease payments	<u>2,670</u>	<u>3,592</u>	<u>2,670</u>	<u>3,592</u>
Included in:				
Current borrowings			965	1,077
Non-current borrowings			1,705	2,515
			<u>2,670</u>	<u>3,592</u>

The finance leases relate to plant and machinery, the largest is for a MRI Scanner, or IT hardware and are for a five year period.

## 24 Provisions for liabilities and charges

	Current		Non-Current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Pensions relating to staff	73	30	724	741
Legal claims	99	106	0	0
EU Emissions Trading Scheme	0	15	0	0
Dilapidation	0	0	114	114
<b>TOTAL</b>	<b>172</b>	<b>151</b>	<b>838</b>	<b>855</b>

	Pensions relating to staff	Legal claims	European Union Emissions Trading Scheme	Dilapidation provision	Total
	£000	£000	£000	£000	£000
At 1 April 2012	771	106	15	114	1,006
Change in the discount rate	84	0	0	0	84
Arising during the year	21	66	0	0	87
Utilised during the year	(74)	(56)	(15)	0	(145)
Reversed unused	(27)	(17)	0	0	(44)
Unwinding of discount	22	0	0	0	22
At 31 March 2013	797	99	0	114	1,010
<b>Expected timing of cashflows:</b>					
Within one year	73	99	0	0	172
Between one and five years	267	0	0	0	267
After five years	457	0	0	114	571
	797	99	0	114	1,010

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

£37,219,378 is included in the provisions of the NHS Litigation Authority at 31 March 2013 in respect of clinical negligence liabilities of the Trust (31 March 2012 at £23,061,788).

## 25 Cash and cash equivalents

	At 1 April 2012 £000	Cash changes 2012/13 £000	At 31 March 2013 £000
Government Banking Service cash at bank	2,516	4,440	<b>6,956</b>
Commercial cash at bank and in hand	<u>(618)</u>	<u>773</u>	<u><b>155</b></u>
Cash and cash equivalents as in Statement of Cash Flows and Statement of Financial Position	<u>1,898</u>	<u>5,213</u>	<u>7,111</u>

## 26 Capital Commitments

There were no commitments under capital expenditure contracts at 31 March 2013 (£0 at 31 March 2012).

## 27 Contingencies

The contingent liabilities relating to the Trust as at 31 March 2013 were £32,000 (£34,448 at 31 March 2012) 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.

## 28 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:

	2012/13 Payments to Related Party £000	2012/13 Receipts from Related Party £000	31 March 2013 Amounts owed to related Party £000	31 March 2013 Amounts due from Related Party £000
<b>Strategic Health Authorities</b>				
South East Coast Strategic Health Authority	0	687	0	124
<b>Primary Care Trusts</b>				
Eastern and Coastal Kent Primary Care Trust	0	49,603	150	2,035
Medway Primary Care Trust	0	145,988	1,500	3,750
West Kent Primary Care Trust	118	16,682	88	1,008
<b>NHS Trusts</b>				
Dartford and Gravesham NHS Trust	3,117	718	370	199
Kent and Medway NHS and Social Care NHS Trust	417	1,337	60	155
Kent Community Healthcare	1,118	248	204	46
Maidstone and Tunbridge Wells NHS Trust	3,498	774	1,194	370
Brighton and Sussex University Hospitals NHS Trust	1	4,536	0	137
<b>NHS Foundation Trusts</b>				
East Kent Hospitals NHS Foundation Trust	206	1,946	63	286
<b>NHS Arms Length Bodies</b>				
NHS Business Services Authority	0	0	0	0
NHS Litigation Authority	5,516	0	0	6
NHS Pensions Agency	12,732	0	1,701	0
<b>Other Government Departments</b>				
HM Revenue and Customs	9,814	0	2,914	0
Medway Council	1,467	0	0	0
The Trust has also received income from charitable funds where the Trust is the corporate Trustee				
Medway NHS Foundation Trust Charitable Fund	0	162	0	0

	2011/12 Payments to Related Party £000	2011/12 Receipts from Related Party £000	31 March 2012 Amounts owed to related Party £000	31 March 2012 Amounts due from Related Party £000
<b>Strategic Health Authorities</b>				
South East Coast Strategic Health Authority	100	539	62	3
<b>Primary Care Trusts</b>				
Eastern and Coastal Kent Primary Care Trust	0	47,771	0	882
Medway Primary Care Trust	122	140,568	438	2,539
West Kent Primary Care Trust	0	13,874	112	241
<b>NHS Trusts</b>				
Dartford and Gravesham NHS Trust	1,655	568	288	85
Kent and Medway NHS and Social Care NHS Trust	365	1,433	102	387
Kent Community Healthcare	985	261	505	557
Maidstone and Tunbridge Wells NHS Trust	3,678	1,089	392	269
<b>NHS Foundation Trusts</b>				
East Kent Hospitals NHS Foundation Trust	237	1,942	69	100
<b>NHS Arms Length Bodies</b>				
NHS Business Services Authority	1,888	9	551	0
NHS Litigation Authority	5,208	0	0	6
NHS Pensions Agency	19,280	0	1,611	0
<b>Other Government Departments</b>				
HM Revenue and Customs	37,191	0	3,107	0
The Trust has also received income from charitable funds where the Trust is the corporate Trustee				
Medway NHS Foundation Trust Charitable Fund	0	135	0	6

## 29 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

All of the Trust's financial liabilities carry nil or fixed rates of interest. 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 £17,000,000 working capital facility with its current Bankers, which has been utilised during the year. There was no outstanding amount at the 31<sup>st</sup> March 2013.

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 2013			
NHS Receivables	9,394	9,394	9,394
Non NHS Receivables	4,624	4,624	4,624
Cash and cash equivalents	7,111	7,111	7,111
	<b>21,129</b>	<b>21,129</b>	<b>21,129</b>
At 31 March 2012			
NHS Receivables	6,466	6,466	6,466
Non NHS Receivables	4,031	4,031	4,031
Cash and cash equivalents	1,898	1,898	1,898
	<b>12,395</b>	<b>12,395</b>	<b>12,395</b>

## Financial liabilities by category

	Other	Book Value	Fair Value
At 31 March 2013			
NHS Payables	5,224	5,224	5,224
Non NHS Payables	18,865	18,865	18,865
Other borrowings	1,859	1,859	1,859
Finance leases	2,670	2,670	2,670
	<b><u>28,618</u></b>	<b><u>28,618</u></b>	<b><u>28,618</u></b>
At 31 March 2012			
NHS Payables	5,071	5,071	5,071
Non NHS Payables	10,845	10,845	10,845
Other borrowings	258	258	258
Finance leases	3,592	3,592	3,592
	<b><u>19,766</u></b>	<b><u>19,766</u></b>	<b><u>19,766</u></b>

## Maturity of financial liabilities

	<b>31 March 2013 £000</b>	31 March 2012 £000
In one year or less	<b>25,321</b>	17,743
In more than one year but not more than two years	<b>1,233</b>	1,077
In more than two years but not more than five years	<b><u>1,606</u></b>	<u>946</u>
	<b><u>28,160</u></b>	<u>19,766</u>

## 30 Third Party Assets

The Trust held £9,471 cash at bank and in hand at 31 March 2013 (£3,081 at 31 March 2012) 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.

## 31 Losses and Special Payments

There were 64 cases of losses and special payments (2011/12: 175 cases) totalling £181,000 (2011/12: £173,825) paid during 2012/13.

There were 0 cases where the net payment exceeded £100,000 (2011/12: 0 cases).

These amounts are reported on an accruals basis but excluding provisions for future losses.

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.