Milton Keynes Hospital NHS
NHS Foundation Trust

Annual Report and Accounts 2013/14

WeCARE

Standing Way
Eaglestone
Milton Keynes
MK6 5LD

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Milton Keynes Hospital NHS Foundation Trust
Annual Report And Accounts
2013/14

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

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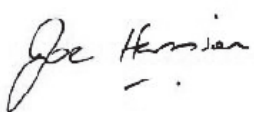
This report is based on guidance issued by the Independent Regulator of NHS Foundation Trusts and was approved by the Board of Directors of Milton Keynes NHS Foundation Trust on 22 May 2014.



Joe Harrison
CHIEF EXECUTIVE

The Annual report can be made available in other languages and formats on request.

Section 1

Introduction

Introduction

Statement from the Chairman

I am pleased to report that the Trust has made significant progress on virtually all fronts compared to last year.

This is against a background of unprecedented numbers of patients attending the emergency department during the year, which has placed great strain on the resources of the hospital and our staff.

There is however still much to do and many challenges lie ahead, but I believe foundations have been laid in 2013/14 which will enable further progress to be made in the current year.

Milton Keynes is one of the fastest growing parts of the UK and our hospital, originally designed in the 1980s to serve 17,000 emergency department attendances per year, is now dealing with circa 80,000 patients. It is clear also that the population we serve is ageing and that more elderly patients tend to present with a number of conditions of increased complexity.

However the demand for our hospital services is not just driven by demographics. It is clear that people are choosing to come to the emergency department because they know we are open 24/7 and see us as more accessible than other parts of the NHS.

It seems our emergency department is at times the default in the system, but that is not what it is designed for. Whilst we will always strive to help everyone who comes to our hospital resources in the emergency department are limited and designed to attend to patients with really urgent needs.

In addition we are finding it increasingly difficult to get patients particularly elderly people, quickly and safely back out of hospital once they have had their treatment, for example into nursing homes . This is not a good experience for them and it ties up our resources and beds unnecessarily limiting our capacity to deal in a timely fashion with new patients.

We are progressing plans to address the shortage of physical capacity in our emergency department however, these are not problems we can totally solve on our own. We intend to try and work with our commissioners and partners in primary care, community care and social services to provide a more efficient and integrated service in the new year.

At present, in my view, the financial risks associated with these systemic problems are mainly borne by the Acute sector and are a significant contributor to the Trust's financial deficit.

Financially it has been a challenging year with the trust recording a loss of £17m. However this is consistent with forecast at the outset of the year and it is pleasing to report we achieved cost improvement savings of £7.4m during the year.

Our regulator Monitor has accepted that the Trust cannot solve its issue of financial sustainability on its own due to its relative small size and limited scope for economies of scale.

Consequently during the year Monitor, NHS England and the Trust Development Authority commissioned McKinsey and Co to carry out a study "To determine sustainable services for Milton Keynes and Bedfordshire".

We await the results of this study with interest. Our vision for the future of the Trust is to be a top rated District General Hospital offering to our community as many services as can be safely delivered locally.

Key to delivering this vision will be developing a reputation for excellence in patient experience, research and development, and education and the resulting ability to continue to attract and retain good people to work for the Trust.

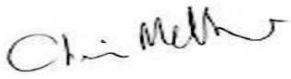
In this regard an exciting development in the year was the agreement to work in partnership with Buckingham University to open a Graduate Medical School on site in 2017. As a result the trust will be changing its name to the Milton Keynes University Hospital NHS Foundation Trust.

The Board has made quality the first item on its agenda and launched a number of initiatives during the year to improve patient safety and to capture feedback from patients and their friends and families of their experience of our services.

We welcomed two new non-executive directors to the Board from 1st March, Tony Nolan, an executive with the Vodaphone Group and Jean-Jacques De Gorter, a director of Spire Healthcare.

Our thanks also go to Graham Anderson and Professor Kate Robinson who leave the Trust after completing their terms of office as non-executive directors both of whom have given excellent service to the Trust over a number of years.

Finally I would like to thank the board of directors, our governors and all our employees who have achieved a great deal over the last twelve months and for the support they have given me.



Chris Mellor
INTERIM CHAIRMAN

Statement from the Chief Executive

Chief Executive's Report

Reflecting on the past year, it is clear just how much we have to be proud of at Milton Keynes Hospital NHS Foundation Trust.

We have made real improvements in the quality of care we provide to our patients. We have more nurses and doctors now than at any another time and we are developing exciting plans for expansion and growth.

These achievements reflect our **focus and objectives – improving patient safety, experience and clinical effectiveness** – which we have restated our commitment to for 2014/15.

We are an ambitious hospital, committed to providing the best standards of care and service for local people.

Improving performance

We can demonstrate our achievements in improving quality – with a reduction in grade three and four pressure ulcers in hospital; more stroke patients are spending time on our dedicated stroke unit and fewer patients falling whilst in our care. We are also treating patients more efficiently and effectively, meaning they don't need to spend as much time in a hospital bed.

We have one of the most improved emergency department (ED) performances in the country, despite ever increasing patient numbers. The ED now sees over four times more patients than it was originally built for, with staff working incredibly hard to maintain the emergency access target so that patient care and treatment is not delayed. It is testament to the multidisciplinary team in the ED that, despite increasing demand and the limitations of the estate, they have maintained quality and access standards throughout the year, with patients seen and treated more quickly this year than in 2012/13 in all but five weeks of the year.

Major developments

In developing our site, we are actively working with partners to **expand our** ED so that we have a suitable environment to deliver quality care and meet the needs of our growing community. We also plan to **expand our cancer services**, improve site access and **develop new academic facilities** in partnership with the **University of Buckingham Medical School**. This last development provides a tremendous opportunity for the trust, helping us to attract skilled and experienced physicians and surgeons to advance services for patients and deliver first class training and education for medical trainees.

Valuing our staff

Our staff are, of course, our most vital asset and along with increasing numbers of medical and nursing staff, we have worked hard to ensure that we support and develop our workforce in line with our We Care values and behaviours. I would like to take the opportunity here to record my sincere thanks to our 3,000 staff who work so hard every day to deliver good, safe care for the hundreds of thousands of patients we see each year.

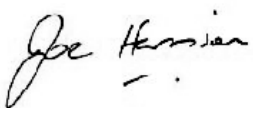
Strategic review

Next year will see the strategic review into healthcare provision in Milton Keynes and Bedfordshire develop options around what future service provision may need to look like if we are to meet the changing healthcare needs of local people, whilst meeting our statutory duty to break-even financially. This process will see local people engaged in telling health commissioners what they want to see provided at their local hospital, as well as in primary and community care.

Ambition and vision – a journey of improvement

We are on an exciting journey of growth and improvement at Milton Keynes Hospital NHS Foundation Trust and I look forward to another year of improving care and working to meet the needs of our community, as well as the requirements of our regulators.

Real, sustainable change and improvement doesn't happen overnight. It doesn't happen in a year. Our commitment is to keep improving and developing; growing and changing over the next three to five years, so that we have a hospital fit for the future, here to care with compassion, kindness and expertise, for generations to come.



Joe Harrison
CHIEF EXECUTIVE

About us

Background

Milton Keynes Hospital NHS Foundation Trust was founded on 1 October 2007 under the National Health Service Act 2006.

The hospital has 526 beds (including day acute and neonatal beds), and employs over 2,800 staff, providing a full range of acute hospital services to the city of Milton Keynes and the surrounding areas.

We are increasingly providing more specialist services to local people and we continue to develop our facilities to meet the needs of a growing population.

Our Vision and Trust Objectives

Our vision is "to be the healthcare provider of choice, growing with Milton Keynes." The Board agreed the following trust objectives to deliver the vision:

Trust Objectives:

1	Improve patient safety
2	Improve patient experience
3	Improve clinical effectiveness
4	Delivery key targets
5	Developing a sustainable future
6	Develop robust and innovative teaching and research
7	Become well governed and financially viable
8	Improve workforce effectiveness
9	Make best use of the estate
10	Develop as a good corporate citizen

526

2800

1984

MK Hospital officially opened
Phase **two** commences 1988
Six additional **28** bed wards
Operating theatre suite

1992

Phase **two** opened
MK General NHS Trust
New MRI scanning unit
28 bed orthopaedic ward
GP paediatric assessment unit
Refurbished A&E department

2005

£1.5m Macmillan haematology and oncology unit
£12m treatment centre dedicated to day cases
60 bed spaces
4 operating theatres

Factual information

Milton Keynes Hospital was officially opened in 1984. The acute services provision at that time included operating theatres, an Emergency department, maternity services, general and speciality wards, full diagnostic x-ray facilities, and a major pathology department.

Other projects that were completed soon after this major development included a postgraduate education centre and an extended physiotherapy department, including a hydrotherapy pool.

Construction of phase two started in 1988 and focused on the expansion of facilities to support the continued population growth of Milton Keynes (estimated increase from 1984 to 1994 - 40%). The development contained six additional 28-bed wards, a further suite of operating theatres, extra accommodation for the pathology department and additional accommodation for staff. Phase two opened in 1992.

Milton Keynes General NHS Trust formally came into being on 1 April 1992. Since then, significant changes have included the expansion of postgraduate education facilities, a new MRI scanning unit and the expansion and re-location of the cardiology unit and coronary care ward. In recent years the site has grown further with the addition of a 28-bed orthopaedic ward, a GP paediatric assessment unit, fracture clinic and the refurbishment of the Emergency department.

Expansion continued with the opening of a £1.5m Macmillan Haematology and Oncology Unit within the main hospital. In January 2005 the biggest single development on the site for ten years, a £12m treatment centre dedicated to day cases and extended day case surgery, was opened with 60 bed spaces and a further four operating theatres. The centre has proved very popular with patients.

During 2006/07 the sexual health centre was refurbished and a new £2.5m angiography unit opened. Construction work on a new multi-storey car park was completed in July 2007 and our cardiology services continue to develop. Extra capacity has been added to clinics such as orthopaedics, ophthalmology and a rolling refurbishment of wards and corridors is ongoing.

Since becoming an NHS Foundation Trust on 1 October 2007 sustained expansion has continued. During 2008/09 Ward 14, previously run by the local primary care trust, was fully refurbished and reopened by the hospital. In April 2009 the hospital opened a new significantly expanded £4.6 million state-of-the-art endoscopy unit and a new 22 bed ward.

In response to the number of patients that required step down facilities rather than acute care, the trust invested in developing a ward into a therapist led facility for patients on the road to recovery. The Phoenix Unit opened in 5 November 2012 and has 20 beds.

2007

£2.5m angiography unit opened
Development of cardiology services
NHS Foundation Trust formation
Extra capacity to orthopaedics and ophthalmology
Multi-storey car park completed

2009

Ward 14 fully refurbished
£4.6m endoscopy unit and new **22** bed ward

2012

Therapist led facility developed
The Phoenix Unit opens with **20** beds

Ambulatory Emergency Care Unit

The Ambulatory Emergency Care Unit (AECU) was officially opened in May 2013 and provides a quick diagnosis for patients who do not need admission. Patients can choose to attend AECU or be referred to the Unit by their GP. This service has improved patient access to emergency treatment and is nationally recognized as good practice.

Our services

The current population of Milton Keynes Unitary Authority is estimated to be 252,400 (Mid-Year Population Estimates 2012) and is one of the fastest growing areas in the country. The population is expected to reach 302,100 by 2026, according to current forecasts. Just over 25% of the population is currently aged under-19 and the 2011-12 Milton Keynes Joint Strategic Needs Assessment (JSNA) identified a need for services to be targeted and more reflective of the borough's comparatively young population. The population aged 65+ is projected to increase by 82.8% between 2012 and 2026. The total natural catchment area of the trust is considered to be circa 15% wider than Milton Keynes Unitary Authority boundary consisting of patients from the market towns of Buckingham and Leighton Buzzard, and the surrounding villages.

Equally significant is growth in the over 60 age group, with current numbers increasing even faster and therefore placing additional pressure on resources. This creates both opportunities and challenges. As well as ensuring current services deliver a high-quality outcome, we also need to focus on the development of key services.

Over the coming years, we will continue to work with a range of stakeholders including Milton Keynes Clinical Commissioning Group (CCG), Community Health Services, Milton Keynes Council and our local involvement network Healthwatch to improve patient services. Co-operation will ensure that patients can access appropriate services as and when they need to, and our goal is to ensure that we offer high-quality, seamless care.

Principal activities

The trust provides a range of services and specialities. All in-patient services and most outpatient services are provided on the Milton Keynes hospital Eaglestone site. MKHFT is organised into a number of corporate directorates and an operational directorate overseeing clinical divisions, all under the leadership of the Chief Executive. The executive directors, and clinical service unit (CSU) leadership teams, are responsible for the day-to-day management and running of the hospital's services.

During 2013/14 it was decided to expand the Divisional Structure and create a fourth Division of Women and Children's, in addition to Medicine, Surgery and Core Clinical Divisions. This will enable more focus on these key services for local people.

Healthcare Review of Milton Keynes and Bedford.

Monitor (the Regulator for Foundation Trusts), the Trust Development Authority and NHS England have commissioned a review of healthcare provision for the residents of Milton Keynes and Bedford. The Trust is participating fully in all aspects of the review which seeks to implement a model of healthcare provision that is clinically and financially sustainable in the medium term. The review published the Case for Change in April 2014 www.shapingmkhealth.co.uk/case-for-change/why-we-need-to-change/.

The final report from the Clinical Commissioning Groups for Milton Keynes and Bedford with proposals for the future is expected in the summer 2014.

Section 2

Strategic Report

Strategic Report

Our History

Milton Keynes hospital was officially opened in 1984. The acute services provision at that time included operating theatres, an Emergency department, maternity services, general and speciality wards, full diagnostic x-ray facilities, and a major pathology department. Due to the increasing population, the hospital continued to expand with an additional six 28 bed wards being opened in 1992. Milton Keynes General NHS Trust formally came into being on 1 April 1992

Milton Keynes Hospital NHS Foundation Trust was founded on 1 October 2007 under the National Health Service Act 2006.

Our hospital

The hospital has 526 beds (including day acute and neonatal beds), and employs 3,000 staff, providing a full range of acute hospital services to the city of Milton Keynes and the surrounding areas. In line with the national picture, the Trust has continued to see an increase in both activity and acuity over the last few years. This has been particularly evident in both emergency and outpatient activity. The level of general population growth has added approximately. 9% to the emergency demand but extra growth in Milton Keynes has increased that to 17% partly due to size of population and partly due to the older population growing twice as fast as the national average.

Our community

The current population of Milton Keynes Unitary Authority is estimated to be 252,400 (Mid-Year Population Estimates 2012) and is one of the fastest growing areas in the country. The population is expected to reach 302,100 by 2026, according to current forecasts. Just over 25% of the population is currently aged under-19 and the population aged 65+ is projected to increase by 82.8% between 2012 and 2026. This creates both opportunities and challenges. As well as ensuring current services deliver a high-quality outcome, we also need to focus on the development of key services.

There are significant pockets of deprivation and poverty: parts of Eaton Manor and Woughton wards are in the 10% most deprived in England in relation to various measures of deprivation, including income, employment and education. Inequalities in terms of social and economic circumstances affect health, for example increased levels of respiratory disease, cancer, type 2 diabetes, poor mental health and substance misuse. There are also inequalities in the outcomes for children and young people across Milton Keynes.

Milton Keynes has a number of challenges ahead of it – a rapidly ageing population, a growing population in number that is also increasingly richer in terms of ethnicity and racial mix, and the tougher economic and financial environment that has implications for health and social care. A key part of the health challenge in Milton Keynes is the increasing numbers of people with complex long-term conditions. Almost £7 in every £10 spent on health care is for people with these conditions.

Healthcare Review of Milton Keynes and Bedford.

The Trust's regulator Monitor, NHS England and Trust Development Authority are reviewing the healthcare provision in Milton Keynes and Bedford. The Trust is participating fully in the review with other stakeholders, Bedford hospital, Milton Keynes Clinical Commissioning Group and Bedford Clinical Commissioning Group. The Review is due to report in the summer of 2014 and make recommendations for future healthcare provision for our community.

Our Strategy

Our vision is "To be the healthcare provider of choice, growing with Milton Keynes" and the Board agreed the following Trust Objectives to deliver the vision:

1	Improve patient safety
2	Improve patient experience
3	Improve clinical effectiveness
4	Delivery key targets
5	Developing a sustainable future
6	Develop robust and innovative teaching and research
7	Become well governed and financially viable
8	Improve workforce effectiveness
9	Make best use of the estate
10	Develop as a good corporate citizen

Our Business Model

The trust Board is responsible for running the trust efficiently and effectively. It has six sub Committees which are required to provide assurance to the Board on the performance of the organisation and these are audit, quality, finance and investment, workforce assurance, charitable funds and remuneration.

The trust Board has seven voting and one non voting non executive directors (six men and two women) and six voting executive directors and one non-voting director (five men and two women).

The non executive's are responsible for holding the executive team to account for the performance of the organisation. The Health and Social Care Act 2012 introduced a duty for the Council of Governors, which comprises of public, staff and appointed governors are responsible for holding the non executive directors to account for the Trust's performance.

The day to day running of the services provided by the hospital is the responsibility of the Divisions and Clinical Service Units:

Divisional and Clinical Service Unit Structure

There are four Divisions, Medicine, Women and Children's, Surgery and Core Clinical & Support Services. The 14 Clinical Service Units (CSU) are responsible for the day-to-day management and delivery of services within their areas, in line with Trust strategies, policies, and procedures. CSUs work within the Trust's Standing Financial Instructions, Standing Orders, Scheme of Delegation and budgetary rules.

Our policies

Staffing policies

The Trust works within the statutory framework and also has agreed policies regarding social, community and human rights issues. All policies are published on the Trust website and are reviewed regularly to ensure that they remain current and complied with.

The Trust is committed to providing a fair, efficient and effective recruitment and selection service as part of its wider commitment to equality of opportunity. The Trust employs a range of policies and procedures to ensure disabled applicants are given full and fair consideration. These include the Recruitment and Selection Policy and a good practice guide to Employing Disabled People.

The Trust is accredited with the "Positive About Disability" or "Two Ticks" symbol, which demonstrates commitment to encouraging individuals with a disability to apply for posts and guarantees an interview if such an individual meets all the essential criteria.

The Trust recognises the value of a diverse workforce and is committed to supporting the employment, training and career development of people with disabilities and staff that become disabled during their employment, this includes the Trust's Management of Sickness Absence policy which sets out our standards and requirements to support staff.

Environmental Policies

The Trust has undertaken risk assessment and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, and has policies regarding reducing the carbon footprint. As can be seen later in this report, Carbon emissions continue to reduce.

The Trust has a number of policies relating to our patients. The Discharge Policy has been reviewed to ensure that appropriate information and ongoing care is provided to our patients as they leave hospital.

Our performance

The Trust Board monitors 67 Key Performance Indicators which are aligned to the trust objectives on a monthly basis.

The performance of the hospital has been affected by the increase in the number of patients it has seen. In spite of this the Emergency Department four hour target performance has improved from 91.7% in 2012/13 to 94.4% in 2013/14.

In 2013-14, the Trust was set a stretch target of 13 cases of Clostridium Difficile (CDiff) Infections (the Trust had 19 CDiff infections in 2012/13). During 2013/14 there were 37 cases were recorded and as a result an independent review by the Health Protection Agency has been commissioned.

The following national targets for cancer have been achieved:

All cancers, 31 day wait for second or subsequent treatment
All cancers: 2 week wait from referral to first appointment

The Trust achieved the nationally set targets regarding the waiting times on the 18 week referral to treatment (RTT) pathways, with the exception of admitted RTT in Q4. The Trust recognised that the waiting list needed to be reduced to ensure it was in a sustainable position going forward. With the approval of Milton Keynes CCG, the Trust has targeted its waiting list to reduce the number of patients waiting over 18 weeks. The waiting list was just under 300 in February 2014 and at the end of April is just over 200.

The number of patients attending the hospital has continued to increase,

- 25,636 patients were elective admissions admitted (i.e. for planned care), a 20% increase on the previous year
- 33,121 patients were admitted as an emergency, which is a 33% increase on the previous year
- 75,333 people attended the Accident and Emergency Department, which is a 4% increase from the previous year
- 3,831 babies were delivered by the Trust staff.

Acute Foundation Trust targets – Minimum standards

The Trust also monitors performance standards against the following:

Indicator	Target	Performance
CQUINs	90%	**56%**
Patient Experience- Family and Friends Test	70%	**67.8%**
The percentage of complaints responded to within the agreed time	93%	**77.5%**

The Trust has taken steps to improve performance in these areas. A project manager has been appointed for the delivery of CQUINs and this project is included in the Transformation Programme governance process. The Trust has commissioned I Want Great Care to undertake on and off line patient and staff experience which will be reported monthly. Escalation process for responding to complaints has been implemented.

Our Staff

The hospital's biggest asset is its staff and it employs 3016 (2584 Whole time equivalents) at the end of the financial year. (Female 2404 and Male 612). As the senior managers of the organisation the Board of Directors comprises of eight non executive directors (six men and two female) and seven executive director (six men and two women).

The trust has continued to invest in learning and development for staff to improve the care given to our patients. An example of this is the dementia awareness training being given to all staff, and, in partnership with the Open University, 48 Health Care Assistants undertook a dementia training module.

The trust's management and Board of Directors monitors key performance indicators regarding its workforce and these include:

- The sickness absence rate for period 2013/14 was 4.24% (4.55% in 2012/13).
- 90% of staff received an annual appraisal in 2013/14.
- 80% of staff completed mandatory training. The Trust recognises the importance of staff undertaking mandatory training and is targeting this in 2014/15 to improve compliance.

A draft workforce strategy will be consulted on during the summer of 2014 for adoption in the autumn and this will provide the framework for organisational development for the organisation.

Our Impact on the Environment

The trust continues to take action to reduce its carbon emissions. The trust's carbon baseline assessment in 2007 was 12,747 tonnes per annum, with a target to reduce carbon to 9,559 tonnes by 2014/15.

The following table shows Co2 performance per annum

2010/11	11,808 Tonnes
2011/12	11,108 Tonnes
2012/13	11,183 Tonnes
2013/14	10,508 Tonnes

The decrease in carbon from last year was due in large part to a mild winter with decreased heating requirements and, for the first time, the use of the trust's medium voltage generators to export electricity to the mains network reducing the reliance on mains voltage.

Our Risks

The following are the key risks for the trust:

Capacity in Emergency Department (ED)

The trust's ED, originally built to take a footfall of 17,000 is now servicing more than four times this number. This is putting a strain on the system which is regularly coping with delayed discharges that amount to in excess of a ward's worth of patients. The Trust is planning to provide additional capacity as an interim measure for the winter in 2014/15, and also has plans for a longer term solution.

Failure to sustain ED targets

Capacity in the ED department is one element to achieving the 95% target of admitting or discharging a patient within four hours. Achievement of the target is also dependent on the demand for the service, the acuity of the patients and having appropriate staffing levels.

Infection control

As mentioned earlier, the trust has been set a target of 19 Clostridium Difficile (CDiff) for 2014/15. The Trust recognises that there is a risk of failing to meet the CDiff target. Following the 2013/14 performance, the Trust has commissioned the Health Protection Agency to undertake an independent review of CDiff cases. The Trust Board recognised that there was no cross-contamination and the priority now is on anti-microbial stewardship with the introduction of a new drug chart to assist with the review of medication.

Achievement of financial targets

The trust delivered its financial plan in 2013/14 with a £17m deficit against a plan of £17.1m deficit. The trust also delivered cost reduction of £7.4m against a target of £8m. The trust has submitted its two year plan to Monitor and £24.9m deficit is planned for 2014/15. In order to achieve this the trust must deliver a cost improvement programme of 4% (circa £7.4m, in line with the national tariff adjustment) plus £1m of full-year-effect from 2013/14 schemes. The delivery total of £8.4m equates to just over 4.5% for 2014/15. Monitor recognises the clinical and financial sustainability challenges the trust faces and, with the Trust Development Authority and NHS England, has commissioned a review of healthcare services for Milton Keynes and Bedford.

Electronic Patient Record procurement

The Department of Health has no plans to extend the contract or continue to fund the current Electronic Patient Records services. National guidance and specific legal advice (taken by Department of Health, London trusts, Oxford University Hospitals and others) has all clearly indicated that trusts need to undertake an EU compliant procurement process for software and services provision post October 2015. The project timescales is to secure business continuity beyond the expiry of the current contract in October 2015. The new system should also form a platform for future benefits delivery including both improved clinical safety and clinical effectiveness. Indeed informatics is the key enabler for the trust to meet its strategic clinical and operational goals, and underpins much of the transformation required to deliver the Quality, Innovation, Productivity and Prevention (QIPP) agenda. The risk for the trust is both in terms of timescale and financial.

Our Estate

The trust has three key strategic development opportunities which it is keen to progress.

Cancer Centre: A new build with the potential for the trust to incorporate allied services alongside, ensuring clinical adjacency is optimised and a comprehensive service for cancer patients. Depending on the delivery solution this may be developed alongside bringing Radiotherapy bunkers on site in partnership with an external partner.

Medical School and Academic Centre: A new build, funded by the University of Buckingham, with potential for the trust to co locate its Post Graduate Centre, releasing space elsewhere on site, whilst replacing the current poor accommodation.

Common Front Door: A major redevelopment of outdated and inadequate Emergency Department facilities, to incorporate the Urgent Care Centre stream of work. This simplification of service access points for patients is firmly aligned with the CCG commissioning plans.

All these schemes are designed to improve service offerings as well as enhancing the environment, demonstrating the trust's commitment to improve patient care. All building developments and stages of the strategy will prioritise the replacement and rationalisation of the oldest estate, with new safer, greener buildings. Over time, the trust will consolidate inpatient ward based areas, ensuring optimal clinical and operational adjacency and efficiency. Our plans will be developed in line with the clinical strategy and clinical staff will have a key role to play in how the site will be developed for the long term. All statutory obligations will be met, providing a safe and suitable patient environment with clear commitment to meeting environmental and Care Quality Commission (CQC) standards and outcomes, particularly those relating to privacy, dignity and comfort of patients.

The local council and planners are engaged and supportive of our plans to build up, not out, preserving green field and many undeveloped areas of the site for the future. We will plan in such a way that our healthcare, education and other service provider partners can be part of the future "health campus" at the MK hospital site. We will look to make it simple for patients to navigate on arrival at the site, particularly between planned and emergency services.

We will look to develop a single, modern and welcoming entrance to the hospital for the largest footfall services such as outpatients, diagnostics and planned services. On arrival at the hospital patients, visitors and staff will see a strong, confidence inducing set of buildings with real visual impact. We will retain, as part of a sustainable transport plan, sufficient parking and travel arrangements for patients, visitors and staff.

Our Investment for the Future

Electronic Patient Record procurement

The Department of Health has no plans to extend the contract or continue to fund the current Electronic Patient Records services. National guidance and specific legal advice (taken by Department of Health, London Trusts, Oxford University Hospitals and others) has all clearly indicated that trusts need to undertake an EU compliant procurement process for software and services provision post October 2015. Whilst the key goal of this project is to secure business continuity beyond the expiry of the current contract in October 2015, it will also form a platform for future benefits delivery including both improved clinical safety and clinical effectiveness. Indeed informatics is the key enabler for the trust to meet its strategic clinical and operational goals, and underpins much of the transformation required to deliver the Quality, Innovation, Productivity and Prevention (QIPP) agenda.

Our Finances

The accounts are prepared under International Financial Reporting Standards and Monitor's Annual Reporting Manual under the National Service Act 2006 and the financial headlines for 2013-14 were:

- Total income of £173.1m, an increase of £10.6m, 6.5%, increase on the previous year.
- Income from clinical activities was up by £9.7m, 6.4%, at £160.8m.
- Retained deficit for year increased to £17.0m from £8.8m the prior year.
- Against Monitor's Continuity of Services Rating the Trust scored '1', in a scale of '1'-'4', where '4' is the highest performance rating, indicating the lowest level of financial risk.

Going concern

A statement of Going Concern is included in Section 1 Accounting policies and other information within the Annual Accounts, an excerpt included below;

IAS 1 requires management to undertake an assessment of the NHS Foundation's Trusts ability to continue as a going concern. These accounts have been prepared on a going concern basis as there has been no application to the Secretary of State for the dissolution of the NHS Foundation Trust and the directors currently believe there is a realistic alternative to doing so. The Directors have therefore prepared these financial statements on a going concern basis.

The Trust has prepared its financial plans and cash flow forecasts on the assumption that adequate funding will be received from Milton Keynes Clinical Commissioning Group ("MKCCG") (contractual income), and through the Department of Health/Monitor (Public Dividend Capital). These are expected to be sufficient to prevent the Trust from failing to meet its obligations as they fall due and to continue until adequate plans are in place to achieve financial sustainability for the trust. However, the directors have identified that there is material uncertainties that casts significant doubt over whether the trust will continue to exist in its current form, and over its ability to discharge its liabilities in the normal course of business.

The current economic environment for all NHS Trusts and NHS Foundation Trusts is challenging with on-going internal efficiency gains necessary due to annual tariff (price) reductions; cost pressures in respect of national pay structures; non-pay and drug cost inflation; as well as nationally set contract penalties for contract performance deviations, combined with commissioner (CCG) expectations to reduce activity through ensuring care can be better provided within the community, i.e. managed outside the hospital.

The trust has incurred a deficit of (£17.0m) for the year ended 31 March 2014. The directors consider that the outlook presents significant challenges in terms of cash-flow for the reasons outlined above, including planned reductions in activity commissioned from the Trust and the need to reduce the underlying cost base of the trust to continuously align capacity and demand.

The trust is in the process of securing £25.3m of (Public Dividend Capital "PDC") funding to support both the Trust's revenue position for working capital and £7.2m for its capital projects, with discussions with Monitor/DoH on-going. This funding will be required for the duration of the financial year whilst the internal savings plan is embedded and organisational realignment discussions are concluded. Provided the trust is in receipt of these funds the Trust should continue to remain a going concern.

The trust is facing a period of unprecedented change over the coming years. During 2013 Monitor, NHS England, along with both Milton Keynes and Bedfordshire CCGs commissioned the 'Milton Keynes and Bedford Healthcare Review'. The first draft of recommendations from that review is expected during the summer of 2014. This could see fundamental economy-wide change to the way that health services are delivered across both areas. The planning undertaken by the trust has recognised that without significant change, the trust will remain in deficit during the foreseeable future.

Positive cash balances are likely to be maintained throughout the period through successfully securing commitments to necessary funding from external bodies (DoH/Monitor) and a contract with the lead commissioner MKCCG that gives assurance of income flows.

The significant risks facing the trust are summarised as follows:

1. The trust has prepared a cash flow forecast which shows a minimum level of headroom of £0.5m. There is a level of uncertainty over whether the Trust will receive an additional £32.5m of PDC required to meet its financial obligations. The Trust has however developed its financial plan assuming that it will receive this funding and thus continue on a going concern basis.

2. There is uncertainty over whether the Trust will achieve its efficiency savings plan of £8.4m which has been assumed in its financial plan. This is a level of savings which is extremely challenging and must be supported with adequate clinical focus and engagement in quality process improvement against agreed and appropriately detailed and delivery plans.

3. There is uncertainty over the level of income that the Trust will receive through its national NHS Acute contract with its Commissioners. This is because there is currently a gap between the trust's assumed income and that currently offered by MK CCG. The principal variance is between the trust's plan and the Commissioner intentions, predicated principally on the delivery of admission avoidance schemes in the community. Although, the Trust recognises the plan by the MKCCG to implement these schemes, past experience is that the implementation has had limited impact on hospital demand and in thus avoiding patient admissions.

4. The level of financial benefit from the transformation programme in 2014/15 and 2015/16 reduces. This will likely lead to a further challenge to the trust financial position without structural change. The future for Milton Keynes Hospital NHS Foundation Trust is likely to be influenced by the outcome of the jointly commissioned activity (NHS England, Monitor, Milton Keynes CCG and Bedfordshire CCG) currently being undertaken by McKinsey, in respect of the Milton Keynes and Bedford Healthcare Review. This is due to deliver an options appraisal during 2014/15

5. There is thus material uncertainties which may cast significant doubt as to the trust's ability to continue as a going concern and therefore it may be unable to realise its assets and discharge its liabilities in the normal course of business. The financial statements do not include any adjustments that would result if the going concern basis were not appropriate.

Our Future Development, Performance and Position

The following factors which are likely to impact the trust's development, performance and position:

- Increasing numbers of patients both emergency and planned.
- Increasing population, especially the elderly and those with complex long term conditions.
- Healthcare Review of Milton Keynes and Bedford.
- Commissioners ability to pay for increasing demand for hospital services.
- Capital investment required to develop the hospital's estate.
- Ability to attract and retain highly skilled staff.

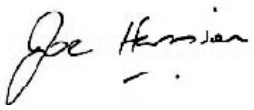
Summary

In 2013/14, the trust has made significant improvements to the care our patients receive. But there is still room for improvement and the organisation continues to drive through improvements in patient care in order to deliver better outcomes for our patients.

The lack of adequate capacity in ED has become a major issue, but otherwise the hospital has a growing catchment area, good accessibility and facilities and with the proposed developments of the academic centre and cancer facilities on site, we believe represent an exciting opportunity for our existing staff and our ability to attract and retain staff.

Longer term, the trust looks forward to the opportunity presented by the Bedfordshire and Milton Keynes Healthcare Review to contribute to a more efficient provision of services across a wider catchment area, bringing enhanced scale and critical clinical mass.

The strategic report was approved by the Board of Directors.



Joe Harrison
CHIEF EXECUTIVE

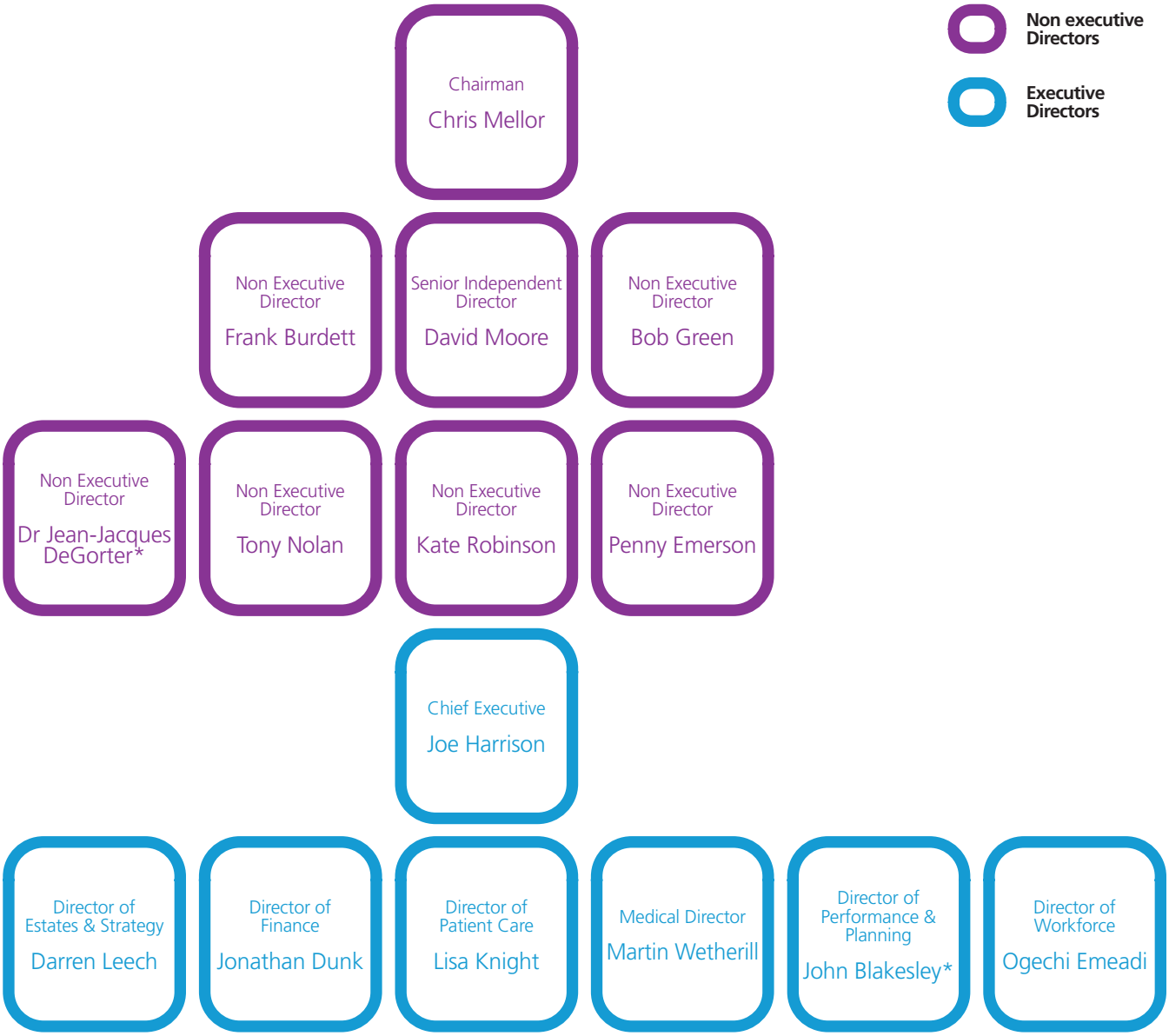
Date: 22 May 2014

Section 3

Directors' Report

Directors' Report

The Board of Directors



* Indicates non voting member

As at March 31, 2014
In addition to the above Board Members, other members of the Board in 2013-14 were:
Graham Anderson, Non executive director
Robert Toole – Interim Director of Finance
Norma French – Interim Director of Workforce

Social and Community Issues

The current population of Milton Keynes Unitary Authority is estimated to be 252,400 (Mid-Year Population Estimates 2012)[1] and is one of the fastest growing areas in the country. The population is expected to reach 302,100 by 2026, according to current forecasts[2]. Just over 25% of the population is currently aged under-19 and the 2011-12 Milton Keynes Joint Strategic Needs Assessment (JSNA) identified a need for services to be targeted and more reflective of the borough's comparatively young population. The population aged 65+ is projected to increase by 82.8% between 2012 and 2026[2].

There are significant pockets of deprivation and poverty: parts of Eaton Manor and Woughton wards are in the 10% most deprived in England in relation to various measures of deprivation, including income, employment and education. Inequalities in terms of social and economic circumstances affect health, for example increased levels of respiratory disease, cancer, type 2 diabetes, poor mental health and substance misuse. There are also inequalities in the outcomes for children and young people across Milton Keynes.

Milton Keynes has a number of challenges ahead of it – a rapidly ageing population, a growing population in number that is also increasingly richer in terms of ethnicity and racial mix, and the tougher economic and financial environment that has implications for health and social care. A key part of the health challenge in Milton Keynes is the increasing numbers of people with complex long-term conditions. Almost £7 in every £10 spent on health care is for people with these conditions.[3]

1 Milton Keynes Intelligence Observatory. Accessed online April 2014.
2 Milton Keynes Council 2013/14 Population Bulletin.
3 Bunt, L. and Harris M. The Human Factor – How transforming healthcare to involve the public can save money and lives. NESTA, November 2009.

The hospital also serves the wider population surrounding Milton Keynes, Northamptonshire, Bedfordshire, Oxfordshire and other areas in Buckinghamshire.

Corporate

Inpatient Survey (June to Aug 2012)

A total of 850 patients were sent a questionnaire and 832 patients were eligible for the survey, of which 412 returned a completed questionnaire, giving a response rate of 49.5%. The average response rate for the trusts using Picker to undertake the survey was 46%.

Compared to the previous year, fewer discharges were delayed and more people rated the hospital as at least seven out of ten on satisfaction with discharge.

The key issues were noise at night, patient communication and our discharge pathways. To ensure these issues continue to get the focus they need, we will be re-launching our noise at night campaign, to remind all staff of the importance of quiet during the evenings. We will be looking again at ways to avoid moving patients at night. We will also shortly be bringing in new quiet-closing bins for all ward areas, which have been purchased with the support of MK Hospital Charity.

To help improve patient communication, we will be introducing the "Hello, my name is…" standards. Where all staff will introduce themselves to patients.

There is also extensive work being done to improve the discharge pathway, to ensure this happens as smoothly and efficiently as possible – and also to ensure that patients are being kept informed at each stage of the process.

We Care Programme

New Trust standards and commitment were launched in May 2013, as part of a programme of cultural change.

These were:

The standards and commitments were developed with extensive input from staff and patients, including:

- 110 patients involved in 'In Your Shoes' sessions, to share their experience of the care they received.
- 290 staff completed graffiti boards about their experience of working at Milton Keynes hospital.
- 50 staff attended 'In Our Shoes' sessions, sharing their experience of working at the Trust.
- 200 staff developed the six detailed standards and commitments.

One patient, Sheila, said: "I was pleased and surprised to be asked to talk about my experiences. I am pleased to see what we have said being taken forward."

The We Care standards and commitments are being embedded in the trust through a detailed implementation plan. To assist with this, there is a strong and visible We Care brand.

Behind the standards and commitments sit a series of aims to improve the culture, which includes an understanding of the need to:

- Put the needs of patients in the centre.
- Involve staff in shaping a shared culture for the new organisation.
- Encourage staff at all levels to innovate and contribute to improvement for patients.
- Help colleagues understand the impact of their behaviour on others, to feel valued and appreciated for doing a good job, and to be motivated to do their best.•
- Develop and empower leaders and frontline clinical teams.
- Encourage staff to feel responsible and to be held to account for delivery .
- Embed an intolerance for sub-standard or non-compliant performance.
- Embed and sustain the vision, standards and continuous improvement approach.

£1.5million investment creates 100 new nursing jobs

In June 2013, the Trust invested £1.5million in extra nursing, creating 100 new nursing roles, for experienced nurses and healthcare assistants.

Lisa Knight, Director of Patient Care and Chief Nurse, said: "Nursing and care support staff play such an important role in caring for our patients and making their experience in our hospital as positive as possible.

"As well as recruiting new staff, we are also offering extensive training and development opportunities for our staff."

This has included supporting 48 healthcare assistants to study dementia care with the Open University, all matrons are studying an MBA module in quality improvement and there is a rolling programme of ward-based training around palliative care, individualised care planning and cardiac monitoring.

Liz Clark, Senior Lecturer in the Faculty of Social Care at The Open University, said: "We are delighted to be working in partnership with Milton Keynes hospital on the training and development of healthcare assistants and it is rewarding to see the impact of the dementia care course on practice. Through this partnership we believe we can tackle the challenges associated with providing high quality care for all."

There are also plans for further critical care training, advanced diabetes training and a specialist course to help patients who have suffered a stroke.

Inspection shows that MK Hospital patients treated with dignity and respect

Inspectors found big improvements at Milton Keynes hospital when they visited in June, especially around nutrition, patient dignity and keeping patients safe.

The inspectors from the Care Quality Commission visited three wards, where they observed the care of patients and spoke to patients and their families.

Comments in the report include:

- Patients told us that staff treated them with respect and dignity.
- We asked patients if they had noticed if staff washed their hands before providing care, they all told us that they had observed staff washing their hands every time.
- There was a large range of food available to meet all patients' religious, cultural and nutritional needs.
- We found that patients were dressed appropriately, had access to their call bells and drinks and they were kept warm.
- We observed that staff called patients by their preferred name and patients appeared relaxed with the staff.
- Where necessary nurses and volunteers assisted patients with their lunch. We saw that the staff took time to prompt and encourage the patients to eat and were polite and respectful in their approach.
- All three wards we inspected had adequate screening in the form of curtains between the beds to help provide privacy and dignity. We saw that the curtains had fastenings so that they did not fall open and had a polite notice printed on the curtains to say do not disturb.
- We spoke with patients on Ward 3, Ward 8 and (the Medical Assessment Unit) MAU who told us they usually saw the same staff and they knew who they would be seeing each day.

Director of Patient Care and Chief Nurse Lisa Knight said: "We are pleased that the CQC has seen the improvements we have made, and heard from the patients themselves that we are getting the important things right. "With further improvements taking place in the next few months, we are confident that we can continue making the care and experience better for our patients."

The CQC carried out a similar inspection of the hospital in August 2012, and had noted five areas for improvement. The CQC is now satisfied that the hospital is meeting the required standards in three of these areas: respecting and involving people who use services, meeting nutritional needs, and safeguarding people who use services from abuse.

The CQC recognises in the report that steps have been taken by the hospital on the remaining two standards – staffing and records – and said that more time was needed for the effects to be seen.

Helping to prevent patient falls

During October, the hospital held a fortnight of activities raising awareness of falls prevention, as part of its ongoing work on this important subject.

Tracey Davies, the hospital's falls prevention coordinator, visited all wards across the hospital to talk to staff, patients and relatives about what they can do to help reduce the risk of falls.

When adult patients arrive on our wards, they are assessed to see if they are at a risk of having a fall. If they are at risk, they are asked questions such as about their mobility, eyesight, hearing and their history of falls. All this information becomes part of their falls prevention care plan. This enables the patient and staff reduce the risk of a fall during their hospital stay and anticipate requirements for the patient's safe discharge back into the community.

Staff also ensure that at night time lights are switched on under the beds, which do not disturb their sleep but do allow the patient to see the floor clearly before stepping out of bed.

NHS Change Day

Milton Keynes hospital was an active participant in NHS Change Day, with dozens of staff making pledges to improve patient care.

Spearheading the local campaign was Marc Yerrell, a support services supervisor, who pledged to save the Trust £20,000 a year through an innovative scheme to recycle "pre-loved" furniture. Each item is placed on the intranet and is catalogued so it can be easily accessed when another department or ward needs it.

Also taking part in this year's NHS Change Day are management trainee Ruth Davies, who has pledged to create a Twitter account to promote the Change Day and the work and ideas it inspires.

Pathology services manager Jill Beech has made several pledges including shadowing the pathology porter on a ward round to become more familiar with new ward locations, thereby being able to help visitors and patients when they are in need of direction.

Our backing for Speak Out Safely campaign

This year, the Trust signed up to support the Nursing Times Speak Out Safely campaign. The Trust want every member of our staff to feel able to raise concerns about wrongdoing or poor practice when they see it and confident that their concerns will be addressed in a constructive way.

The Trust has promised that where staff identify a genuine patient safety concern, we will support them, fully investigate and, if appropriate, act on their concern. We will also give them feedback about how we have responded to the issue they have raised, as soon as possible.

In addition, Julie Bailey, from the group Cure the NHS, spoke to nearly 100 clinical and non clinical staff regarding the care issues her mother faced as a patient at Mid-Staffordshire hospital.

Partnership with MK College

Patients at Milton Keynes hospital have been receiving extra company and support from students studying at a local college.

Milton Keynes hospital has welcomed 17 health and social care students from MK College hoping to pursue a career in nursing. The hospital has teamed up with the college to offer placements on adult wards for one day a week, over three months.

The students, aged 17 and over, are observing nursing staff to gain first-hand experience of hospital care. The prospective nurses are helping patients with personal care and supporting people who find it difficult to eat and drink.

Some patients do not have regular visitors during their stay, so the students are also encouraged to spend time with their patients by talking, reading or playing cards.

Jane Naish, deputy director of patient care, said: “This is the first time Milton Keynes hospital has offered placements to local students and we’re delighted to be working with the college.

“Everyone involved is keen to create a great experience for the next crop of nurses, and I’m happy to say the students are excited, too.”

Each student is mentored by a Healthcare Assistant (HCA), who has completed extensive training provided by the hospital’s practice development team.

Volunteers support patient care

Patients who have difficulty eating are given a helping hand by a team of volunteers. Mealtime volunteers are part of a 400-strong volunteer workforce.

Sue Smith, who has been a mealtime volunteer for around five years, signed up shortly after her husband was admitted to the hospital.

She said: “When I was looking after my husband, I saw the great work done by the nurses, and I wanted to help.

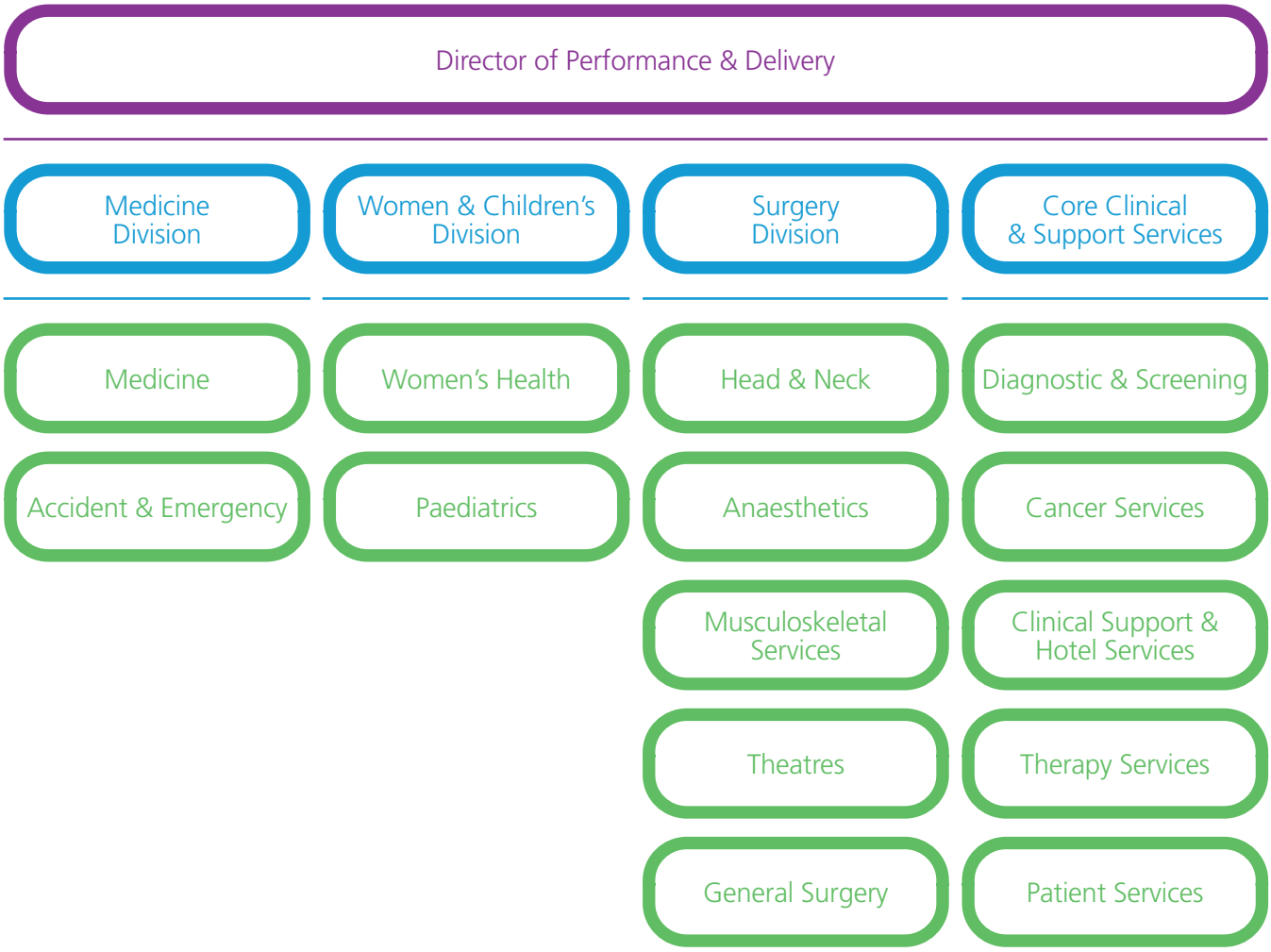
“I’ve been retired for a little while now, so volunteering helps me to meet new people and make a difference. If I can make someone smile, that’s all that matters.”

The hospital’s mealtime volunteers receive training by the hospital’s dieticians to be able to safely and confidently feed patients. The volunteers’ indispensable work helps patients who have difficulty feeding themselves – and makes sure those patients get the nutrition they need for a speedy recovery.

“I’m an extra pair of hands for the ward,” said Sue. “When I’m helping out, it means the nurses can get on with organising discharges or prescriptions. It also means they don’t have to carry the soup!”

Divisional & Clinical Service Unit Structure

The Trust has increased its divisions to four, Medicine, Women and Children's, Surgery and Core Clinical & Support Services. The Clinical Service Units (CSU) are responsible for the day-to-day management and delivery of services within their areas in line with Trust strategies, policies, and procedures. CSUs work within the Trust's Standing Financial Instructions, Standing Orders, Scheme of Delegation and budgetary rules. Further information about the Trust's structure and services are available on our website www.mkhospital.nhs.uk.




Welcome to
Milton Keynes Hospital
NHS Foundation Trust
We CARE
Milton Keynes Hospital
NHS
Tell us about your care
Outpatients and Day Patients

Medicine Division

New emergency care unit

Emergency patients are being seen much more quickly by senior doctors and nurses, thanks to a new unit.

The Ambulatory Emergency Care Unit (AECU) takes patients who need a quick diagnosis and treatment but are not likely to need admission to the hospital. Patients can come from Emergency Department (ED) or are referred directly by their GP. The unit was officially opened in May by the Mayor of Milton Keynes.

The new unit is one of a number of improvements being made to emergency care at the hospital, resulting in patients being seen and treated much more quickly. Not only does the new unit give its patients more suitable, rapid care, it also relieves pressure on ED, allowing it to focus on seriously ill patients in need of admission to the hospital.

Acute medicine consultant Chris Lindesay said: “Our aim is to tell patients why they feel the way they do, and help them get home quickly and safely.

“We have access to rapid diagnostic tests, so we can get answers quickly. We also have the outpatient antibiotic therapy service (OPAT) and venous thromboembolism (VTE) service based here, so the nurses can be available straight away to give patients the care they need.

“Once patients are diagnosed and treated, we can then give them advice on their medication, and arrange for it to be issued. This means patients are able to get everything they need in one place, and don’t have to stay in hospital any longer than they need to.”

Patients themselves do not need to do anything differently. As always, patients are urged to only attend ED in a genuine emergency, and to consider whether alternatives – like their GP or pharmacy – would be more appropriate. However if patients do feel they need emergency care, the hospital will see them and decide whether they need to be seen within ED itself, or can be seen within the adjoining AECU.

New lung procedure brings treatment closer to home

A new service in Milton Keynes hospital is helping dozens of patients get a diagnosis and treatment more quickly and closer to home.

Previously patients who had problems with fluid around their lungs needed to travel to Harefield in West London for tests and treatment. Thanks to the service launched in August 2013, patients can now have access to medical thoracoscopy in Milton Keynes.

The service was set up by Dr Ajikumar Kavidasan, making the hospital only the second in the region to offer the procedure.

He said: "We are delighted to be able to offer medical thoracoscopy locally, and have seen around 40 patients so far.

"It means we can help patients get an early diagnosis and relief from any symptoms, all closer to home. It is a much better experience for the patient."

Medical thoracoscopy is designed for patients who have problems with the membranes surrounding their lungs, which may have thickened or filled with fluid (pleural effusion). The procedure allows access to the pleural space in a minimally invasive way with a fibre-optic camera. This means fluids can be drained and biopsies can be taken, providing instant relief and a swift diagnosis without surgery.

The patient has an ultrasound scan initially and then is sedated for the procedure with local anaesthetic. The procedure is often needed for patients with cancer and can also be needed by patients with a variety of short and long term conditions.

MK takes national lead in improving care for most seriously ill patients

Doctors and nurses from across the country gathered in Milton Keynes to find out more about how to offer support to patients after a stay in intensive care.

Milton Keynes has one of the country's few groups to provide guidance and support to these patients and their families, called ICU Steps. The group hosted a conference, which featured experiences from former intensive care patients and their families, as well as advice for other groups to get up and running.

After patients leave intensive care, patients can suffer a range of physical symptoms and also experience psychological side effects such as anxiety, depression, nightmares, short-term memory problems and hallucinations.

Mo Peskett, Senior Sister at the hospital's Department of Critical Care, who was instrumental in establishing the group, said: "Once they have recovered physically, we invite them into the ward to help them get a sense of what treatment they received and why, which can form a vital part of their psychological recovery.

"Many of the people who come to our drop-ins share their sense of relief when they realise their symptoms are normal. There is a real need for all patients who have had a critical illness to be able to access this service. I am pleased that the conference was a real success, with intensive care clinicians from other hospitals leaving full of inspiration for setting up a similar groups in their areas."

Women & Children's Division

Bedford Hospital Paediatric services

During the summer of 2013, clinical concerns were raised about children's services at Bedford hospital. For a temporary basis, Milton Keynes provided support for children requiring Emergency Department treatment and children requiring planned overnight inpatient care.

The interim changes resulted in a slight increase in patients aged 19 and below needing treatment at Milton Keynes hospital.

Children's services staff prepared thoroughly for the change to ensure no impact on patient care. Plans were put in place to ensure sufficient staffing and resources to meet the increase in demand.

Lisa Knight, Director of Patient Care and Chief Nurse, said: "We worked with Bedford hospital to ensure children's services continue to run safely and effectively. This was of the upmost importance for our patients in Milton Keynes, and also the small number of patients who came to us from Bedfordshire."

Young artists share their ideas for a happy hospital

MORE than 220 children drew pictures with their ideas for making Milton Keynes hospital services more child-friendly.

The winning three pictures have been made into large posters, which are being displayed around the hospital. Their ideas, along with the comments from other children, parents and carers, are being used to make a range of improvements in the hospital.

Almost 300 people took part in the "In Your Little Shoes" consultation, which also included a series of workshops and an online survey.

Using the feedback, the hospital has been:

- Making children's areas of the hospital more colourful and child-friendly, including looking at artwork, curtains and bedding.
- Reviewing the books and toys provided for older children
- Reminding staff how much children like to see them smiling!
- Starting additional training in communication skills
- Reviewing the written information provided to parents
- Making more fruit available for children in the hospital and reviewing the children's menu

The feedback was also used to inform the plan for Leo's Appeal, which is raising money for the hospital's children's services.

International Day of the Midwife

Milton Keynes hospital celebrated the International Day of the Midwife by raising awareness of the support Supervisors of Midwives can offer to expectant mums.

Supervisors of Midwives (SoM) are experienced practising midwives who have undertaken additional training and education to support, guide and supervise midwives in the provision of safe, high quality care.

Local expectant and new mums are able to benefit from SoMs' advice and support, helping them to understand and make decisions and choices about their maternity care. For example, an SoM may offer advice on where a woman gives birth and their birth plan, if they feel they are unable to do this with their own midwife.

SoMs can also listen and help explain events to women whose labours deviated from their birth plan and are left with questions, to help them understand what happened during the labour process, as well as how and why decisions were made.

Angela Weatherley, Lead Midwife for Midwifery Led Care and a Supervisor of Midwives, said: "Supervisors of midwives help ensure safe care is provided to women and their babies. They also make sure that the care an expectant mum receives is right for them and meets their needs. Many people may be unaware of the support that is available from SoM and how to get in touch with one, so we have been using the International Day of the Midwife to help raise awareness."

Children's voices help shape hospital services

Children and parents visiting the children's ward at Milton Keynes hospital can now keep up with the outside world using a free Wi-Fi service.

The service helps children and young people keep in touch with their friends, do homework research, or simply to provide entertainment during a long hospital stay.

Parents and carers – many of whom stay on the ward with their children - will also benefit from using the service. It will help them to get support from friends and family, stay in touch with work, or simply provide some light relief during a stressful time.

Denise Campbell, the ward sister, said: "We are delighted that our new Wi-Fi service is now live. Hospital stays can be difficult for both the children and their parents, and this will be a huge help.

"We do as much as we can to improve the experience of our patients, and it is great to be able to set up a service that patients and their parents have told us they would like."

Surgery Division

New Surgical Emergency Pathway

Surgery ran a pilot from December 2013 to improve our emergency pathways. For the pilot, an additional emergency consultant was provided from Monday to Friday 8am to 6pm and an Advanced Nurse Practitioner (ANP) was based on the Surgical Assessment Unit (SAU).

These new roles ensured that patients had faster and safer access to the emergency surgical team – minimising delays for patients requiring an operation and making more efficient and effective use of the emergency theatres. The on-call consultant managed the flow of patients into the Emergency Department (ED) and SAU, ran daily hot clinics and undertook regular ward and board rounds.

During the first three months, 441 patients accessed the service and improvements included:

- 25% reduction in length of stay.
- 53% admission avoidance.
- 34% of patients requiring surgery were treated and discharged on the same day.
- No verbal or written complaints were received from patients or their carers. Prior to the pilot patients regularly complained about delays.
- Improved emergency theatre utilisation.
- The ANP was able to pull surgical patients through the system faster by working with ED and seeing the patients in SAU.

Following the success of the pilot, the team will now substantively appoint three emergency consultants and two ANPs.

Reopening of the Glaucoma Service

After a three-year closure, the Ophthalmology Department was able to successfully reopen its glaucoma service at the end of November 2013 with the appointment of a new consultant with sub-specialist interest in glaucoma, Mr Areeb Moosavi. This development has allowed for the hospital to begin repatriating patients who had previously been required to travel to other providers, enabling local service users to receive care closer to home. Further, the expansion of our ophthalmology services contributes to the department's objective of becoming both a centre of excellence for the provision of care for common ophthalmological conditions and patients' provider of choice for the area.

Mr Moosavi shared the following comments on his recent involvement with the reopening of the service and plans for its future development: "It has been and continues to be an exciting challenge (and privilege) to develop a new consultant-led glaucoma service at Milton Keynes. The population of this rapidly growing community deserve a high quality glaucoma service local to their homes. We are also in the process of repatriating those patients that have had to travel to other hospitals because this service was not available here.

"We are now open to 'choose and book' glaucoma referrals from GPs. My team and I provide specialised glaucoma clinics and I can offer glaucoma specific surgery to those that need it. We still have much more to do, such as acquiring more equipment to provide more outpatient and surgical procedures for glaucoma and reduce the need to refer elsewhere. In the future, I hope to develop a community optometrist led glaucoma monitoring service which I can oversee with virtual clinics."

Collaborating on hip fractures

Evidence over the last few years has proved benefits of a collaborative approach to looking after patients with a hip fracture. The multidisciplinary hip fracture steering group has worked very hard over the past year to improve the care patients receive. The overall aim is to achieve best practice: surgery within 36 hours, jointly agreed care protocols, shared care, cognitive assessment, geriatrician led peri-operative assessment, multidisciplinary rehabilitation and secondary prevention including falls and bone health assessment.

Following the appointment of a consultant geriatrician, fragility advanced nurse practitioner (ANP) and lead fractured hip clinician there has been a much improved collaborative approach to looking after this vulnerable group of patients. April 2013 – March 2014 saw 249 hip fractures admitted to orthopaedics, with all cases being submitted to the National Hip Fracture Database (the largest hip fracture audit in the world). All patients are automatically admitted under the shared care of a consultant geriatrician and orthopaedic surgeon and seen by the Fragility ANP. Average time to theatre over the course of the year was 30 hours (from Emergency Department admission) and 97% of patients received bone health and falls assessment / ongoing referrals during their admission.

As a result, a 50% reduction in length of stay has been noticed over the last year; and is currently around 12-14 days. Pressure ulcer rates are below national average. With an additional payment eligible for each patient where records show that care meets agreed standards the trust has benefitted from additional income of approximately £175,000. The hip fracture steering group continue to look at enhancing the patient pathway further over the next year.

Nurse-led discharge helping patients get home sooner

Milton Keynes hospital has seen a reduction in the length of stay for patients as a result of nurse-led discharge.

Carole Page, clinical service improvement lead for surgery, has been supporting qualified nurses on the Ambulatory Care Unit to discharge patients.

In March 2014, 73% of all ear, nose and throat discharges were nurse-led. Nurse-led discharge is recognised as a voluntary extended role that requires training and support and a competency assessment.

Nurses have to demonstrate their knowledge of the discharge process, health and recovery information specific to the procedure undertaken, potential post-operative complications of anaesthesia and an understanding of their accountability in discharge decisions.

A discharge checklist is used and the nurse and patient discuss the patient's recovery and discharge plan, ensuring an informed, timely and safe discharge from the Trust.

As well as benefiting patients, nurse-led discharge gives nurses the chance to extend their role, offering an opportunity for self-development.

Core Clinical & Support Services Division

Making every contact count

From September to December, patients having an outpatient appointment in the Urology and Gastro-enterology clinics were asked about their lifestyle.

Nurses asked patients when they are carrying out the usual observation checks such as blood pressure, height and weight.

If a patient expressed an interest in making changes to their lifestyle, they were given a leaflet outlining tips to make small changes that could make a big difference, as well as signposting to local organisations that can offer further support.

Helping people to stop smoking, drink less alcohol, eat more healthily, be more physically active and keep to a healthy weight could give patients the best possible outcome. The pilot formed part of the Making Every Contact Count (MECC) campaign, designed to encourage staff that have contact with patients to make the most of opportunities to highlight ways they could improve their lifestyle.

Cancer care closer to home

Cancer patients are now able to get treatment closer to home, with the hospital expanding its chemotherapy service.

Since April 2013, the hospital has been seeing twice as many patients for chemotherapy treatment. Previously these Milton Keynes patients needed to travel to Northampton.

Sally Burnie, Milton Keynes hospital's head of cancer services and lead cancer nurse, said: "We know how important it is for patients to receive their care as close to home as possible. When you are being treated for cancer, it is a particularly challenging time physically and emotionally, and every extra mile for treatment makes a difference. So we are delighted that we are able to help more local patients get the care they need without the extra travel."

Milton Keynes hospital had been carrying out between 700 and 800 oncology treatments per year. This has been increased by a further 700 treatments.

Simon Stokes is one of the patients whose treatment has been moved from Northampton to Milton Keynes.

He said: "The hand-over process was good and things were followed up quickly. It is much better having everything together in one place. I'm from Milton Keynes and it is much more convenient for me coming here."

Leadership programme

A leadership programme successfully piloted in the Core Clinical and Support Services Division at Milton Keynes hospital is being used to turn around acute trusts displaying concerns identified in the Francis Report.

The Best of the Best Programme was implemented at Milton Keynes hospital following work undertaken by Hillcroft House UK Ltd. This identified the need to give managers the right tools to become good leaders and in turn for this effective leadership to cascade down through the organisation.

Chief Executive Joe Harrison said: "Everything we do must be about giving patients the best possible care – and as the Francis Report made clear, good leadership within the NHS is an essential part of that.

"Here at Milton Keynes hospital, we've seen the difference leadership development can make through our Core Clinical and Support Services Division. The results speak for themselves. Patients are truly put at the forefront and quality is improving.

"We can see the difference in both the leaders themselves and also in the team as a whole. Staff in Core Clinical now show an exceptional pride in what they do. They feel an ownership and personal responsibility to improve our hospital for patients."

Pathology open days

Pathology has been opening its doors to the public, to help the public gain a greater understanding of what happens in a hospital lab.

Sessions have been organised for patient representatives, including Patient Participation Group members from local GP surgeries, but were also open to the general feedback. The tours looked at various aspects of the pathology service, including biochemistry, haematology, blood transfusion, microbiology and cellular pathology.

Feedback was overwhelmingly positive, with visitors thanking the team for sharing their knowledge in such a clear and interesting way.

Hospital helping patients get around more easily

Patients can now find it easier to get a wheelchair when they need one, through new wheelchair parks and a 'sponsor a wheelchair' scheme.

In response to patient feedback, the hospital has taken action to make sure enough wheelchairs are available where they are most likely to be needed. New wheelchair parks opened on September 16 and are located in the seven most popular locations.

Marc Yerrell, Support Team Supervisor, said: "Patients with poor mobility told us that it could sometimes be difficult to find a wheelchair when they need one. The new wheelchair parks are solving this problem."

Fundraising – Review of 2013-14

Almost £300,000 was raised from individuals, companies, schools and events over the past year, which funded new items of equipment, ward enhancements and other items to benefit our patients.

In September we launched Leo's Appeal, named after our mascot Leo the Lion and raising funds for the children's wards at the hospital. So many former patients, parents and staff from the children's wards have already got behind the appeal, which is raising £200,000 for enhancements to the wards. Many local businesses and schools have also been inspired to get involved, including National Locums, which has 27 members of staff climbing Ben Nevis for the appeal – Bidwells Property Consultants, who have named the appeal their charity of the year and the Kingston Centre, who have already raised more than £5,000.

The appeal is raising funds for a redevelopment of the isolation suites on the unit – where very poorly children stay –through to funding additional play equipment, turning treatment rooms into sensory areas and supporting improved facilities for parents.

Although it has been a challenging year financially for fundraising, over the past 12 months we've been strengthening our volunteer, fundraiser and donor base to support future fundraising activities and really promoting the Milton Keynes Hospital Charity as one of the causes to give to in 2014:

- A total of £300,000 raised through charitable events and donations.
- A total of 500 donors recruited to the Trust.
- Recruited a new fundraising officer to the Trust to support community and events fundraising.
- Development of our charity ambassador programme, recruiting individuals to help and support our activities.
- Doubling our number of corporate partners in 2013-14 including ID Medical, FS1 Recruitment, Bidwells, Kingston Retail Park, Midsummer Place, Santander, NHBC, Network Rail, Sainsbury's, MK Theatre, Skyline Taxis and Geoffrey Leaver Solicitors.
- We also became the MK News Charity of the Year, specifically for Leo's Appeal and since September have had more than 20 stories in the local press.

Vanessa Holmes, Fundraising Manager said:
"This year we've really been investing in our fundraising to give support to our fundraisers out in the community. We were delighted to launch our charity ambassador programme, which means a growing number of people (six so far) will actively be promoting our charity within their networks. We were also thrilled to have successfully recruited Jenny, our fundraising officer, who within two months of starting had already raised £1,000 in her own time through a sponsored "Keeper for a Day" at Woburn Safari Park. This year charitable funds have been spent on some great items to enhance patient care- including a brand new milk kitchen on the children's ward, vital signs monitors, fun new curtains for our children's wards, reclining chair beds, chemotherapy chairs and a phototherapy unit to treat babies with jaundice. Next year we will also be fundraising for our cancer services and organising our first Leo's Appeal Winter Ball. So exciting times lie ahead!"

Valuing Our Staff

Staff Engagement and Staff Survey

The national staff opinion survey was undertaken between October-December 2013.

The survey was sent to a random sample of staff, and 408 staff members (53%) completed it, which is a significant increase on the previous year. Through the Trust's "We Care" initiative , we will work with staff and take action to continue improving Milton Keynes hospital, both for our patients and our staff. A summary of the survey response is as follows:

Overall the results were better than average for 21% of the outcomes – compared to 14% in the previous year. We have achieved above average for the percentage of staff:

- who feel work pressure
- having a well structured appraisal in last 12 months
- witnessing potentially harmful errors
- near misses or incidents in last month
- reporting errors, near misses or incidents witnessed in the last month
- experiencing physical violence from patients, relatives or the public in the last 12 months, feeling pressure in last 3 months to attend work when feeling unwell and
- having equality and diversity training in the last 12 months.

2013 NHS staff survey

Response Rate	2012	2013	Improvement / Deterioration
	49%	**53%**	**Improvement of 4%**

	2012		2013		
Top 4 Ranking Scores	**Trust**	**National Average**	**Trust**	**National Average**	**Improvement / Deterioration**
Percentage of staff having equality and diversity training in last 12 months	70%	55%	**67%**	**60%**	**Deterioration of 3%**
Percentage of staff feeling pressure in last three months to attend work when feeling unwell	29%	29%	**26%**	**28%**	**Deterioration of 3%**
Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	32%	34%	**32%**	**33%**	**No Change**
Percentage of staff experiencing physical violence from patients, relative or the public in last 12 months	15%	15%	**13%**	**15%**	**Deterioration of 2%**

We have made significant improvements in the following areas:

- Percentage of staff appraised in last 12 months (80% in 2013 and 71% in 2012 and below average compared to other acute Trusts)
- Percentage of staff having well structured appraisals in last 12 months (40% in 2013 and 32% in 2012 and this is above average for acute Trusts).
- Staff recommendation of the Trust as a place to work or receive treatment (3.63 in 2013 and 3.41 in 2012 and below average compared to other acute Trusts)

Areas for Improvement:

	2012		2013		
Bottom 4 Ranking Scores	**Trust**	**National Average**	**Trust**	**National Average**	**Improvement / Deterioration**
Percentage of staff agreeing that their role makes a difference to patients	91%	89%	**87%**	**91%**	**Deterioration of 4%**
Percentage of staff receiving job-relevant training, learning or development in last 12 months	83%	81%	**78%**	**81%**	**Deterioration of 5%**
Effective team working	3.74	3.72	**3.68**	**3.74**	**Deterioration of 0.06 points**
Work pressure felt by staff	3.22	3.08	**3.13**	**3.06**	**Deterioration of 0.09 points**

Actions taken since 2012 Staff Survey:

The new Trust standards and commitments were implemented following feedback staff gave as part of the previous staff survey as well as the We Care process. Key initiatives this year as a direct result of staff feedback include:

- Staff said they did not see senior managers enough. Our directors and non- executive directors now visit a clinical area or department before each Board meeting to meet staff and patients. In addition, directors have spent time going 'back to the floor' with frontline staff across all disciplines
- Staff commented that patients did not have enough time to eat their meals, or were not given enough support to eat if they needed it. Appropriate nutrition is vital to assist patients' recovery, so every ward now has a protected mealtime which helps patients eat their meals without disruption and enable staff to support patients unable to eat independently.
- Staff reported that their environments were in need of improving. Trust decorators have worked hard on refurbishing several areas of the hospital. Wards 19 and 20 have also had been renovated to make them better for staff to work in and for patients to be treated in.
- Staff said there was not enough staff in some of the clinical areas. During 2013 there was investment in nursing and HCA rules resulting in innovative recruitment initiatives to recruit New recruits began to join the workforce in the Autumn
- There is now a monthly CEO roadshow where all staff are invited to attend and hear from and speak to the CEO
- Staff said that the internal communications system, Cascade, was top down communication and there is now feedback from any comments or questions raised by staff to management from Cascade.
- Staff said that patients' had commented that they did not know the names of staff treating them. Over the year all staff have been issued with corporate name badges.
- Staff said that they wanted water coolers for patients and themselves and these are being provided.
- A number of staff said that they had not received their annual appraisal and all managers were asked to provide an action plan to ensure that 90% of staff receive their appraisal by 31st March 2014. This has been achieved.

Further actions plans will be developed with staff involvement and will be communicated to all staff. Initial findings highlight that the key areas for improvement are:

- An increase in number of staff agreeing that their role makes a difference to patients
- A reduction in the work pressure experienced by staff
- An increase in staff who have effective team working
- Staff appraisal rates to be improved and maintained
- A reduction in the additional hours staff feel obliged to work
- The availability of hand washing materials and staff perception of this
- Staff's perceptions of the fairness and effectiveness of incident reporting
- Staff experiencing harassment, bullying or abuse from staff
- Reduction in number of staff experiencing discrimination
- Increase in the number of staff believing the Trust provides equal opportunities for career progression or promotion.

CQUIN results

The key CQUIN indicators have improved locally across all five indicators and are in line with the average for acute Trusts. These are set out in the table below:

Question	MKH in 2012	Average (median) for Acute Trusts	MKH in 2013
"care of patients / service users is my organisation's top priority"	58	68	**72**
My organisation acts on concerns raised by patients / service users	66	71	**73**
I would recommend my organisation as a place to work	49	59	**56**
If a friend or a relative needed treatment, I would be happy with the standard of care provided by this organisation	50	64	**59**
Staff recommendation of the Trust as a place to work or receive treatment	3.41	3.68	**3.64**

Equality and Diversity

The trust has a longstanding commitment to ensuring that our services and employment practices are fair, accessible and appropriate for all patients, visitors and carers in the community we serve, as well as the talented and diverse workforce we employ. The trust board receive a comprehensive annual report of equality and diversity information

The trust is committed to providing an environment equally welcoming to people of all backgrounds, cultures, nationalities and religions. Our We Care standards and commitments help us to achieve this aim.

67% of staff who participated in the national staff survey reported that they had received equality and diversity training within the last 12 months. The national average was 60% meaning that MKHFT is above average for acute Trusts.

79% of all our staff have received equality and diversity training as part of their statutory and mandatory training.

The workforce and service lead for equality and diversity are both members of the Workforce Assurance Committee which is responsible for overseeing equality and diversity for the Trust.

The trust is committed to providing a fair, efficient and effective recruitment and selection service as part of its wider commitment to equality of opportunity. The trust employs a range of policies and procedures to ensure disabled applicants are given full and fair consideration. These include the recruitment and election policy and a good practice guide to employing disabled people . The trust is accredited with the "Positive About Disability" or "Two Ticks" symbol, which demonstrates commitment to encouraging individuals with a disability to apply for posts and guarantees an interview if such an individual meets all the essential criteria.

The trust recognises the value of a diverse workforce and is committed to supporting the employment, training and career development of people with disabilities and staff that become disabled during their employment, this includes the trust's management of sickness absence policy which sets out our standards and requirements to support staff

Staffing Profile

Staff in Post as at 31/03/2014:

Staff Group	Number of Staff	FTE
Add Prof Scientific and Technic	100	93.14
Additional Clinical Services	539	451.16
Administrative and Clerical	536	472.46
Allied Health Professionals	120	99.25
Estates and Ancillary	332	237.60
Healthcare Scientists	118	106.92
Medical and Dental	340	326.55
Nursing and Midwifery Registered	931	797.61
Total	**3,016**	**2,584.71**

The following is a breakdown of staff by gender:

Female	2,404
Male	612
Total	**3,016**

The Board comprises of eight non executive directors (six male and two female) and seven executive directors, (five male and two female).

Sickness Absence

The sickness absence rate for period April 2013 to March 2014 = 4.24% (4.55% in 2012/13)

Absence Rate for year 01/04/2013 to 31/03/2014:

Milton Keynes Hospital NHS Foundation Trust Year 1st April 2013 to 31st March 2014	Cumulative Abs (FTE)	Cumulative Avail (FTE)	Cumulative % Abs Rate
All Staff Groups	39,033.62	921,689.58	4.24%

The management of sickness absence continues to be a priority for the Trust, focusing on 'hotspot' areas in order to bring conclusion to individual cases. We continue to educate managers on their role in managing sickness absence and have a structured programme of activity to reduce our level of sickness absence including:

1. E-Rostering for all wards which allows for real-time sickness absence reporting which is leading to more accurate and timely information.
2. Monthly monitoring of staff that have triggered against our target.
3. A range of health promotion strategies to encourage staff wellbeing.
4. A new Trust Managing Sickness Absence Policy was consulted, agreed and launched in 2013

Retirements on Ill Health

There were 4 people who retired on ill health and the pension liability for all those was £303,000.

Occupational Health (OH)

The OH Service undertake pre and on-employment fitness for work assessments, provide an immunisation/screening programme to ensure staff are protected against infectious diseases in line with Department of Health guidance, in addition to supporting the Trust with the management of sickness absence and providing advice in relation to health conditions which may have an impact upon an individual's health at work or vice versa. The service continues to provide a face to face counselling service for psychological support. The service is currently in a trial period for the provision of physiotherapy to enable early intervention for musculoskeletal problems, and also receives support from a dietician on a weekly basis to assist with the wider public health issue - tackling obesity.

The OH Service provides flu vaccinations for staff to protect patients and reduce staff absenteeism.

Learning & Development

In the past year the Learning and Development Department have further extended their annual training programme to ensure they continue to offer a wide range of management and personal development programmes to meet the needs of differing staff groups across the organisation. This included 'Aspiring Managers' a workshop for those staff with no previous experience that are looking to move into a future management position and 'Vital Conversations' which is aimed at senior staff that wish to develop their skills and confidence when undertaking difficult conversations.

We have also extended our range of programmes aimed at staff working within bands 1-4, new workshops have included: - handling difficult situations, essential skills for administrators, professional telephone skills. In addition to our annual programme we have funded and supported 48 Health Care Assistants through an Open University 'Improving Dementia Care' module. We successfully obtained additional funding to support a research project which will look at the potential impact on patient care resulting from this training.

Flexible use of the Learning Beyond Registration funding has enabled us to support the senior nursing team in developing bespoke programmes in partnership with Bedfordshire University including a 'Stroke Programme' which will be run on-site for nursing staff working on the Stroke Unit and other relevant areas and a masters level 'Leadership Programme for Matrons' which resulted in the development of several service improvement initiatives within the Trust.

Organisational Development

Themes from the staff survey are being linked to the wider organisational development work being undertaken through the "We Care" and the Leadership Development programmes.

The "We Care" project is based on an understanding that patient experience is hugely influenced by "human interactions" that they have with staff and that staff who feel actively engaged in their work provide better care to patients. The purpose of the programme has been to use staff and patient feedback to develop core "Values" for the Trust and to describe the underpinning behaviours and actions that will support those values being shown in all our systems, activities, processes and in staff behaviours.

A pool of staff have been trained to deliver 'We Care' teams sessions across the trust during 2014, to assist with the embedding of these values and behaviours and enabling teams to identify their own objectives around behaviour. The embedding of actions will support the strategic direction of providing consistent high quality care of which staff can be proud. Staff must also however continue to see action taken on the feedback they give and that from patients and the project has given on-going feedback to staff.

The Leadership Development programme for CSU and divisional teams was designed to support the values identified within the "We Care" programme, including an "engaging and involving" leadership style. The leadership development project was launched in December 2012 and the first cohort has now completed all their sessions. A second cohort commenced their programme in January 2014 and will continue until the summer of 2014.

Directors' Remuneration

Details of the Board of Directors remuneration are included in the Remuneration Report. (section 5)

Volunteers

Milton Keynes hospital is fortunate enough to have over 300 volunteers who are a valuable asset helping and supporting patients, the general public and the Trust's paid staff.

Our volunteers range from students who want to train as midwifes, nurses or doctors, retirees, individuals who want to improve their own health and wellbeing or who want to gain new skills and knowledge, to those that have been patients. Our teams of volunteers help make an enormous positive impact on the care that the hospital delivers and have supported the Trust during 2103/14 by giving over 23,000 hours of their time.

Volunteers have given their time to support areas like the Emergency Department helping with administration or ensuring the comfort of patients/relatives, in the Macmillan Unit meeting and greeting visitors, and providing refreshments and in some of our reception areas providing a welcoming and information service.

There are over 50 volunteering opportunities ranging from administration roles to meal time assistant volunteers. We can usually find something that is of interest to the individual, which they can fit in around their personal and work lives, with a minimum commitment of two hours per week, depending on the role.

Other organisations within the hospital such as Friends of Milton Keynes hospital and Community (which provide the shop in main reception and trolley service), Milton Keynes Hospital Radio, MK Arts for Health and Bucks Vision, recruit volunteers in other roles which support the patients, general public and staff at the Trust, which we are extremely grateful for their loyalty and commitment.

Patient Experience

The Patient Experience Team (PET), deal with feedback received from the four C's: - comments, compliments, concerns and complaints. Compliments and are shared with appropriate staff and an acknowledgment sent to the patient and a thank you letter is also sent to individual staff who have been named in compliments. This is undertaken by the Chief Executive.

Formal complaints are dealt with in line with trust policy and take into account the complainant's wishes on how they would like their complaint resolved. Local resolution takes the form of either a written response to the complainant or a meeting with the responsible staff or both.

Concerns (informal complaints) are taken forward as agreed by the complainant and are dealt with, as much as possible, 'on the spot'. Sometimes issues raised, such as appointment issues, take a few days to resolve, however during resolution the patient is kept fully informed.

By the end of June 2014, the Patient Experience Team will be changing its name back to the Complaints and PALS Team. The PALS element of the team will be based just off Main Reception, next door to the Car Parking Office. This will ensure greater accessibility for our patients and the public.

	Year			
	10/11	11/12	12/13	13/14
Number of Formal Complaints	300	246	295	**174**
Number of Informal Complaints	345	478	443	**265**

Timely responses to formal complaints have been an issue earlier this year. Delays have been experienced in receiving investigation responses from staff. In addition there have been issues in respect of the quality of the investigation responses undertaken, and delays in the checking process for final responses. This is monitored very closely and a formal escalation process is now in place, and improvement has been seen in the last quarter of this year. This improvement has seen a rise in performance in respect of responding to complaints within timescales agreed with the complainant of 20%, the up to date achievement being 95%.

The PET deal with some concerns within one working day and the information from these concerns, although not nationally reportable, is recorded as a verbal complaint on the trust's complaint database (DATIX) since 2011.

	Year		
	2011/12	2012/13	2013/14
Number of Verbal Complaints dealt with by PET	257	211	**222**

The PET also takes calls from patients and the public who are trying to access information and advice. These calls are logged on the PALS module of DATIX. The PET also responds to all comments left on the NHS Choices website. The comments, whether positive or negative, are shared with the responsible staff. In the case of negative comments staff are requested to ensure the feedback is used to improve the service they offer and a response with regard to the action taken has to be sent to the PET.

	Year			
Type of call	10/11	11/12	12/13	13/14
Advice	46	62	182	**228**
Information	226	138	88	**422**
Signposting	95	21	4	**37**
Compliments	-	-	-	**17**
NHS Choices comments – positive	-	-	-	**124**
NHS Choices – negative	-	-	-	**37**
Total	**367**	**221**	**274**	**865**

The Trust received 3607 (as reported at 7th April 2014, and including compliments (124) received via NHS Choices website) compared to 3587 compliments in 2012/13.

Every month each division is made aware of the number of complaints they have received, the type of complaint and the area responsible. This information is provided to the clinical governance facilitators who ensure that this is fed back through the individual CSUs clinical improvement group. The number of compliments is also reported.

Complaints information and analysis is provided on the trust's patient experience report, quarterly.

Service improvements from Patient Feedback

In response to feedback from the Friends and Family Test, Picker surveys, 15 steps the following are examples of actions the Trust has taken:

- Ssh! People are sleeping campaign – noise at night and using under bed lights
- Food and drink- brought in hydration stations so patients could get a hot drink when they want and posters telling patients food and drink available 24/7
- Sensory loss walkabout with patients and governors feedback being used for new signage, garden maintenance, more disabled car parking
- 15 steps with young people on in patient children's ward – teenage den with computers developed
- Changed visiting hours to 12/2 in response to patient and carer feedback
- Redesigned the ward entrance with colour photos of each wards' sister, useful information, our values

Improvements in Patient/Carer Information

It is important that the Trust provides patients and carers with appropriate information regarding their care. The following are examples of improvements to information that is provided:

- Funded and implemented 'This is Me' by the Alzheimers society for carers of patients to enable appropriate care to be given to the patient

Professionally designed and implemented following key patient leaflets which are in easy to read and attractive format

- Your stay in hospital (includes meal times, visiting hours)
- Preventing falls in hospital
- Preventing Pressure ulcers
- Information and advice for carers of patients with dementia
- Staying with your partner in hospital (partners are allowed to stay overnight on the maternity wards)
- Staying with your child in hospital

Preformance Review

Monitor's Compliance Framework and the Care Quality Commission

Monitor is the Independent Regulator of NHS Foundation Trusts and uses the Compliance Framework to assess the performance of each Trust. Monitor took on new powers from April 1st 2013 as the sector regulator for health and now has responsibility for licensing providers of NHS-funded services holding them accountable through the Compliance Framework.

The Care Quality Commission also continues to undertake continuous assessments of the services that we provide to ensure we meet the national standards of quality and safety. The table below details our performance for 2013/14.

Indicator	Assessment Benchmark / Target		Trust Performance	Outcome
NATIONAL REQUIREMENTS				
Clostridium Difficile Infections	Maximum 13		**37**	**Not Achieved**
MRSA Bacteraemia (hospital associated)	Maximum 0		**3**	**Not Achieved**
All cancers, 31 day wait for second or subsequent treatment	Drugs treatments Surgery Radiotherapy	98% 94% 94%	**100%** **97.2%** **100%**	**Achieved**
All cancers: 62-day wait for first treatment	GP referred NHS Screening Consultant upgrade	85% 90% 85%	**See Note Below**	**See Note Below***
All cancers: 2 week wait from referral to first appointment	All cancers Symptomatic breast	93% 93%	**96.7%** **95.2%**	**Achieved**
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways.	90%		**89.2%**	**Not Achieved**
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed non-admitted pathways.	95%		**97.6%**	**Achieved**
Maximum wait of 4 hours in A&E from arrival to admission, transfer or discharge	95%		**94.4%**	**Not Achieved**
ACUTE FOUNDATION TRUST TARGETS – MINIMUM STANDARDS				
CQUINs	90%		**56%**	**Not Achieved**
Patient Experience- Family and Friends Test	70%		**67.8%**	**Not Achieved**
The percentage of complaints responded to within the agreed time	93%		**77.5%**	**Not Achieved**

*** Note: 62 day cancer wait**

The trust's position on the Open Exeter (external) system showed 86.1% compliance. However, after having examined the data in detail the trust has determined that the data held on the Open Exeter system contains discrepancies relating to activity recorded at tertiary providers. Following the trust's review of the data, the trust has concluded that it has achieved 84.9% and therefore cannot have the confidence that the target of 85% has been met.

Actions to address Performance

The trust is taking the following actions to improve performance against the national indicators:

CDiff

- Commissioned an external review of the CDiff cases and make recommendations to the Trust on any improvements;
- Ensure Antimicrobial Stewardship mandatory training to prescribers is delivered – starting February 2014 and that plans are in place to cover all prescribers;
- Review and ensure C difficile PII policy is implemented if indicated.

MRSA

- Review current practices regarding sample taking and testing.

All cancer 62 days

- Additional capacity being provided to ensure patients are seen as soon as possible at all points in their journey;
- Work with the tertiary centres to ensure that evidence of treatment is returned in a timely manner;
- Increase internal real time validation.

RTT Admitted

- Patients being booked in order of referral;
- Manage the waiting list to ensure consistent flow across the list;
- The pooling of patients within specialties and clinical teams;
- Ensure consistency of urgent and routine classification;
- Agreement with CCG process for effective management of referrals.

Emergency Department (ED)

- Plans for interim expansion of ED;
- Model for new Assessment Unit at beginning Q4 2014/15, to create a single entry point for emergency admissions;
- Changes in management team for ED department;
- Working with the CCG to co-locate Urgent Care Centre with ED.

CQUIN

- The CQUIN schedule for 2014/15 has been agreed with CCG, which has enabled earlier planning than in 2013/14;
- Project manager appointed for CQUIN delivery and is part of the Transformation Project management team;
- Performance will be monitored through the Transformation Board which reports to management board and Finance and Investment Committee.

Patient Experience- Family and Friends Test

- Trust has procured “I Want Great Care”, that will collect both online and offline information from Patients and Staff on their experience which will report monthly;
- Trust will use quantitative and qualitative feedback on the organisation, departments, wards and clinics to make improvements for the patients.

Complaints

- Escalation process for complaints not being responded to within the set timeframe is being implemented;
- Weekly reports to Executive directors regarding governance issues includes Complaints performance;
- Compliance with Complaints timescales is challenged at divisional performance meetings by the Executive directors.

Activity performance

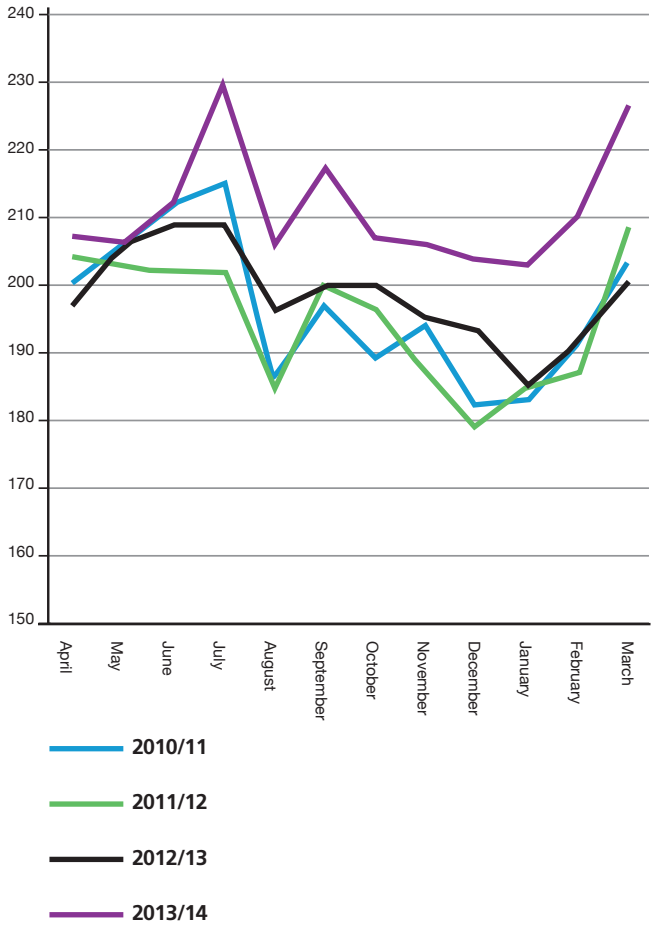
Performance in 2013/14 included the following:

- 296,485 outpatient attendances at the hospital, which almost 38,000 greater than last year;
- 25,636 patients were elective admissions admitted (i.e. for planned care), a 20% increase on the previous year;
- 33,121 patients were admitted as an emergency, which is a 33% increase on the previous year;
- 75,333 people attended the Accident and Emergency Department, which is a 4% increase from the previous year;
- Improved performance in maximum wait of four hours in Emergency Department 2013/14 94.4% compared to 91.4% in 2012/13;
- 3,831 babies were delivered by the trust staff;
- Readmission rates were 8.1% compared to 7.6% in 2012/13 and 8.8% in 2011/12
- Waiting times on the 18 week referral to treatment pathways achieve nationally set targets and were not met with prior agreement with CCG. This enables the trust to reduce the backlog of patients on the waiting list to a sustainable position going forward;
- The number of formal complaints received decreased significantly in 2013/14 with 175 compared to 290 in 2012/13.

The trust received more GP referrals, saw more patients in the emergency department and undertook more emergency admissions whilst also delivering more elective activity and outpatient attendances than planned.

The trust has seen a noticeable increase in the number of patients attending emergency department and a comparison of activity against past years is shown in the graph below:

Average No. of A&E attenders



Sustainability

The trust's 2007 carbon baseline assessment was 12,747 tonnes per annum, with a target to reduce carbon to 9,559 tonnes by 2014/15.

The following table shows Co2 performance per annum to date:

2010/11	11,808 Tonnes
2011/12	11,108 Tonnes
2012/13	11,183 Tonnes
2013/14	10,508 Tonnes

The decrease in carbon from last year will be due in large part to a mild winter with decreased heating requirements and for the first time the use of the trust's medium voltage generators to export electricity to the mains network. This reduces the reliance on mains voltage as well participation in government backed STOR and Falcon energy saving programs. This combined with a trust initiative to only buy replacement or additional highly rated energy saving appliances wherever possible and on-going staff awareness initiatives to reduce consumption has produced a substantial fall in carbon over the last financial year.

Stakeholder Engagement

The trust actively engages with stakeholders on the performance of the trust and any proposed changes in services. There are many groups and organisations with which the trust engages.

One of the trust's top priorities has always been to focus on how to improve our services to our patients by listening to concerns and feedback from service users.

Over the past year, the trust has engaged different methods to successfully collect patient views and responses on how we can continuously improve the patient and public experience at the hospital. For example the 15 Steps initiative, where patients and the public assess the environment and recommend improvements.

The trust implemented the revised board and committee structure to ensure that there are clear reporting lines and accountabilities.

We are committed to listening and acting on the feedback we receive from those who use our services. The trust places great importance on the information it receives from our patients, their families and carers.

Engaging with our local community

Our policy is to consult and involve members, patients and other stakeholders on improving the care we provide. We do this by finding out what our patients and other stakeholders think about the care they have received and, through our Council of Governors, asking for views on our longer-term plans. A consultation on how the Trust engages with its members was undertaken in 2012/13 and changes to practices to ensure that members are not just informed of issues regarding the Trust, but are actively involved in shaping services. For example members have been informed on events regarding the Healthcare Review public forum meetings.

The main forum for representing the interests of patients, carers, employees and the local community is through the Council of Governors, which includes elected representatives from the public, staff, local business, the voluntary sector, the CCG, the local authority and Youth Council.

Milton Keynes CCG

The Trust has established a working relationship with the GP Commissioning Groups for the contract negotiations and longer term health care planning.

Health and Adult Social Care Select Committee

The chief executive, the chairman and governors have continued to keep the elected representatives of the Council and in particular, the Health and Adult Social Care Committee appraised of service issues at the trust.

The Council have continued to support the strategic solution of the trust. In addition, the Council has a representative on the Council of Governors, Councillor Debbie Brock, who provides information and updates to the trust on issues facing the Council.

Health and Wellbeing Board

The director of patient care and chief nurse represents the hospital on the Health and Wellbeing Board and reports any issues back to the trust Board and governors, as appropriate. The chair of the Health and Wellbeing Board, Councillor Debbie Brock, is also an appointed representative on the Council of Governors.

Healthwatch MK

The remit for both the Council of Governors and Healthwatch MK is complementary, both bodies representing the health interests and concerns of the members and people of Milton Keynes. Throughout 2013/14 collaboration continued as appropriate. The Chair of Healthwatch MK is an appointed Governor on the Council of Governors and a Governor is a co-opted member of the Healthwatch MK. The trust participated in the Here's Healthwatch event with stalls on diagnostic services, patient experience and membership.

Council of Governors

The Council of Governors has met formally eight times during the year, (nine including the Annual Members' Meeting). Although the timetable of meetings has been altered to ensure that the Council of Governors meets the week following trust Board, to receive updated performance information. Governors have also been involved in a wide range of activities, from recruiting members, 15 Steps, PLACE inspection and commenting on the trust's strategy. Additionally, Governors developed an information leaflet for distribution to parish councils, local GP surgeries and the local community on their role.

The Council of Governors has received regular updates on progress on addressing the issues raised by the Care Quality Commission regarding dignity and nutrition and monitor regarding Trust-wide governance issues. Governors are also involved in the nomination committee, engagement group, and food quality group.

Patient 15 Steps

The governors have been instrumental in the implementation of 15 steps programme. This provides feedback on the environment and first impressions of an area in the hospital. As a result recommendations are made for improvement and wherever possible these are implemented immediately.

A governor has also sat on the group considering clinical excellence awards, and the PLACE inspection.

Media relations / activity

Milton Keynes Hospital NHS Foundation Trust regularly appears in local weekly newspapers and on local radio stations and community websites. It is also features occasionally on regional TV.

In 2013/14, our news coverage included:

- Extensive coverage of the opening of the hospital's new Ambulatory Emergency Care Unit (AECU) and during its first year of operation. There was particular media interest in the official opening by the Mayor of Milton Keynes in May and a visit from the Shadow Health Secretary in June.
- The hospital's consultation of young patients and their families – "In Your Little Shoes" – received coverage both during the consultation itself, and when the results were announced in July. The photo sharing site Flickr was also used to share some of the children's postcard suggestions with a wider audience.
- In June 2013, the trust received local and regional media interest because it had invested £1.5million in extra nursing, creating 100 new roles for experienced nurses and healthcare assistants.
- Improvements to dementia care have been featured both in local and specialist media, particularly the innovative healthcare assistant training programme in partnership with the Open University.
- Media interest in Emergency Department was particularly high in the run-up to winter, resulting in visits from local, regional and national broadcast media.
- Regular coverage of Leo's Appeal through both traditional and social media has helped to raise awareness of this £200,000 children's services appeal with the local community.

As well as proactive media work, the trust also responds to enquiries and requests from the media. The trust has a strong commitment to an open and positive approach to media relations and, as a publicly funded body, is committed to ensuring that an Executive director or senior manager is available for interview when there is significant media interest in order to help balance the overall reporting on any news story and ensure that the trust's key messages are delivered to local people.

During the year the trust has continued to develop its social media presence, which had been launched in 2011/12. The hospital's Twitter account now has more than 1,600 followers, double the number it had at the start of the year. The hospital's charity has increased its followers from almost 500 at the start of the year, to almost 900 now. In addition, the charity has active support on Facebook and almost 500 likes.

A refreshed hospital website was also under development at the end of 2013/14, and is planned for launch in May 2014. This brings the website in line with the trust's corporate identity and also makes it easier for people to find the information they need about the trust.

A new communications strategy was agreed at the end of 2013/14, which will help develop and improve communications moving forward.

Partnerships – improving healthcare for our patients

The trust is committed to provide the best healthcare possible for the people of Milton Keynes and beyond. In order to do this, the trust has a number of partnerships.

Oxford University Hospitals NHS Trust

Patients who require specialist care that the Milton Keynes hospital cannot provide are referred to Oxford University Hospital's for tertiary care.

Bedford Hospital NHS Trust

In 2013/14, Milton Keynes provided support with paediatric inpatient services for the patients who would have usually attended Bedford hospital. The trust also has ongoing partnership with Bedford hospital in certain care pathways e.g. vascular surgery.

Luton and Dunstable University Hospital NHS Foundation Trust

Patients requiring maxillo facial specialist care are referred to Luton and Dunstable University Hospital NHS Foundation Trust.

Northampton General Hospital NHS Trust

Oncology treatment was provided by Northampton Hospital for cancer patients. Northampton General Hospital served notice on Radiotherapy service they provided to patients referred to them from the trust. The trust has established a local provider to undertake radiotherapy from 1 April 2014 until a longer term solution can be established. .

University of Buckingham

The trust has partnered with the University of Buckingham to provide a academic centre on the Milton Keynes hospital site. Planning for an academic centre is well underway and the University of Buckingham is actively seeking students to commence at the University in 2015. Students are expected to undertake their clinical training at the hospital from January 2017.

Oxford Deanery

All the trust's trainee doctors are graduates from the Oxford Deanery.

Section 4

Quality Report

Quality Report

Statement on quality from the Chief Executive

Every year hundreds of thousands of patients trust us to care for them with kindness, compassion and professionalism. They trust us to make sure they are cared for safely, that they receive the best treatment we can offer, and that we will put their needs first and foremost.

Providing this quality of care – the quality of care we would want for ourselves and for those we love – is at the heart of what we do and what we strive to do, every day, for every patient.

I am proud of the quality of care we provide at Milton Keynes Hospital. Of course there are areas where we can and must do more to keep improving, but we have also made real improvements throughout the year.

In January 2013, the Care Quality Commission (CQC) raised concerns about staffing numbers, and we have worked hard throughout the year to resolve that problem. We invested an extra £1.5million at the start of the year in frontline nursing posts, and our recruitment campaigns have attracted high quality nurses and healthcare assistants. We have also invested in nursing training, which has included 42 healthcare assistants completing an Improving Dementia Care course with the Open University; a £70,000 investment in university education for post-registration nurses; specialist training in stroke care; and a generous 12 days of protected study time for all newly qualified nurses as part of their nine-month preceptorship programme.

Demand for our emergency department (ED) has continued to prove challenging this year, as physical space remains a limiting factor. The unit is now seeing more than four times more patients than it was originally built for and we are actively working with our partners to resolve this so that we have a suitable environment to deliver high quality care. In the short term we are opening an additional x-ray room and more assessment spaces. Over the summer of 2014 we will be starting work on a bigger assessment space for patients who need admitting to the hospital.

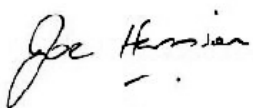
We are encouraging our patients to give us feedback on their care and experience so we can learn and develop services in line with local expectation and need. This has seen the continued roll out of the Friends and Family Test across all areas of the trust; using social media to seek patients' views; and piloting the use of "happy face, sad face" ratings machines in our children's ward. In March 2014 we also signed up to iwantgreatcare, and are looking forward to using real time feedback more effectively and ensuring that information is easily accessible and understood by patients and staff.

We continue to work on ensuring that we prevent and reduce the incidence of healthcare associated infections; and that we focus on areas where we know we can reduce harm to patients - including patient falls and pressure ulcers. We are also working hard to meet the growing dementia care needs within our local population.

Our priorities have been and remain improving patient safety, clinical effectiveness and patient experience. Quality is central to the care we provide at Milton Keynes Hospital and I look forward to continuing our work, alongside patients and our health and social care partners, to continue improving the quality of services we provide for local people.

Statement of Assurance

This report has been reviewed by the Board of Milton Keynes Hospital NHS Foundation Trust. The Chief Executive is the responsible officer and I sign to state that, to the best of my knowledge, the information contained in this report is accurate.



Joe Harrison
CHIEF EXECUTIVE

Date: 29 May 2014

During the last year our hospital:

Cared for **58,757** in-patient

Cared for **296,485** outpatients

Attended to **75,333** people in A&E

Delivered **3,831** babies

Carried out more than **202,673** scans

Received more than **892,693** requests for tests

Introduction

This report gives an overview of performance across our key priorities, which illustrates our commitment to providing a quality service for patients. The report also outlines our measures for assuring and sustaining performance for the future, recognising that there are areas requiring improvement.

Milton Keynes Hospital is a district general hospital providing a broad range of general medical and surgical services, including A&E. We continue to develop our facilities to meet the needs of a growing population. The hospital provides services for all medical, surgical, maternity and child health emergency admissions.

In addition to providing general acute services, Milton Keynes Hospital increasingly provides more specialist services, including cancer, cardiology and oral surgery and has the responsibility for treating premature babies born locally and in the surrounding areas.

Our aim is to provide quality care and the right treatment, in the right place, at the right time. The Trust Objectives are focused on delivering quality care with the first 3 objectives being:

1. Improve Patient Safety
2. Improve Patient Experience
3. Improve Clinical Effectiveness

Supporting our framework for quality we have a rigorous set of standards for monitoring against local and national targets. This helps us to continually assess our performance and tackle issues as they arise. The Trust is developing our Quality Strategy which will define the overarching priorities for the Hospital in the forthcoming years. It is expected that this will be adopted by the reported to the Trust Board in Q2 of 2014/15.

As well as our staff, we are also proud of our strong relationships with our stakeholders: The involvement of patients, the public, governors, local information networks, and health system partners is integral to our development.

Our governors are involved throughout the year in monitoring and scrutinising our performance. The governors continue to demonstrate their enthusiasm and commitment to fulfilling their role as elected representatives of patients and the public, through their direct activity with the community as well as their participation in Milton Keynes Healthwatch meetings and other community forums. A Governor also attends the Quality Committee which monitors performance of the Hospital against the quality priorities set in the Quality Account.

During the year, we have continued to be actively engaged with the Milton Keynes Council Health and Adult Care Select Committee and the Health and Wellbeing Board on subjects of importance to the community.

This report gives an overview of performance across our key priorities in 2013/14, which illustrates our commitment to providing a quality service for patients. The report also outlines our measures for assuring and sustaining performance for the future, recognising that there are areas requiring improvement.

Priorities for Improvement

Introduction

The Quality Accounts are annual reports to the public about the quality of services that providers of healthcare deliver and their plans for improvement.

The purpose of the Quality Accounts is to enable:

- Patients and their carers to make well informed choices about their providers of healthcare;
- The public to hold providers to account for the quality of the services they deliver; and
- Boards of NHS providers to report on the improvements to their services and to set out their priorities for the following year.

As part of our quality account for 2014/15 the Trust is required to choose at least 3 quality priorities for the year to be included within Part 2 of our Quality Accounts.

There are criteria for choosing these priorities which are:

- They should be determined following a review of the quality of service provision
- They should reflect both national and local indicators
- They should be aligned with the three domains of quality: patient safety, clinical effectiveness and patient experience

Once agreed the quality account must report upon how progress to achieve the priorities is identified including how they will be monitored/measured and how they will be reported by the Trust.

How we did last year?

In our Quality Accounts last year 2012/13 we identified 3 priorities for improvement. These were

- **Priority 1: Elimination of Grade 3 and 4 avoidable pressure ulcers**
- **Priority 2: 95% compliance with the WHO checklist for safer surgery**
- **Priority 3: 5% reduction in falls and a 5% reduction in falls resulting in serious harm**

We have decided that Priority 1 and 3 still need to be our focus and as such progress on this is reviewed below in our Priorities for 2014/15.

We have been successful in making improvements with Priority 2 95% compliance with the WHO checklist for safer surgery.

In 2012/13 the Trust reported two never events involving surgical procedures, these were a “retained foreign object post-operation” and “wrong site surgery” as described by the Department of Health.

In 2013/14 we reported 0 never events and the audit of compliance with completion of the WHO surgical checklist was reported monthly as below.

2013/14	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Surgical WHO checklist	100%	99.9%	99.8%	99.9%	99.8%	99.9%	100%	100%	99.9%	99.9%	100%	100%

Monitoring of the WHO surgical checklist will continue this year as one of our Local Quality Requirements agreed with our commissioners (MK Clinical Commissioning Group).

Our Priorities for 2014/15

Priority 1

Elimination of Grade 3 and 4 avoidable pressure ulcers.

Priority 2

For all emergency admissions to be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of arrival at hospital.

Priority 3

A 5% reduction in hospital based falls.

Priority 4

To reduce our mortality from sepsis.

Priority 1

Elimination of Grade 3 and 4 avoidable pressure ulcers

Why have we chosen this priority?

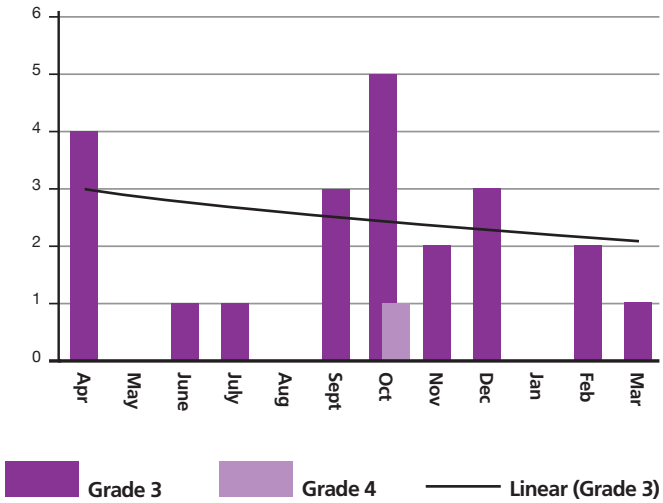
The number of hospital acquired pressure ulcers is considered to be an overall benchmark of the quality of nursing care delivered in a Trust. For a patient they can be distressing and painful and may lead to a patient staying in hospital longer than was necessary.

For all of the reasons above we are dedicated to improving our rate of hospital acquired pressure ulcers.

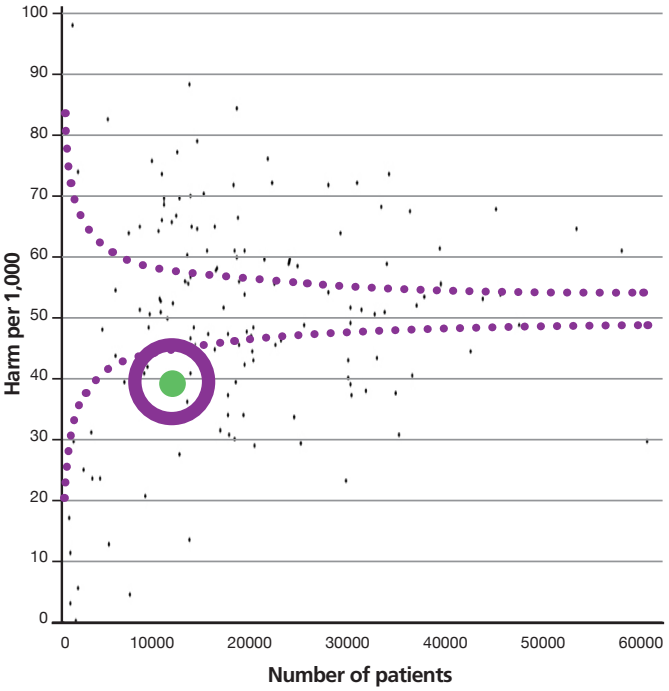
How we did last year 2013/14

Unfortunately there has been an increase in hospital acquired pressure ulcers this year in comparison to the two previous years. The Trust has completed a series of investigations as to why this has occurred and will continue to make improvements to ensure that patient safety is not compromised. A thematic analysis showed that there were many causes but the use of anti-embolic stockings in the prevention of deep vein thrombosis was a significant factor. The numbers reported each month have begun to decline since a peak in October 2013.

Grade 3 and Grade 4 Hospital Acquired Avoidable Pressure Ulcers MKHFT 2013/14



We are able to compare ourselves to other Trusts using the National Safety Thermometer. This is a tool used to record all patients who may have pressure ulcer, on the same day each month by all NHS hospitals. This includes patients who have been admitted with pressure ulcers as well as those developed in hospital.



The funnel plot below shows how well we are performing in prevalence compared to all other hospitals and includes all patients who have developed pressure ulcers at home as well as in hospital.

- are all other acute hospitals
- is Milton Keynes Hospital

Below the purple funnel line is better than average.

How will we monitor and measure progress of this priority?

Incidents of pressure ulcers are recorded on the Nursing Metrics and board score card monthly. These are reports that show how we are performing on quality.

Each ward sister receives the monthly metrics and reviews the results with their Matron and Head of Nursing.

All Grade 3 and 4 pressure ulcers acquired in hospital are reported as Serious Incidents and are subject to comprehensive Root Cause Analysis and lessons that can be learnt are shared.

How we will report on the progress of this priority?

Pressure ulcers are presented monthly to the Board and published on every ward. In addition we will produce quarterly Quality Accounts updates to the Quality Committee.

What are we going to do to achieve it?

- New training concentrating on how to prevent heel sores.
- Sisters undertaking daily ward rounds checking that compression stockings are removed and heels have been checked.
- We have bought additional specialist boots that help prevent heel sores.
- We have introduced a new leaflet that explains to patients how they can prevent pressure sores for themselves.
- Trained all of our Matrons to provide specialist pressure ulcer advice.
- We measure all of the wards on how they assess a patient's risk of developing a pressure sore, how accurate they are, and we publish this data on the Nursing Metrics.
- Ward sisters have to present to the chief nurse the reasons for a pressure sore occurring on their ward, and how they will prevent it from happening again.
- All of our actions have been pulled together in an action plan in order to help us manage our actions.

Priority 2

For all emergency admissions to be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of arrival at hospital

Why have we chosen this priority?

In December 2013 Sir Bruce Keogh published a report into NHS Services 7 days per week. Fundamentally the pattern of urgent and emergency care does not follow the NHS working week of Monday to Friday, nine to five. He identified the above indicator as one of the primary measures that should be put in place by all Trusts to improve clinical outcomes for patients.

As a hospital we can no longer justify, like most others, to deliver care in this way. For example Sunday is consistently our busiest day of the week, and on New Year's Day, a bank holiday, the Trust experienced its highest number of ambulance attendances ever, so we know that the presence of our clinical teams does not match the highest peaks of demand for the Trust.

There are stark outcomes associated with a mismatch of clinical services nationwide. Research has consistently shown that patients admitted as acute medical emergencies at the weekend had a 14% increased chance of mortality than those admitted on a weekday. (Bell et al)

For the commissioning round in 2014/15 it is expected that many of the recommendations in the Keogh report will be mandated through the NHS contract. It is known that much fundamental change to the way we operate out of hours is going to be necessary in order for us to meet this challenge.
Benefits for our patients:

- Lower mortality and morbidity rates for patients
- Reduced length of stay for patients
- Consultants available to talk to families outside of working hours, i.e. during visiting times
- A reduction in admissions if patients are seen in assessment areas

How we did last year 2013/14?

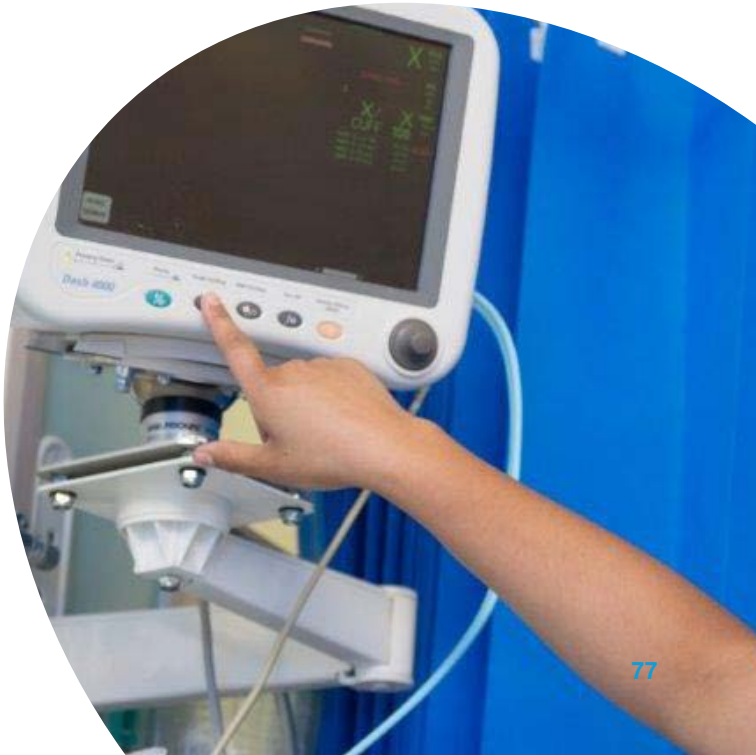
We did not need to report on this in 2013/2014. This year we will collect baseline data to measure ourselves against.

What are we going to do to achieve it?

We see this year as our planning year. The reason we need such a long time to plan this project is because we know that this will involve large scale service redesign and probable investment. It is important that we understand all the possible options available to us to improve our 7 day working. This includes understanding the capacity of our present services against the standards set down by Sir Bruce Keogh. After that we can begin to plan how to reduce the gap between the two.

How will we monitor and measure progress of this priority?

We will produce quarterly Quality Account updates to the Quality Committee.



Priority 3

Reduction in hospital based falls by 5%.

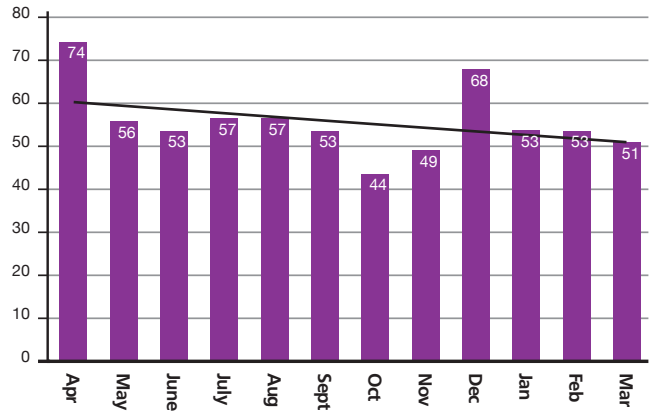
Why have we chosen this priority?

Last year we set ourselves the target of reducing falls by 5% and have unfortunately fallen short of this, although the number of falls has reduced in the second half of the year. This demonstrates that actions last year are having an effect. It is therefore appropriate we keep this as a priority so that we can sustain and continue to reduce the number of falls in hospital.

How we did last year 2013/14?

The Hospital recorded 668 falls within 2013/14 compared to 669 falls within 2012/13. However we treated more patients in 2013/14 compared to 2012/13 (over 5000 more).

Number of inpatient falls 2013/14 MKHFT



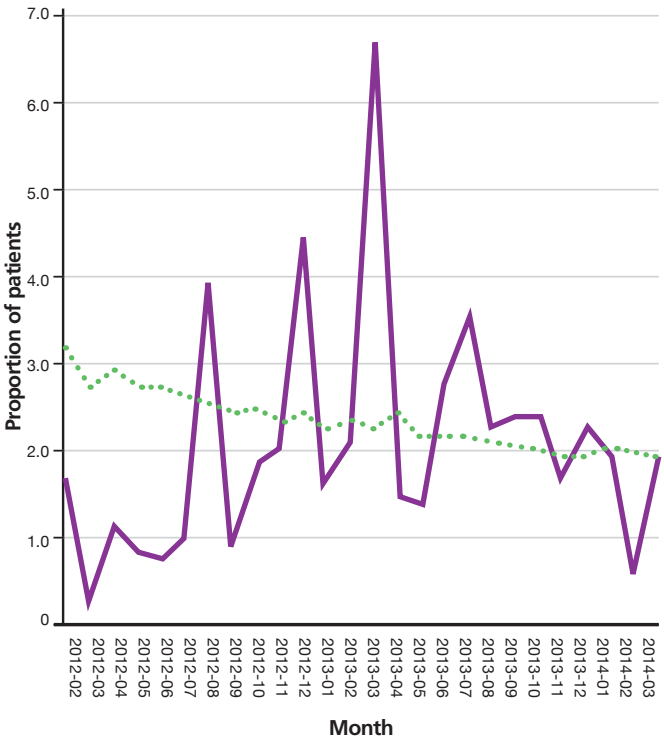
The Nature of Falls

Analysis of falls by the Falls Prevention Coordinator provided a greater understanding of why and how patients were falling or the "nature" of falls. This provided key areas for planning training and interventions.

Comparison with others

The NHS Safety Thermometer can be helpful to see how we are doing compared to other acute hospitals. One day a month all acute hospitals and other care settings have to report on a number of key safety measures. This graph shows the number of patients who have fallen in the last 72 hours and includes all patients who have fallen before coming into hospital as well as in hospital. The graph from March 2014 shows how much our falls have reduced and that we compare well with other acute hospitals

Patients who fallen in the last 72 hours in a care setting



The purple line is the percentage of patients who have fallen in the last 72 hours in and out of hospital measured at Milton Keynes Hospital

The green dotted line is the national average

How will we monitor and measure progress of this priority?

Incidents of falls are recorded on the Nursing Metrics and board score card monthly. Each ward sister receives the monthly metrics and reviews the results with their matron and Head of Nursing. We will repeat the analysis of the nature of falls to ensure that we are addressing the key areas for improvement.

How we will report on the progress of this priority?

Quarterly updates of the Quality Accounts to the Quality Committee.

What are we going to do to achieve it?

This year the falls coordinator achieved our target of training 90% of our nursing staff on falls prevention. This has been a significant piece of work which has taken us 8 months to achieve. Our staff have been trained to:

- Identify patients who are at risk of falls
- Understand the factors that cause patients to fall
- Manage the environment around a patient to reduce falls risks
- Write an individualised falls prevention plan

We have also undertaken special training with our staff so that they can better prevent falls in patients with dementia as this is one of the highest risk factors for falls.

Priority 4

To reduce deaths from sepsis

What is sepsis?

Sepsis is infection that travels into the blood. Each year in the UK, it is estimated that more than 100,000 people are admitted to hospital with sepsis and around 37,000 people will die as a result of the condition.

Why we have chosen this as a priority?

- Sepsis is the leading cause of death in hospital worldwide (McClelland& Moxon 2014)
- The incidence of sepsis is increasing, likely in part to be due to an ageing population who are more at risk of infection
- The UK Sepsis Trust estimates over 12,500 lives per year could be saved if sepsis is recognised and treated in its early stages
- Early identification and treatment is key to reduction in death from sepsis. There is evidence to show that we can make improvements in our recognition and treatment of sepsis
- Administration of intravenous antibiotics within one hour of diagnosis of sepsis is the gold standard and priority treatment

How we did last year 2013/14

We have undertaken in-depth analyses of our Hospital Standardised Mortality Ratio's (HSMR's), to gain a greater understanding of the causes of death within our Trust. However the number one cause of death in the hospital is sepsis, as it is nationally. Many Trusts have shown that by targeting the treatment and management of patients with acute sepsis, lives can be saved.

How will we monitor and measure progress of this priority?

A review of patient notes who attended the Emergency Department with sepsis is underway. This is to provide a baseline of how well we are doing at identifying early and treating patients with sepsis. This will help us to understand where improvements in care can be made and also provide us with data so we can see that we are getting better over the year. Most importantly this information will be shared with our clinical areas so they can ensure they are driving forward best practice.

How we will report on the progress of this priority?

Quarterly Quality Account updates to the Quality Committee.

What are we going to do to achieve it?

- We are measuring and publishing how successful we are at identifying patients who are displaying signs of sepsis
- Teaching for junior doctors on sepsis recognition and management, particularly the importance of rapid prescription and administration of intravenous antibiotics, will be rolled across all medical specialities
- We have created a special microteaching pack for our multi-disciplinary teams
- All of our doctors undertake special training on sepsis management when they start in the Trust.
- We have developed a sepsis box in the emergency department which has all the equipment needed for rapid treatment of a septic patient in one place and every adult and paediatric inpatient and assessment area will have one of these boxes by July 2014


NHS STAFF

Statement of Assurance from the Board of directors

During 2013/14 Milton Keynes Hospital NHS Foundation Trust provided and/or sub-contracted 36 relevant health services.

Milton Keynes Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care for all of these.

The income generated by the relevant health services reviewed in 2013/14 represents 100 per cent of the total income generated from the provision of relevant health services by the Milton Keynes Hospital NHS Foundation Trust for 2013/14.

Participation in Clinical Audit

There were 36 national clinical audits and 4 national confidential enquiries during 2013/14 relevant to health services that Milton Keynes Hospital NHS Foundation Trust provides.

During that period Milton Keynes Hospital NHS Foundation Trust participated in 29 [82%] national clinical audits and 4 [100%] national confidential enquiries in which we were eligible to participate.

The national clinical audits and nationals confidential enquiries that MKHFT participated in, for which data collection was completed during 2013/14 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terns of that audit or enquiry.

Where available we have quoted the participation rates provided by the national clinical audits themselves. Case ascertainment may be less or more than 100% in some of these audits, depending on the method used to calculate the expected number of cases.

For national clinical audits marked by an asterisk, confirmation of percentage case ascertainment was not available from the national clinical audit provider in time for publication but we believe our contribution for these audits to be 100%.

NCEPOD Study Eligible 2013-14	Participated	Cases Submitted
Alcohol Related Liver Disease NCEPOD study	Yes	3
Subarachnoid Haemorrhage NCEPOD Study	Yes	1
Lower Limb Amputation	Yes	6
Tracheostomy NCEPOD Study	Yes	7

Eligible National Clinical Audits 2013/14	Category	Participated	% Cases Submitted / Comments
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Heart	Yes	75%
Bowel cancer (National Bowel Cancer Audit Programme)	Cancer	Yes	112 cases
Bowel cancer (National Bowel Cancer Audit Programme)	Cancer	No	
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	Heart	Yes	100%*
Case Mix Programme (CMP)	Acute	No	
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Long term conditions	Yes	52 patients
Diabetes (Paediatric) (NPDA)	Long term conditions	Yes	100%*
Elective surgery (National PROMs Programme)	Other	Yes	100%*
Emergency use of oxygen (British Thoracic Society)	Acute	Yes	100%*
Epilepsy 12 audit (Childhood Epilepsy)	Women & Children	Yes	100%*
Falls and Fragility Fractures Audit Programme (FFFAP), includes National Hip Fracture Database (NHFD)	Older People	Yes	100%*
Head & neck cancer (DAHNO)	Cancer	Yes	17 cases
Inflammatory bowel disease (IBD)Includes: Paediatric Inflammatory Bowel Disease Services	Long term conditions	No	
Lung cancer (National Lung Cancer Audit)	Cancer	Yes	133 cases
Maternal, infant and new born programme (MBRRACE-UK)	Women & Children	Yes	100%
Moderate or severe asthma in children (care provided in emergency departments)	Women & Children	No	
National Audit of Seizures in Hospitals (NASH)	Acute	Yes	100%*
National Audit Programme (SSNAP)		Yes	NA
National Cardiac Arrest Audit	Acute	No	
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Long term conditions	Yes	100%*
National Comparative audit of Blood transfusion	Blood and transfusion	Yes	100%*
National Emergency Laparotomy audit (NELA)	Acute	Yes	100%*
National Heart Failure Audit	Heart	Yes	298 cases
National Joint Registry (NJR)	Acute	Yes	100%*
National Review of Asthma Deaths (NRAD)	Acute	No	
National Vascular Registry	Heart	Yes	100%*
Neonatal intensive and special care (NNAP)	Women & Children	Yes	100%
Non-invasive ventilation -adults (British Thoracic Society)	Acute	Yes	100%*
Oesophago-gastric cancer (National O-G Cancer Audit)	Cancer	Yes	31 cases
Paediatric asthma (British Thoracic Society)	Women & Children	Yes	100%*
Paediatric bronchiectasis	Long term conditions	No	
Paracetamol Overdose	Acute	Yes	100%*
Pulmonary Hypertension	Heart	Yes	100%*
Renal replacement therapy (Renal Registry)	Long term conditions	Yes	100%
Rheumatoid and early inflammatory arthritis*	Long term conditions	No	
Sentinel Stroke	Older People	Yes	109 cases submitted since May 2013
Severe Sepsis and Septic Shock	Acute	Yes	100%*
Severe trauma (Trauma Audit & Research Network)	Acute	Yes	100%*

Review of Clinical Audits

The reports of 2 national clinical audits were reviewed by the provider in 2013/14 and MKHFT intends to take the following actions to improve the quality of healthcare provided have been put in place. For example:

National Clinical Audit	Actions to improve quality of care
Community Acquired Pneumonia	• Introduction of a proforma to improve the care pathway and how we record patients symptoms • All patients with shortness of breath or with potential sepsis will have a chest x ray • Streamlining of referral processes from GP • Ensure all patients are reviewed by physiotherapy • Guidelines for specialist referral
Oxygen Therapy	• Continue to promote oxygen prescription • Work with the nursing staff to ensure that oxygen prescriptions are correctly administered

The reports of 41 local clinical audits were reviewed by the provider in 2013/14 and Milton Keynes Hospital NHS Foundation Trust intends to take the following actions to improve the quality of health. For example:

Local Clinical Audit	Actions to improve quality of care
Iron Deficiency Anaemia	• Ensure all relevant blood tests are completed • Colonoscopy to be offered after negative gastroscopy
Readmission to Hospital in the year following Stroke	• We have looked at reasons for readmission to identify avoidable causes of early readmission • Discharge planning to consider why there had been previous readmissions • Improve recognition and treatment of post stroke seizures to prevent readmissions and unnecessary investigations
Caesarean section	• To agree preventative antibiotic prior to elective Caesarean section referring to Antimicrobial policy • Improve documentation and recording of preventative antibiotics
Surgical Prophylaxis for Elective Gynaecological Procedures	• Surgical team to prescribe antibiotics at pre-operative round • Single dose of antibiotics to be given at the start of anaesthetic process • Improve documentation and recording of preventative antibiotics
Comparison of current practice of making up feeds on paediatric ward with new BDA guidelines	• Refresher session on the audit results and making up special milk feeds • Reiterate the importance of monitoring the room temperature and recording this • To review the guidelines next year

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Milton Keynes Hospital NHS Foundation Trust in 2013/14, that were recruited to participate in National Institute of Health Research studies approved by a research ethics committee was 426, with some data left to be reported. Our target for the year was 450 and we hope to come very close to this once all the recruitment data has been received.

We also carried out over 700 Paediatric Observation Priority scores in A&E for the POPS study which is a portfolio study but is not recorded in official reports.

34 studies in total have contributed to this recruitment figure. This year we have given NHS permission for a further 19 portfolio studies along with a number of student projects and a number of studies where MKHFT will act as a participant identification centre.

The Research and Development department had a budget of £500,000 for 2013/14, which has been used to provide research and development staff to support portfolio studies across the Trust. This not only includes research nurses but also the support services that are an integral part of the research process: pathology, pharmacy and radiology.

Our aim is to provide patients with the latest medical treatments and devices and offer them an additional choice where their treatment is concerned. These are just a few examples of the National Institute of Health Research portfolio studies that we have approved this year:

CHOPIN: Chemoprevention Of Premalignant Intestinal Neoplasia (ChOPIN) - incorporating Inherited Predisposition of Oesophageal Diseases (IPOD)

This is a multi-centre study within the UK and has been designed to investigate the possible role of inherited factors that may increase the risk of oesophageal cancer and understand why this condition develops and perhaps provide new targets for therapy. We have recruited 22 patients for this study already this year.

ENCEPH

This study aims to find out what the early signs of encephalitis are, so that in the future doctors will be able to provide appropriate treatment to a patient as soon as possible. We hope that in turn this will improve their chances of a better recovery. This study is open to both adults and children. We have recruited a total of 12 patients into this study.

Parkinson's Pain Study

People with Parkinson's disease (PD) experience symptoms including shaking and slowness of movement. It is now increasingly recognised that symptoms not involving movement happen frequently in PD, and these are referred to as 'non-motor symptoms'. This study is looking at how much pain and the types of pain that people with Parkinson's disease have. The results will help us to understand pain in Parkinson's disease. In the long term, we hope that this will lead to improved treatment.

Raising the Profile of R&D and developing own account Research

This year we have worked to raise the portfolio of R&D within the Trust. We held stands in main outpatients and the Eaglestone restaurant for both patients and staff as part of International Clinical Trials Day and supported the 'OK to ask' campaign, which aimed to increase awareness of trials in the general public and tell them it is OK to ask your clinician about any studies that may be open to you.

In October we held a Research Awareness Seminar which was well attended by clinicians in our Trust and academics from local universities. This featured talks from the Oxford Academic Health Science Network, Research Design Service, University of Buckingham and The Open University. A number of Milton Keynes Hospital Foundation Trust (MKHFT) staff who are embarking on research projects of their own design also presented. This served as an excellent networking opportunity and as a result more clinicians within MKHFT are designing own account research.

Open University Show Case: We hosted an afternoon of presentations from researchers from the University. This again was an excellent networking opportunity and collaborations have formed as a result of this afternoon of stimulating talks.

The Trust now holds monthly Research Collaboration Meetings which are attended by colleagues from Buckingham University and the Open University and our own research active clinicians and research staff. We meet to discuss new collaborative ideas, grant opportunities and provide expertise to help push forward own account research.

Goals agreed with Commissioners CQUIN

The CQUIN (Commissioning for Quality and Innovation) framework is a national framework for nationally and locally agreed quality improvement schemes. A proportion (2.5%) of MKHFTs income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between NHS Milton Keynes Commissioning Care Group and MKHFT for the provision of NHS services through the Commissioning for Quality and Innovation payment framework (£3.25 m). This compares to a figure of £3.262m (2.5%) in 2012/13.

What we have achieved has not yet been finally agreed with our commissioners. There are penalties to non-achievement of the CQUIN targets.

Eight CQUINs were agreed with our commissioners as outlined opposite.

Goal	Name	High level detail	Performance 2013/14
1	Friends and Family Test (FFT)	FFT was in place for inpatient areas in 2012/13. Onward development of FFT for 2013/14 included: Introduce to Emergency Department from April 2013 Continue to implement FFT into maternity by October2013 Improve staff FFT performance	We achieved all of the elements of this CQUIN
2	NHS Safety Thermometer	A monthly prevalence data report on Pressure Ulcers, Falls, Urinary Tract Infection associated with catheters and Venous Thromboembolism (Assessment and Prophylaxis) To reduce pressure ulcers by 50%	We achieved the data collection element of this CQUIN but did not achieve the 50% reduction in pressure ulcers
3	Dementia	90% success in screening patients for risks of dementia and ensuring appropriate onward referral for management. Provision of leadership, training and knowing how well supported carers of people with dementia feel	We achieved the leadership element, and the dementia carers audits. We have struggled to complete the dementia screening element. This year we plan to employ specialist individuals to undertake this task
4	Venous Thrombo-embolism	95% of all adults (minus exclusions) who have been risk assessed for VTE Number of RCAs completed in the event of a Hospital Acquired VTE	We expect to achieve all of the elements of this CQUIN
5	Antimicrobial Stewardship	Self-assessment of antimicrobial stewardship and management using agreed assessment tool and improvement of score by year end	We expect to achieve all of the elements of this CQUIN
6	Prevention of Falls	Reduce the number of inpatient falls to equal to or less than 53 per month Establish a training plan achieving 90% attendance by year end of identified staff groups	We achieved the training element of this CQUIN and reducing the number of falls for the last three months of the year
7	Improved Discharge Planning	Improving Length of Stay, the use of EDD (estimated date of discharge) and non-medical discharge processes and improving patient satisfaction with discharge processes	We have improved the number of patients with a longer length of stay but did not improve what patients say about our discharge process
8	Improving care pathways for life limiting conditions	Adopting the AMBER care bundle to improve care pathways with people with life limiting conditions	We implemented the AMBER care bundle in about 50% of the places required.

Care Quality Commission (CQC) registration and compliance

Milton Keynes Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is as Registered to provide the following regulated activities –

- Maternity and Midwifery Services
- Diagnostic and screening procedures
- Family planning
- Termination of Pregnancies
- Surgical procedures and treatment of disease, disorder or injury

Milton Keynes Hospital NHS Foundation Trust has no conditions on its registration.

Review of Compliance of Essential Standards of Quality and Safety

We were inspected by the CQC in June 2013; this was a revisit following concerns the previous year. The report concluded the following:

1. Treating people with respect and involving them in their care – compliant
2. Providing care, treatment and support that meets people's needs – compliant
3. Caring for people safely and protecting them from harm – compliant
4. Staffing – improvements required
5. Quality and suitability of management - improvement required

This was a significant improvement on the previous inspection and we are putting in place improvements to make us fully compliant. We are committed to making the improvements required to make us fully compliant. We are in the process of understanding and preparing for the new style of CQC inspection.

Data Quality

Milton Keynes Hospital NHS Foundation Trust submitted records during 2012/13 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was:
  99.5% for admitted patient care;
  99.8% for outpatient care; and
  99.5% for accident and emergency care.

- which included the patient's valid General Practitioner Registration Code was:
  100.0% for admitted patient care;
  100.0% for outpatient care; and
  100.0% for accident and emergency care.

Milton Keynes Hospital NHS Foundation Trust Information Governance Assessment Report overall score for 2013/14 was 87% and was graded Green.

Milton Keynes Hospital NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the Trust is awaiting the report from the Audit Commission.

Milton Keynes Hospital NHS Foundation Trust will be taking the following actions to improve data quality:

- Ensuring that staff have access to system training and support
- Providing a Data quality dashboard to the operational teams
- Developing independent internal validation and monitoring

Reporting against core indicators

Set out in the table below are the quality indicators that trusts are required to report in their Quality Accounts.

Additionally, where the necessary data is made available to the Trust by the Health and Social Care Information Centre, a comparison of the numbers, percentages, values, scores or rates of the trust (as applicable) is included for each of those listed in the table with

a) the national average for the same; and

b) with those NHS trusts and NHS foundation trusts with the highest and lowest of the same, for the reporting period.

Where data is not included this indicates that the latest data is not yet available from the NHS Information Centre.

Domains of Quality	Level	2011/12	2012/13	2013/14
DOMAIN 1 PREVENTING PEOPLE FROM DYING PREMATURELY				
Summary Hospital-Level Mortality Indicator (SHMI) value and banding	MKHFT	0.9929 Band 2	1.0043 Band 2	1.04 Band 2
	National	1.00	1.00	1.00
	High /Low	0.71-1.25	0.68-1.21	0.63-1.16
% of admitted patients whose treatment included palliative care	MKHFT	0.6%	1.06%	1.20%
	National	1%	Not yet available	1.19%
	High /Low	0%-3.3%	Not yet available	0-3.2%
% of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care	MKHFT	13%	Not yet available	27.5%
	National	18%	Not yet available	20.6%
	High /Low	0-44.2%	Not yet available	0-44.1%

Note: the wording annotated with an asterix below is prescribed wording in Monitor guidance.

Indicator 1: Summary Hospital-Level Mortality Indicator (SHMI) value and banding

Milton Keynes Hospital NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission.*

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by;

- Continuing to review the data set within this indicator for any changes that may indicate a decline in the safety and quality. We have undertaken a substantial case note review and have identified two areas for action. These are out of hours care for patients and the critical care pathway for deteriorating patients.

Indicator 2: % of admitted patients whose treatment included palliative care

Milton Keynes Hospital NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission.*

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by;

- Continuing to review the data set within this indicator for any changes that may indicate a decline in the safety and quality.

Indicator 3: % of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care

Milton Keynes Hospital NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission.*

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by;

- Continuing to review the data set within this indicator for any changes that may indicate a decline in the safety and quality.

Domains of Quality	Level	2011/12	2012/13	2013/14
DOMAIN 3 HELPING PEOPLE RECOVER FROM EPISODES OF ILL HEALTH OR FOLLOWING INJURY				
*Patient Reported Outcome Measures for:	* Patient Reported Outcome Measures are retrospective reported measures and as such data for 12/13 is not yet available			
Groin hernia surgery	MKHFT	0.08	Not yet available	Not applicable not enough cases
	National	0.09	0.09	
	High /Low	0.03-0.14	0.017-0.158	
Varicose veins surgery	MKHFT	N/A	Not yet available	Not applicable not enough cases
	National	0.09	0.09	
	High /Low	0.05-0.17	0.024-0.138	
Hip replacement surgery	MKHFT	0.42	0.46	Not applicable not enough cases
	National	0.42	0.44	
	High /Low	0.306-0.532	0.333-0.502	
Knee replacement surgery	MKHFT	0.29	Not yet available	Not applicable not enough cases
	National	0.30	0.31	
	High /Low	0.18-0.385	0.244-0.387	
Emergency Readmissions to hospital within 30 days standardised percent	MKHFT		7.6%	
	National (Small Acute)		Not yet available	
	High /Low		Not yet available	
Emergency Readmissions to hospital within 28 days <16 standardised percent Changed in 2013/14 to 28 days split 0-16 and 16+ To be completed after year end	MKHFT			12.71%
	National			9.87%
	High /Low			0-14.87%
Emergency Readmissions to hospital within 28 days >16 standardised percent	MKHFT			11.91%
	National (Small Acute)			11.07
	High /Low			0-12.69

What are PROMS - Patient Reported Outcome Measures

The NHS is asking patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. This will help the NHS measure and improve the quality of its care.

Indicator 4: PROM scores groin hernia surgery;

Milton Keynes Hospital NHS Foundation Trust considers that this data is as described for the following reasons:
The data sets are nationally mandated and internal data validation processes are in place prior to submission.*

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by;

- awaiting the availability of a second data set on which actions may be taken if required.

The number of cases performed and as such the number of responses may not meet the level that will provide information for further analysis but we will continue to monitor the availability of data from the national data base.

Indicator 5: PROM scores varicose veins surgery;

Milton Keynes Hospital NHS Foundation Trust considers that this data is as described for the following reasons:
The data sets are nationally mandated and internal data validation processes are in place prior to submission.*

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by;

- awaiting the availability of a second data set on which actions may be taken if required.

The number of cases performed and as such the number of responses may not meet the level that will provide information for further analysis but we will continue to monitor the availability of data from the national data base.

Indicator 6: PROM scores hip replacement surgery;

Milton Keynes Hospital NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission.*

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by;

- awaiting the availability of information from the national data case and review how our outcome measures and how we compare to other hospitals who provide similar services and if we can make improvements

Indicator 7: PROM scores knee replacement surgery

Milton Keynes Hospital NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission.*

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by;

- awaiting the availability of information from the national data case and review how our outcome measures and how we compare to other hospitals who provide similar services and if we can make improvements

Indicator 8: Emergency Readmissions to hospital within 28 days

(This was changed by the National Information Centre in 2013/14 to 28 days from 30 days readmissions)

Milton Keynes Hospital NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission.*

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by;

- continuing to review why patients are readmitted and working with our partners within the community health services and local social care teams in making changes to reduce readmissions.

Domains of Quality	Level	2011/12	2012/13	2013/14
DOMAIN 4 ENSURING PEOPLE HAVE A POSITIVE EXPERIENCE OF CARE				
Responsiveness to inpatients personal needs	MKHFT	65.0		63.7
	National	67.40	Not yet available	68.1
	High /Low	56.5-85.0	Not yet available	57.4-84.4
% of staff who would recommend the provider to friends or family needing care High is better	MKHFT	46%	50%	59%
	National	65%	65%	66%
	High / Low	33-96%	35-94%	40-94%

Indicator 9: Responsiveness to inpatient personal needs

Milton Keynes Hospital NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission.*

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by;

- continuing to support staff in sharing our Trust's values that were based upon feedback received through the 'We Care' programme. We are also reviewing how care is being given and supporting staff with clear standards of care such as Meal times and a new standard document for assessing patients care needs on admission.

Indicator 10: % of staff who would recommend the provider to friends or family needing care

Milton Keynes Hospital NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission.*

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by

- supporting staff with essential training that helps them provide better care such as preventing falls and caring for patients with dementia so that they feel that the hospital provides care that they would be happy for their friends and family to receive. More staff this year have said they would recommend the hospital and this year they will be able tell us more often so we can continue to see the improvements that we making.

Domains of Quality	Level	2011/12	2012/13	2013/14
DOMAIN 5 TREATING AND CARING FOR PEOPLE IN A SAFE ENVIRONMENT AND PROTECTING THEM FROM AVOIDABLE HARM				
% of admitted patients risk assessed for VTE High is better	MKHFT	65.00	96.00	96.00
	National	67.40	94.10	96.00
	High / Low	56.5-85	10 - 84.6	75-100
Rate of C difficile per 100,000 bed days Low is better	MKHFT	11.30	13.36	13.7
	National	21.80	Not yet available	17.3
	High / Low	0-51.6%	Not yet available	0-30.7
Total patient safety incidents	MKHFT	3307	2850	2796
Rate of patient safety incidents per 100 admissions *Based upon data available at time of report	MKHFT	4.78	4.55	4.5
	National (Small Acute)	6.95	6.79	6.4
	High / Low	2.13-14.37	*3.48-17.64	*3.48-17.64
Total patient safety incidents resulting in severe harm or death	Total Number MKHFT	22	19	21
Rate patient safety incidents resulting in severe harm or death *Based upon data available at time of report	% MKHFT	0.40%	*0.67%	0.1
	National (Acute)	1.20%	0.90%	0.1
	High / Low	0 - 7.0%	0.1 - 2.4%	0-0.4

Indicator 11: % of admitted patients risk assessed for VTE

Milton Keynes Hospital NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission.*

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by;

- providing more support in data collection to ensure that the assessment completed in health records are recorded for the measure.

Indicator 12: Rate of C difficile

Milton Keynes Hospital NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission.*

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by;

- reviewing the cases individually to ensure there are no lapses in care that may contribute towards Clostridium difficile and continuing to ensure safe antimicrobial prescribing.

Indicator 13: Rate of patient safety incidents and % resulting in severe harm or death

Milton Keynes Hospital NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission.*

Milton Keynes Hospital NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by;

- continuing to review the data set within this indicator for any changes that may indicate a decline in the safety and quality as we are below the national average for this indicator.

Other Information

In selecting our quality metrics for the quality overview we have chosen measures from the Trust Board scorecard which forms part of our continuous Trust review and reporting. These measures cover patient safety, experience and clinical outcomes and are metrics that are nationally known to be important indicators in their respective areas, as well as those which reflect our quality priorities. Where possible we have included historical performance and where available we have included national benchmarks. Some of the measures have changed over time and as such information regarding these changes is included.

Hand hygiene compliance

Ensuring all hospital staff clean their hands between patients has contributed towards a reduction in health care associated infections across the NHS. The hospital has reported an improvement in compliance of hand hygiene throughout 2013/14.

Hospital-acquired pressure ulcers (Grades 3 and 4) and Serious Incidents

All Grade 3 and 4 pressure ulcers are reported as a Serious Incidence and the increase number of Serious Incidence reflects the increase in the number of reported Pressure ulcers.

The hospital has increased training to all ward staff about preventing pressure ulcers, and a new care record for pressure ulcer prevention has been introduced.

This is why keeping pressure ulcer reduction as one of our key priorities is the right thing to do.

Patient Falls

The number of patient falls has remained at the same level but we have treated more people as inpatients in our hospital so we are seeing a reduction in the rate of falls. As such we are keeping falls prevention as a priority so we can make sure the improvement we have made continues. Training for all staff in assessing risk of falls and preventing falls continues.

Medication incidents

Medication incidents are reported onto our incident reporting system when errors have been made. An error is reported even if no harm has happened to a patient and can be about prescribing, giving (known as administering) or dispensing (when the pharmacy department issues medications). Reporting medication incidents is the right thing to do and investigations into incidents often provide all staff with learning and sharing of improvements to practice.

As a hospital we have a low number of incidents reported compared to what is expected based upon the number and types of patients we care for (extra 5000 patients). The number of reported medication incidents last year was stable compared with the previous year. In light of the increased number of patients we treated this reflects that we need to improve our medication incident reporting. We will review this again next year.

Never Events

There are over 20 listed never events listed by the National Patient Safety Agency (NPSA). They are selected as they are considered to be incidents that should not happen.

We have made a significant improvement on 2012/13 and are satisfied that our processes for reviewing all incidents, is working well and we are being honest and open.

Indicator	Measurement used	Performance 2010-11	2011-12	2012-13	2013/14
PATIENT SAFETY					
Hand hygiene compliance	Internal target – percentage compliance as measured by Hand Hygiene measured by exception to compliance	95.20%	97.00%	89.5%	**93.8%**
Hospital-acquired pressure ulcers (grades 3 and 4)	Internal target – total number measured by weekly incidence reporting log	9 (grade 3 only)	4 (grade 3 only)	6 (grade 3 only)	**23 grade 3 1 grade 4**
Patient falls	Internal target – total number of reported incidents.	669	588	669	**668**
Medication incidents	Internal target – total number of reported incidents.	554	474	386	**380**
Serious incidents	Internal target – total number of reported incidents.	44	53	101	**125**
"Never" events	This is a based on a nationally accepted list of events published by the National Patient Safety Agency.	0	0	2	**0**
CLINICAL EFFECTIVENESS					
Hospital standardised mortality ratio (HSMR): all	Risk of death relative to national average case mix adjusted from national data via Dr Foster Intelligence: this is a national definition. Target is below 100	92.9	84	106.6	**88.1**
Perinatal death rate	This data is provided to the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries)	Perinatal 6.1 per 1,000 –	Perinatal rate 5.4 per 1,000	Perinatal rate 6.5 per 1,000	**Perinatal rate 7.8 per 1,000**
Still birth rate	This data is provided to the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries)	Stillbirth 4.3 per 1,000	Stillbirth 5.1 per 1,000	Stillbirth 5.7 per 1,000	**Stillbirth 5.7 per 1,000**
Readmissions under 30 days (elective)	Emergency admissions within 30 days of elective discharge, including day cases. Internally set target	NA	NA	12.4	**2.8%**
Readmissions under 30 days (non-elective)	Emergency admissions within 30 days of non-elective discharge, including day cases. Internally set target	NA	NA	2.6	**13.4%**

Hospital standardised mortality ratio (HSMR)

To understand the peak in 2012/13 a case note analysis and improvement actions were undertaken. We have significantly improved but want to continue this progress which is why we selected improving sepsis care as one of our priorities for 2014/15 as the analysis found that sepsis was an area that required improvement.

Perinatal and still birth rate

MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) is a national reporting system run by the National Perinatal Epidemiology Unit. The aim is to provide good information to support the safe delivery of maternal and new born and infant health care. Reporting system has changed from CEMACH (Confidential Enquiry into Maternal and Child Health) to MBRRACE from January 2013. As such comparative data will not be available until later this year

Indicator	Measurement used	Performance 2010-11	2011-12	2012-13	2013/14
PATIENT EXPERIENCE					
Informal complaints from patients	The number of informal complaints from patients received by the Trust	343	475	443	**269**
Formal complaints	The number of formal (written) complaints from patients received by the Trust	300	246	295	**175**
Midwife : birth ratio	Birth Rate Plus Midwifery Workforce planning tool	1 to 30	1 to 30	1 to 30	**1 to 29**
WORKFORCE					
Staffing level incidents	Internal target – total number of reported incidents	193	199	174	**218**
Incidents of violence towards staff	Internal target – total number of reported incidents	79	46	29	**56**

Indicator	Target and source (internal/regulatory /other)	2010-11	2011-12	2012-13	2013-14
PERFORMANCE AGAINST KEY NATIONAL PRIORITIES AND REGULATORY REQUIREMENTS 2010 TO 2014					
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	>96% set by Monitor	Achieved 99.7%	Achieved 99%	Achieved 97.8%	**Achieved 97.7%**
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	>85% set by Monitor	Achieved 92.3%	Achieved 88.56%	Achieved 87.84%	**See note below***
Maximum wait of 2 weeks from GP referral to date first seen for all cancers	>93% set by Monitor	Achieved 97.5%	Achieved 98.8%	Achieved 96.8%	**Achieved 96.7%**
Maximum waiting time of 31 days for subsequent cancer treatments: drug treatments	>98% set by Monitor	Achieved 100%	Achieved 100%	Achieved 100%	**Achieved 100%**
Maximum waiting time of 31 days for subsequent cancer treatments: surgery	>94% set by Monitor	Achieved 100%	Achieved 100%	Achieved 98.6%	**Achieved 97.2%**
Maximum of 2 weeks wait from referral to being seen: symptomatic breast cancer patients	>93%	Achieved 96.3%	Achieved 98.8%	Achieved 95.9%	**Achieved 94.6%**
REFERRAL TO TREATMENT WITHIN 18 WEEKS					
Admitted	Admitted: >90%	Achieved 91.7% Specialty: achieved 16/18	Achieved 91.1% Specialty: achieved 9/19 (only 13 relevant	Achieved 91% 15 out of 19 specialties are above 90% or have no patients recorded	**Not achieved 89.2% 10 out of 13 specialties are above 90%**
Specialty	Specialty: set by Monitor and Care Quality Commission; cannot under-achieve >3/18	As above	As above	As above	**As above**
Patient on incomplete pathway	Patient on an incomplete pathway: 92%	Achieved 93.9%	Achieved 93.6%	Achieved 95.4%	**Achieved 94.8%**
A&E treatment within 4 hours (including Walk-In Centre)	>95% Set by Monitor and Care Quality Commission	Achieved 96.4%	Achieved 96.3%	Not Achieved 91.7%	**Not achieved 94.4%**
Rapid Access Chest Pain Clinic % seen within 2 weeks	100% Set by Care Quality Commission	Achieved 100%	Achieved 100%	Achieved 100%	**Achieved 100%**
Cancelled operations: %age readmitted within 28 days	>95%	Achieved 99%	Achieved 96%	Not Archieved 95%	**Not achieved 90.8%**
Clostridium Difficile infections in the Trust	Set by DH /SHA	Achieved 33 against 56	Achieved 16 against 32	19 Against 14	**Not achieved 37* against 13**
MRSA bacteraemia (in Trust)	Zero tolerance set by DH	Achieved 1 against 4	Achieved 2 against 2	Achieved 0	**Not Achieved 3 against 0**
MRSA bacteraemia (across Milton Keynes total health economy)	Zero tolerance set by DH	6	Achieved to date 5 against 4	Achieved 0	**6**

*Notes:

1. 62 day cancer

The trust's position on the Open Exeter (external) system showed 86.1% compliance. However, after having examined the data in detail the trust has determined that the data held on the Open Exeter system contains discrepancies relating to activity recorded at tertiary providers. Following the trust's review of the data, the Trust has concluded that it has achieved 84.9% and therefore cannot have the confidence that the target of 85% has been met.

2. Clostridium difficile

The trust tested every case of diarrhoea in a patient, even though the current guidance issued by the HPA does not require it, and have reported all such positive results attributable to the Trust

ANNEX 1

Statements from NHS : Milton Keynes, Milton Keynes Healthwatch and Milton Keynes Council's Health and Adult Social Care Select Committee

(including explanation of changes to final version of QA after receiving the statements)

Thank you for inviting us to comment on the MKHFT Quality Accounts.

This is the main acute hospital for Milton Keynes and we naturally receive considerable feedback from the population on the quality of its service provision. Whilst our ability to comment in detail is somewhat compromised by the timescales offered we have had opportunity to discuss several issues with your staff via our local Quality Account Board. We trust the following observations are useful:

Looking at this from a patient's perspective, such documents can be extremely difficult to comprehend. We understand that great strides have been taken in recent years to improve presentation to make accounts more "user friendly".

However, we feel it would be useful if additional explanatory text was introduced into the document to help people to understand the significance of data that has been included. For example there appears to be a 4% increase in SHMI value and banding in the last year, and 13% increase in % of admitted patients whose treatment included palliative care- but no comment on the significance or otherwise of this.

In addition, patients may find it difficult to comprehend why you have chosen specific priorities over others. For example reduction in hospital falls should be an ongoing matter for review and indeed the Trust has made great progress already in this area. Whilst clearly wishing to maintain this position- and improve on it- people may find it difficult to appreciate that there is no specific target for improvement in respect of serious incidents. Serious incidents have risen by @25% since last year but there is no explanation of why this should not cause concern.

We recommend that for clarity data is included in tables with an appropriate description of what the figure represents e.g. %age, headcount, per thousand etc.

Comments from local people have continued to reflect the concerns that they have for the Trust to achieve lower waiting times, reduce appointment cancellations and for better communications between departments, between hospital and other services and with patients and their families. We note that the Trust has also commented on patient concerns about the discharge process and believe that this indicates a willingness to engage positively to achieve improvements in this area.

We note that reference is made in the document to involvement in Healthwatch meetings but could we suggest that reference to "Local information networks" (known as "LINks") is removed. Healthwatch Milton Keynes was formed (replacing LINk:MK) in April 2013 and we look forward to the Trust engaging with us in future in order that we can share evidence presented to us by the general public to help to improve quality standards at the hospital.

Thank you for consulting with us.

Statement from Milton Keynes Council Health and Adult Social Care Select Committee dated

Health And Adult Social Care Select Committee Quality Accounts Panel Report

8 May 2014
Milton Keynes Hospital Nhs Foundation Trust (MKHFT)

The Panel considered this to be a big improvement on last year's Quality Account, although they felt it still needed to be more accessible to the general reader.

The Panel was of the opinion that there were too many tables in the Account and would have liked to have seen more narrative, indicating the direction of travel following on from previous years. They would also have liked to have seen consistency of data so that year on year improvements could be monitored.

The Panel were advised that the tables were prerequisite to the approach to Quality Accounts proscribed by Monitor. However the Panel were of the opinion that the directions issued by Monitor were guidance only and not statute, and did not need to be followed to the letter if that made for a more comprehensible and readable Quality Account. The Panel also commented that it was not always clear what the units where which were being cited in tables and that this needed to be explained.

However, there were fewer graphs this year; those that had been included were much more understandable and the Panel commended the Trust for this approach.

The Account stated that the number one cause of death in hospital was sepsis, but there was no explanation as to what either the quantative or percentage figure was compared to other causes of death in hospital and this needed to be clarified.

The Panel noted that although the number of serious incidents had risen, this may well be due to an increase in reporting which was being encouraged as part of the Hospital's commitment to be open and transparent. However the Panel did not entirely accept the assertions of the Trust's representatives that there was no cause for concern and that it was simply all due to more effective reporting. The Panel accepted that better reporting could explain some of the year on year increase, but were concerned that the rise in serious incidents continued to show a significant upwards trend.

There was no explanation as to what a 'serious incident' was, which the Panel thought was unhelpful.

The MKFT was represented at the meeting by Wedgwood Swepston, Head of Development and Planning and Kate Falkner, Lead Nurse for Quality and Improvement. They undertook to review the graphs and tables in the Quality Account and how they were displayed to see if presentation could be improved or even if some of them could be dropped completely and the information presented in another format. The Panel was concerned that too many indicators could be confusing and may not actually tell the reader anything significant.

The Panel concluded that this year's Quality Account was an improvement on the 2013 edition, although there were issues with data connections, clear explanations and a lack of comparative data showing the direction of travel from last year.

The Panel thanked Mr Sweptson and Ms Falkner for their attendance and the positive approach they were taking to address the Panel's concerns.

Statement from Milton Keynes Clinical Commissioning Group dated

Response from Milton Keynes CCG to MK Hospital NHS Foundation Trust Quality Account for 2013-14

Thank you for forwarding a copy of the draft Quality Account 2013/14 for Milton Keynes Hospital Foundation Trust to Milton Keynes CCG.

The review of quality priorities 2012/13 demonstrates improvement, and the hard work and commitment from both individuals and teams that this achievement represents, should not be overlooked.

The CCG can confirm that the information in the Quality Account is accurate and that the range of services described and priorities for improvement is representative. Priority 1 relating to pressure ulcers and priority 3 relating to falls, both use the patient safety thermometer data as the measure of performance. It would be helpful to document performance in 'comparison to others' using the same funnel plot model to support accurate interpretation of the data.

The document focuses on a specific range of achievements and areas for improvement. The CCG is aware that the trust is in the process of implementing a number of initiatives to improve performance in relation to national priorities and regulatory requirements and welcomes this commitment. The trust is also working closely with the CCG to improve the capturing and reporting of patient experience of care data through contractual arrangements.

The CCG is pleased to see that there are four priorities for improvement going forward this year: elimination of grade 3 and 4 pressure ulcers, reduction in hospital based falls, reduction in mortality due to sepsis, and appropriate consultant clinical assessment of patients within 14 hours of time of arrival at hospital. All priorities support protecting patients from avoidable harm, and improving clinical outcomes and are aligned with CCG priorities.

Details in relation to CQUIN achievement is representative. The CQUIN payment framework aims to support the cultural shift towards making quality the organising principle of NHS services, by embedding quality at the heart of commissioner–provider discussions. For this reason the CCG looks forward to supporting the trust to achieve CQUIN performance for 2104/15.

The CCG acknowledges the trust is aspiring to achieve incremental improvements in the quality of care for patients, in response to a variety of national initiatives including the Francis Report, Keogh Review and the Berwick Report. The CCG welcomes the opportunity to work collaboratively with the trust to support continuous improvement in quality of care provided to patients.

We look forward to seeing the publication of the account.

ANNEX 2

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 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 NHS 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 2013/14;
- 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 2013 to May 2014
- Papers relating to Quality reported to the Board over the period April 2013 to June 2014
- Feedback from the commissioners dated not received
- Feedback from governors on quality priorities dated 24 April 2014
- Feedback from Local Healthwatch organisations dated 9 May 2014
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2014
- The national patient survey February 2014
- The national staff survey February 2014
- The head of Internal audit's annual opinion over the trust's control environment dated 8 April 2014
- CQC quality and risk profiles dated March 2014
- 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;
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

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

By order of the Board

22 May 2014 Date.....Chairman

22 May 2014 Date.....Chief Executive

ANNEX 3

Independent Auditor's report

Independent Auditor's Report to the Council of Governors of Milton Keynes Hospital NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Milton Keynes Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Milton Keynes Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the "Quality Report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Milton Keynes Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Milton Keynes Hospital 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 2014, 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 Milton Keynes Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Number of Clostridium difficile infections for patients aged 2 or more; and
- Maximum 62 day waiting time from urgent GP referral to treatment for all cancers.

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 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 guidance; 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 consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents specified within the detailed guidance. 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.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – "Assurance Engagements other than Audits or Reviews of Historical Financial Information" issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

- 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.
- 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.
- Reading the documents.

A limited assurance engagement is smaller 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.

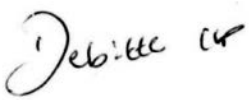
The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, 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.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Milton Keynes Hospital NHS Foundation Trust.

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 2014:

- 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 guidance; 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.



Deloitte LLP
Chartered Accountants
St Albans
29 May 2014

ANNEX 4

Feedback on the Quality Account

If you would like further information contained within this report, please write to

Michelle Evans-Riches, Trust Secretary

Milton Keynes Hospital NHS Foundation Trust,
Eaglestone
Standing Way
Milton Keynes MK6 5LD

Or email her at michelle.evans-riches@mkhospital.nhs.uk

Section 5

Governance & Risk Management

Governance Of The Trust
Trust Committees
Code Of Governance Disclosures
Annual Governance Statement

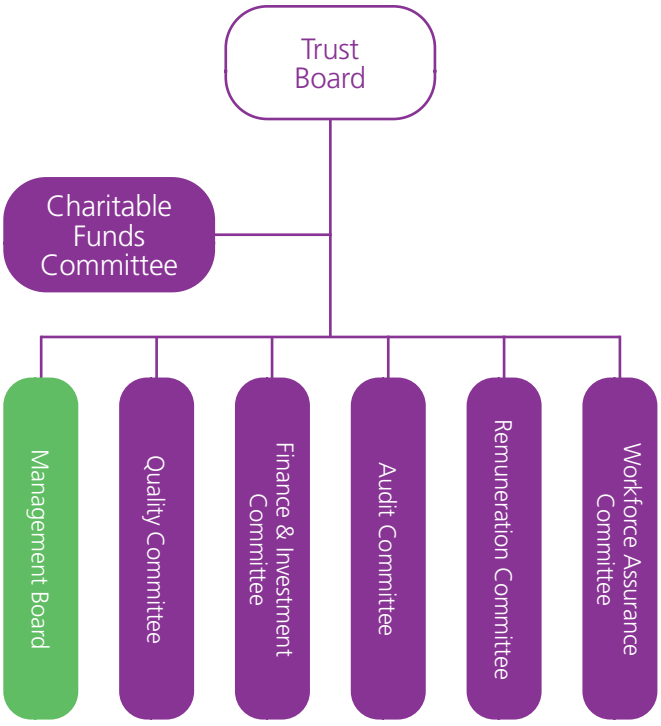
Governance & Risk Management

Governance of the Trust

Our approach

The strategic management of the trust is undertaken by the Board of Directors, and with the Board sub-committees which monitor performance against quality and financial indicators. The operational management of the trust is the responsibility of the management board which has balanced representation by clinicians and executive directors. The Council of Governors is responsible for holding the Board to account.

The following diagram shows the trust Board and sub-committee structure.



Council of Governors

Decision making

The primary role of the Council of Governors is to contribute to the development of forward plans for the trust with the Board of Directors, and to ensure that the interests of the community served by the trust are appropriately represented. The Council of Governors has statutory responsibilities for the appointment, appraisal, remuneration and removal of the Chair, non-executive directors and external auditors. It has a role to consult with members and the public and reflect the views of the membership. Its role also involves ownership of the membership strategy and the development of plans for growing and expanding our membership.

The Health and Social Care Act 2012 introduced a duty on the Council of Governors of the rust to hold the non executive directors to account for the performance of the trust. Through the board development sessions with the governors' practical measures of how this can be achieved have been developed. For example, the non executive director chair of a Committee presenting reports to the Council of Governors.

The Council of Governors is chaired by the trust chairman. It consists of 15 governors elected by public members of the trust, each representing a geographic constituency, seven governors elected by staff of the trust, and five appointed governors. The table at Appendix 1 shows the constituencies and their governors. The table at Appendix 2 lists the governors and their attendance record at the eight Council of Governors meetings that took place in the year. All governors complete an annual declaration of interests form and this is available on request from the trust secretary.

The vice chair of the Council of Governors is Bob Collard who was appointed in October 2012, for a period of two years. An election for the role of the vice chair will be taking place in the summer of 2014.

Elections

Governor Elections 2013/14

In 2013/14 elections were held for the following seats on the Council of Governors.

Date	Constituency (see Appendix 1for key)	Result
6 June 2013	Bletchley & Fenny Stratford, Denbeigh, Eaton Manor & Whaddon	Peter Ballantyne
6 June 2013	Hanslope Park, Olney, Sherington, Newport Pagnell	Roger Hornblow
6 June 2013	Walton Park, Danesborough, Middleton, Woughton	Vincent Leiu
10 July 2013	Outer Catchment Area	Adrienne Rutter
26 July 2013	Emerson Valley, Furzton, Loughton park	Brian Hobbs
26 July 2013	Walton Park, Danesborough, Middleton, Woughton	Lesley Bell
26 July 2013	Staff: Doctors and Dentists	Dawar Abbas
23 August 2013	Linford South, Bradwell, Campbell Park	Bob Collard
4 October 2013	Staff: Non clinical staff groups e.g. Admin & Clerical, Estates, Finance, HR, Management	Eszter Pritchard
4 October 2013	Staff: Nurses and Midwives	Kim Weston
11 March 2014	Linford South, Bradwell, Campbell Park	Chris Phillips

These vacancies arose because the governor's term of office came to an end.

During 2014/15 elections will be held for the following governor positions:

Constituency	No. of vacancies
Stantonbury, Stony Stratford, Wolverton	1
Outer Catchment Area	1
Staff: Non clinical staff groups e.g. Admin & Clerical, Estates, Finance, HR, Management	1

*The extended Area continues to be difficult to obtain any nominations for despite it being advertised at each election. This area will continue to be targeted in 2014/15.

Appointment of Non-Executive directors (NED)

Due to the end of Graham Anderson's term of office in February 2014, the Trust embarked on a recruitment campaign with the assistance of Harvey Nash.

The nominations committee, chaired by Bob Collard and supported by Harvey Nash, interviewed a short list of candidates, and recommended the appointment of Tony Nolan. Due to the high standard of applicants and cognisant of Kate Robinson's term of office coming to an end in October 2014, the nominations committee also recommended the appointment of Dr Jean-Jacques deGorter, who will be a non executive associate member of the trust board until Kate Robinson leaves.

The nominations committee took into account the skills and experience of the existing Board members and those required to strengthen the Board. The committee were actively seeking to appoint a NED with clinical experience and this was achieved by the appointment of Dr Jean-Jacques DeGorter. In addition, the Committee thought that Tony Nolan's experience in customer focused and performance improvements industry was particularly useful for the board.

Terms and conditions of NEDs are available from the trust secretary.

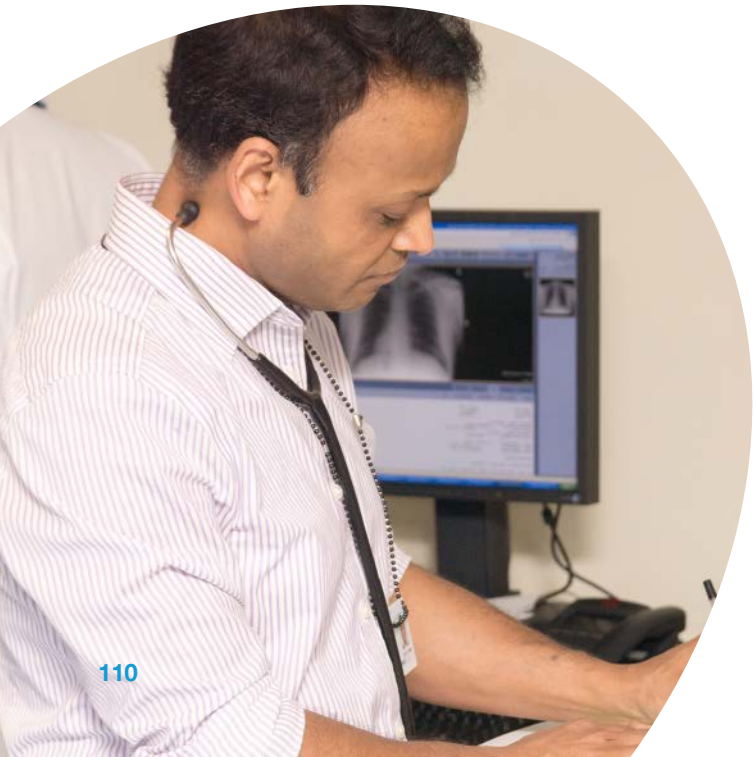
Appointment and Removal of Chairman and Non executive directors

The trust's Constitution (paragraph 26 and Annex 7) specifies how the chairman and non executive directors are appointed and the process for removal from office. The Council of Governors is required to make decisions in both appointment and removal of people to these key roles.

Appointment of the Chairman

David Wakefield tendered his resignation from the role as chairman and left the trust at the end of August 2013. The lead governor, Bob Collard met with Monitor to discuss the arrangements to appoint a replacement. Monitor advised that given the position of the trust which was in breach of its licence, Monitor would recommend to the Council of Governors a suitable interim replacement. The nominations committee met with the candidate on 9 July 2013 and recommended the Council of Governors to appoint Chris Mellor as the interim, chairman from 9 September 2013 to end June 2014.

The recruitment of a permanent chair is underway with Harvey Nash supporting the trust.



Nominations Committee

The nominations committee is a sub-committee of the Council of Governors and makes recommendations to Council of Governors on the appointment, appraisal, remuneration and removal of the chair and non-executive directors and also on the appointment or removal of auditors. The nominations committee is chaired by a public governor.

The nominations committee has considered the remuneration of the chair and other directors and agreed that there should be no increase in salary for 2013/14. It is formally involved in the appraisal process of non-executives and reviews the appointment of external auditors.

The members of the nominations committee for 2013/14 are shown in Appendix 2.

Board Development

In 2012/13 the trust commissioned Deloitte to undertake a board effectiveness review and the subsequent recommendations were taken forward in 2013/14. The Board has had two development sessions facilitated by Deloitte and an action plan has been developed and is being implemented. As part of the development programme, a session was also held with the Chairman and the Council of Governors to gather their views on improvements that could be made and this session was also facilitated by Deloitte.

Chris Mellor's tenure as interim chairman is due to end on 30 June 2014 and meetings to review Board development progress are being organised with the Board and the Council of Governors with the newly appointed chair by the end of June 2014.

Governor Development

In 2013/14, governors took part in a patient experience workshop facilitated by Picker. The lead governor has also attended a seminar run by Deloitte regarding national healthcare sector performance.

The engagement group, which comprises of governors, have been involved in developing the governor development programme. There are three elements to the development programme:

Mandatory	Recommended	Other
Governance of trust Role of Governor, Non executive directors Trust induction FTN Induction Programme	Risk management dementia awareness external audit	Internal & external opportunities

Actions in progress:

- Governors are invited to attend the one day trust induction day for volunteers and governors.
- Dementia awareness training and external audit training is being undertaken in June 2014.
- The FTN Govern Well programme is circulated to the Governors and four governors are attending seminar on accountability in Manchester on 30 April 2014.

Board of directors

The composition of the current Board of Directors is detailed below:

Name	Appointment
Chris Mellor	Chairman (from 6 September 2013)
Graham Anderson	Non executive director (until 28 Feb 2014)
Frank Burdett	Non executive director
Jean-Jacques De Gorter	Non executive director (from 1 Mar 2014)
Penny Emerson	Non executive director
Robert Green	Non executive director
David Moore	Non executive director
Tony Nolan	Non executive director (from 1 Mar 2014)
Kate Robinson	Non executive director
Joe Harrison	Chief Executive
Lisa Knight	Director of Patient Care
Darren Leech	Director of Strategy and Estates
Martin Wetherill	Medical Director
John Blakesley	Interim Director of Performance and Planning (from 1 April 2013) substantive Director of Performance and Delivery
Ogechi Emeadi	Director of Workforce (from 31 March 2014)
Jonathan Dunk	Director of Finance

Non-Executive Directors

Graham Anderson
NON-EXECUTIVE DIRECTOR (SENIOR INDEPENDENT DIRECTOR UNTIL 28 FEB 2014)

- Joined the Board in March 2008
- Specialised knowledge of investment, business development, planning and implementation, marketing and public relations and strategy
- Over 20 years of Board and Executive experience
- In 2006 appointed to the Board of Milton Keynes Chamber of Commerce. Appointed Vice-President in 2009. Appointed as Ambassador to MK Business Leaders in January 2008
- Extensive Inward Investment experience in the local area - worked with Milton Keynes Partnership to attract inward investment to Milton Keynes for 30 years and to retain and deepen investment of existing key employers. Consultant to Invest Milton Keynes (May 1995 - April 2009)
- Deputy Director of CBI (Confederation of British Industry) at Centre Point (1992-1994)
- Executive Chairman of The Disabilities Trust, a National Charitable Trust (1994 to 2007)
- Life Vice-President and former Chairman of the Disabilities Trust
- Former Chairman of Berks, Bucks and Oxon Branch of the Royal Institution of Chartered Surveyors
- School Governor (Winslow Combined School (1999 – present)
- Chairman, the London Chorus
- Qualified Chartered Surveyor

Dr Frank Burdett
NON-EXECUTIVE DIRECTOR

- Joined the Trust in February 2012. Four year appointment.
- Until recently Pro Vice Chancellor at The University of Northampton with responsibility for strategy across research, innovation, enterprise, marketing, and international, as well as oversight of the School of Health, Northampton Business School and the School of Science and Technology
- Created over £30 million of successful projects including the Portfolio Innovation Centre, the ICON Sustainable Construction Centre and the NVision 3D Immersive Visualisation Centre
- Co-founded the University's Research Centre for Health & Wellbeing with the local PCT and County Council
- Prior career includes roles as Associate Dean and then Director of Commercial Affairs at the University of Bedfordshire, as Marketing Manager at Acorn Computer Group plc and as an academic at Bath Spa University
- Previously Council member of East Midlands Innovation (EMInn), Board member of Northamptonshire Enterprise Limited (NEL), Board member of Business Link Northamptonshire, Chair of East Midlands Universities Association Innovation Committee, Steering Group member of the Lord Stafford Awards, Director of BLC Leather Technology Centre, Director of UN Enterprise Ltd. and Director of ICON (EM) Ltd

Dr Jean-Jacques de Gorter
NON-EXECUTIVE DIRECTOR (FROM 1 MAR 2014)

- Joined the Trust in March 2014. Three year appointment.
- Dr de Gorter has held hospital and GP appointments in the NHS, Australia and New Zealand before joining NHS Direct as a Medical Director
- Joined the private sector as Director of Clinical Services at BUPA Hospitals.
- Since 2007 he has been Group Medical Director of Spire Healthcare Ltd.
- He lives in Buckinghamshire.

Penny Emerson
NON-EXECUTIVE DIRECTOR

- Joined the Board in February 2012. Three year appointment.
- Partner in a healthcare consultancy providing organisational development, change management and business strategy support to NHS, public sector and pharmaceutical industry clients
- 14 year career in senior corporate leadership roles spanning four large pharmaceutical companies and two global healthcare communications agencies.
- RGN Westminster Hospital

Robert Green
NON-EXECUTIVE DIRECTOR

- Joined the Trust in January 2013. Four year appointment.
- Qualified Chartered Accountant with PwC
- Over 30 years Board and senior financial experience mostly in the UK but also in the Far East and US
- Was Group Finance Director of Wilson Connolly, based in Northampton, a FTSE 250 company
- MA Mathematics, Oxford University
- Has lived in Milton Keynes for 12 years

Chris Mellor
CHAIRMAN (FROM SEP 2013)

- Consultant working mainly in the utility and health sectors. He is currently Interim Chairman of Milton Keynes Hospital NHS Foundation Trust. Prior to this role, he was Interim Chairman of Sherwood Forest Hospital NHS Foundation Trust for nine months until June 2013. For eight years until March 2012 he was Deputy Chairman of Monitor .
- Chairman of Northern Ireland Water Ltd for four years from 2006. Before that, Chris was CEO of AWG Plc the Privatised Water and Waste Water Utility for six years, and eight years as Finance Director.
- Non executive director of Grontmij UK Ltd the Consulting Engineering Group quoted on the Dutch SE. for seven years, as a Non executive director of Addenbrokes Hospital Trust and as a member of the Government's fourth Advisory Committee on Business in the Environment.
- A qualified accountant and has worked in both the private and public sectors.
- A frequent speaker on leadership, change management and sustainable development.

David Moore
NON-EXECUTIVE DIRECTOR (SENIOR INDEPENDENT DIRECTOR FROM 1 MARCH 2014)

- Joined the Trust in March 2012. Four year appointment.
- Spent 28 years working internationally for Citibank returning to the UK in 2008 as Managing Director for Citi Private Bank Operations Division in EMEA and Asia before retiring at the end of 2011.
- Significant experience in governance, finance, operations, strategic planning, quality and change management
- Public Member of Network Rail from 2008 through 2011
- Lay Member of the Council of the University of Leicester sitting on Finance, Remuneration and Health & Safety Committees
- Independent Auditor for the Welton Townlands Trust
- Holds a Masters of Business Administration (MBA) and BA in Social Sciences

Tony Nolan
NON-EXECUTIVE DIRECTOR (FROM 1 MAR 2014)

- Joined the Trust in March 2014. Four year appointment.
- Held senior positions in multi-national companies
- Currently the Group Head of Business Improvement for Vodafone Group.
- Extensive experience in performance in a customer focused setting.
- Lives in Buckinghamshire.

Non-Executive Directors continued

Professor Kate Robinson BA PLD RGN RHV
NON-EXECUTIVE DIRECTOR

- Joined the Trust in October 2008
- 18 years of Board and Executive experience
- Former Chair of Luton Sixth Form College Corporation
- Extensive contribution to committees, boards and panels regionally and nationally in the sphere of education, research and health.
- Published and presented papers nationally and internationally on a variety of education and health topics, including patient safety
- Previous non-executive director experience at Bedfordshire and Hertfordshire Ambulance Trust and Bedfordshire and Hertfordshire SHA.
- Professor of Nursing, University of Bedfordshire.

David Wakefield
CHAIRMAN OF THE BOARD OF DIRECTORS (UNTIL 31 AUGUST 2013)

- Joined the hospital in April 2011. He has been a non-executive director with NHS Milton Keynes and Milton Keynes Community Health Services for the last five years, so has a good understanding of patients' needs.
- David is also a qualified accountant and has held a number of senior roles, including as Commercial Finance Director for Royal Mail.
- Non executive director with Courier Services Ltd between 2008-11
- Chair of MK Community Health Services between 2009-11
- David was appointed as interim Chairman of Royal Bolton Hospital Foundation Trust on August 2012 for one year.
- David has no significant commercial commitments.

Executive Directors

John Blakesley
INTERIM DIRECTOR OF PERFORMANCE AND PLANNING (01/04/13 - 31/03/13)
DIRECTOR OF PERFORMANCE AND DELIVERY (FROM 1 APRIL 2014)

- Over 30 years of experience in the NHS. His career started in Pathology, before moving into general management. He has undertaken a range of executive director roles as Director of Performance and Delivery and Deputy Chief Executive as well as Director of Market Management (Commissioning for a large PCT.)
- In addition, John has experience of the commercial sector with a specialised surgical company.
- Particular interest is using information systems as a means to improve patient care and decision-making
- Becoming the substantive Director of Performance and Delivery on 1 April 2014

Jonathan Dunk
INTERIM DIRECTOR OF FINANCE
(FROM 1 JULY 2013 UNTIL 30 MARCH 2014, WHEN MADE SUBSTANTIVE)

- CIPFA qualified accountant with 10 years senior experience in the acute trust setting.
- Currently part of the NHS Leadership Academy, Nye Bevan Programme, taking high performing NHS employees through to a new qualification in NHS Executive Leadership.
- Prior to arriving at Milton Keynes was heavily involved in the pioneering acute trust franchise process implemented at Hinchingbrooke NHS Trust.
- Been employed within the NHS for 14 years, initially entering through the National Graduate Programme.

Ogechi Emeadi
DIRECTOR OF WORKFORCE 31 MARCH 2014

- Prior to joining the Trust in March 2014, was Deputy Director of HR at North Middlesex University Hospital.
- Over 20 years' experience working in HR in the NHS delivered on strategic and operational human resources initiatives and organisational development agenda.
- Passionate about improving staff health and wellbeing and driving forward staff development.

Norma French
INTERIM DIRECTOR OF WORKFORCE (FROM 1 APRIL 2013)

- Following a successful career as an Executive director in the NHS, Norma built up a portfolio of skills and experience in all aspects of Human Resources, general management and corporate governance.
- As Director of Workforce and Corporate Governance at the Royal Marsden NHS Trust, one of the first and most successful foundation trusts, she led on all FT matters including membership engagement, as well as the full range of HR and Organisational Development responsibilities.
- Since 2008, Norma has undertaken many Interim Director roles in a range of acute settings including specialist, multi-sited NHS Foundation Trusts, combined with a specialist project work particularly on top team creation and organizational structures design, as well as complex employee relations investigation.
- Her particular expertise lies in the development and implementation of innovative human resources and organisational development interventions to achieve organisational goals and enable the integration of leading human resources policies into all aspects of service delivery. She also advises on Trust mergers and acquisition, restructuring; change management and transfer of undertakings; complex investigations; policy development and negotiation and redundancy.
- MA in Human Resource Management and is a member of the CIPD, and is qualified to administer Myers-Briggs Type Indicator (MBTI) Tests Step 1 and 2.

Executive Directors continued

Joe Harrison
CHIEF EXECUTIVE

- Joined the Trust in February 2013.
- Formerly Chief Executive at Bedford Hospital for two years.
- 20 years' experience of working in the acute sector of the NHS, covering both big teaching hospitals and district general hospitals.
- Roles have included a range of senior operational and corporate positions at several London hospitals with a track record of improving patient services and performance

Lisa Knight
DIRECTOR OF PATIENT CARE

- Appointed as Chief Nurse and Director of Patient Care in October 2012, with a wealth of experience gained from a range of nursing disciplines.
- Having trained and spent the first few years of her career at hospitals in north London, Lisa spent a year at an acute medical oncology unit in Toronto. On her return to the UK, Lisa pursued her interest in burns and plastic surgery care, working in units at University College Hospital and the Royal Free Hospital, utilising her postgraduate diploma in this specialty.
- Operations Manager for surgery at Chase Farm, covering anaesthetics, operating theatres and intensive care. This was followed by roles at North Middlesex as senior nurse for the A&E and Medicine; interim Deputy Chief Nurse at Epsom and St Helier and interim Chief Nurse at Addenbrooke's.
- Particular nursing interests include effective pathways for the care of the elderly, safeguarding adults and managing the needs of patients with dementia.

Darren Leech
DIRECTOR OF STRATEGY AND ESTATES (FORMERLY CHIEF OPERATING OFFICER)

- Director in a number of hospitals, with roles largely focused on operational service delivery
- Joint post with a PCT in Cambridgeshire, conducting a major strategic review and re-design of clinical services across hospital and community service settings
- Professional background in pharmacy
- Currently a researcher at Ashcroft International Business School, Cambridge

Robert Toole
INTERIM DIRECTOR OF FINANCE (FROM JANUARY 2013 UNTIL 30 JUNE 2013)

- Fellow Chartered management Accountant with extensive acute hospital trust and Primary Care (including a Community arm) Trust experience.
- Prior to joining the NHS in 2004 he worked for 13 years at Rolls Royce Plc including the role of Vice President - Finance, for the global helicopter business based in the USA.
- His earlier career included finance roles in Carnaud Metal Box plc and a family business.

Mr Martin Wetherill MRCS LRCP MB BS
MEDICAL DIRECTOR

- Worked for Milton Keynes hospital for more than 20 years and has a special interest in teaching and service transformation
- Trust's Clinical Transformation Director
- Led the trauma, orthopaedics and rheumatology teams as clinical director at Milton Keynes from 1991
- Active committee member for regional and national committees including those regarding professional practice, teaching and assessment for consultant status of orthopaedic surgeons
- Medical Director from July 2011

Board Performance

The performance of the trust Board was monitored through a series of meetings with the independent regulator Monitor. Impending non executive director vacancies were discussed with Monitor with regard to the skills and knowledge required to strengthen the Board.

The chairman of the board meets with each non executive director on a one to one basis to discuss forthcoming issues and their individual performance. The non executive directors have a weekly telephone conference to discuss issues and these are raised by the chairman with the chief executive.

In 2012/13 the trust commissioned Deloitte to undertake a Board effectiveness review and the subsequent recommendations were taken forward in 2013/14. The Board has had two development sessions facilitated by Deloitte and an action plan has been developed and is being implemented. As part of the development programme, a session was also held with the Chairman and the Council of Governors to gather their views on improvements that could be made and this session was also facilitated by Deloitte.

A review of progress against the action plan will be undertaken before the end June 2014, when Chris Mellor leaves the Trust.

The Chairman's performance was assessed by Graham Anderson, SID, before he left office at the end of February 2014 and was reported to the Council of Governors in April 2014. The Chairman is undertaking performance review meetings with each NED in collaboration with the lead Governor and will report the outcome to the Council of Governors in June 2014.

Register of interests

The Trust maintains two registers of interests. The first includes interests of all directors; the second interests of the Council of Governors. Both documents are available for public inspection (contact the trust secretary). An annual report is made to the trust Board regarding the interest of executive directors and Non executive directors. If there is any item which could have a conflict of interest at a Board or Committee meeting the respective Director is required declare the interest and leave the meeting.

Board Of Directors - Declarations of Interests as at 31 March 2014

The table below sets out the declarations of interests made by all members of the Board of Directors.

Director and Title	Do you, your spouse, partner or family member hold or have any of the following: - A directorship of a company? - Any interest or position in any firm, company, business or organisation (including charitable or voluntary organisation) which has or is likely to have a trading or commercial relationship with the Foundation Trust? - Any interest in an organisation providing health and social care to the National Health Service?	Do you, your spouse, partner or family member have a position of authority or voluntary organisation in the field of health and social care?	Do you, your spouse, partner or family member have any connection with any organisation, entity or company considering entering into a financial arrangement with the Foundation Trust including but not limited to lenders of banks?
Blakesley, John Director of Planning & Performance	No	Yes – MK Hospital Charity	No
Burdett, Frank Non executive director	No	No	No
DeGorter, Jean-Jacques Non executive director	Yes: 1. Spire Healthcare Ltd 2. Classic Hospitals Ltd 3. Thames Valley Hospital Ltd 4. London Fertility Centre Ltd	No	Yes. Commercial arrangements in place at four sites in the UK with Cancer Partners UK
Dunk, Jonathan Director of Finance	Yes Wife works in Legal Department at Cambridge University Hospitals NHS FT	No	No
Emeadi Ogechi Director of Workforce	No	No	No
Emerson, Penny Non executive director	Yes: 1. Bridge Health Consulting Limited. Provides services to NHS & others 2. Emerson field Limited	No	No
French Norma Interim Director of Workforce	Yes: 1. Associate with Acertos Search & Selections 2. Associate with Space-4 Consulting 3. Spouse Consultant physician at CNWL Trust	No	No
Green, Robert Non executive director	Yes: Bond Estates Holdings LTD Chasely Associates LTD Independent member – MK Development Partnership (Part of MK Council)	No	No
Harrison, Joe Chief Executive	Yes: 1. Spouse CEO West Herts NHS Trust 2. Two Family members Durrow Healthservice Mgt 3. Family member Medicline	No	No
Knight, Lisa Director of Patient Care & Chief Nurse	Yes: Spouse is group Finance Director Alto digital	No	No
Leech, Darren Chief Operating Officer	Yes: 1. Partner works at Cambridge University Hospitals NHSFT 2. Family member – works at Portsmouth Hospital NHS Trust	No	Lord Ashcroft International Business School, Anglia Ruskin University Cambridge
Mellor, Chris Interim Chairman	Yes: 1. Christopher Mellor Consulting LTD 2. Appointed by Monitor as Chairman of Peterborough Regional Steering Group	No	No
Moore, David Non executive director	Yes: 1. College Court Conference Centre Ltd 2. Treasurer and lay member of council - University of Leicester	No	No
Tony Nolan Non executive director	No	No	No
Wetherill, Martin Medical Director	Yes: Partnership with spouse– Orthopaedic Practice Shalstone Medical Services	No	No

Council Of Governors - Declarations of Interests as at 31 March 2014

The following table details of Governors who have declared an interest.
The remaining Governors have declared no interest in each of the categories.

Name and Governor	Do you, your spouse, partner or family member hold or have any of the following: - A directorship of a company? - Any interest or position in any firm, company, business or organisation (including charitable or voluntary organisation) which has or is likely to have a trading or commercial relationship with the Foundation Trust? - Any interest in an organisation providing health and social care to the National Health Service?	Do you, your spouse, partner or family member have a position of authority or voluntary organisation in the field of health and social care?	Do you, your spouse, partner or family member have any connection with any organisation, entity or company considering entering into a financial arrangement with the Foundation Trust including but not limited to lenders of banks?
Moutrie, Michael Public	York House Centre, Stony Stratford	Spouse is a Trustee of Save the Children	
Rutter, Adrienne Public	Employed by Age UK 2007 to 2012 and now a Volunteer	No	No
Thomas, Ann Public	League of Friends Milton Keynes Hospital Ltd	No	No
Brock, Debbie Appointed Partner	Milton Keynes Council Midland Road Management Company (MK Cenotaph Trust) MK Mediation Service MK Council Disability Advisory Group Spouse: 1. MK Parks Trust 2. MKYMCA 3. MK theatre and Gallery	Milton Keynes Council	Milton Keynes Council
Hill, Clair	League of Friends Milton Keynes Hospital Ltd	No	No
Hastings, Alan	No	No	Chair, Healthwatch MK

Trust Committees

Committees

The Board has six sub committees; audit, quality, finance and investment, charitable funds, workforce assurance and remuneration committee.

Audit Committee

The audit committee was chaired by a non executive director Bob Green. The chair has recent financial experience as detailed in the biography above. The chair and chief executive are required to attend the May meeting when the committee reviews the draft annual report and accounts.

The audit committee meets five times a year, each meeting (apart for that in May) considers:

- The work of the internal audit, including whether audits have been followed up and issues resolved. The committee requests that senior officials and/or directors attend where actions have not been followed up to its satisfaction. The committee agrees the work plan of internal audit once a year;
- the work of the external auditors, including any issues that they wish to raise;
- the work of the Trust's counter-fraud team;
- a list of all debts that are to be written off;
- updates to the IFRS work and accounting policies;
- the board assurance framework and corporate risk register.

The audit committee provides assurance to the Board on:

- the effectiveness of the organisation's governance, risk management and internal control systems;
- the integrity of the trust's financial statements, the trust's annual report and in particular the statement on internal control;
- the work of internal and external audit and any actions arising from their work.

The audit committee monitors the review of the board assurance framework and the corporate risk register.

The audit committee reviews auditor independence both as part of its scrutiny of the annual report and accounts and as part of its annual review of the auditors' work. The audit committee is satisfied that there are no issues that compromise the external auditors' independence from work outside the Trust.

Quality Committee

The quality committee chaired by a non executive director, Kate Robinson met nine times in 2013/14. It reports directly to the Board and provides assurance about the quality of care provided by the trust and for overseeing the delivery of the quality priorities set by the Trust in its quality accounts. The quality committee has overseen the development of the adult nursing metrics and monitors performance against these. The committee has provided assurance to the Board regarding Mortality rates and there has been significant improvement in performance.

The quality committee has also received the CQC compliance report regarding follow up dignity and nutrition and supporting workers inspections and receives updates on the action plan to address the areas of improvement.

Finance and Investment Committee

The finance and investment committee chaired by David Moore met fifteen times during the year. It received monthly reports on the financial position of the trust, cash flow forecast and transformation programme updates. The committee was also responsible for monitoring the capital spend and through regular reporting monitors the implementation capital projects.

The financial planning process for 2014/15 was considered by the committee which recommended the budget to the Board of Directors.

Charitable Funds Committee

The charitable funds committee is chaired by a non executive director Frank Burdett. The trust changed the registered charity name from Healthcare:MK to Milton Keynes Hospital Charity and has to adhere to the rules of the Charities Commission. The charitable funds committee has encouraged the use of charitable funds to improve the service provided to patients.

Workforce Assurance Committee

The workforce assurance committee is chaired by non executive director Penny Emerson had its first meeting in January 2014 and has met twice during 2013/14. The workforce assurance committee is responsible for developing the workforce strategy and providing assurance to the Board that it is being implemented effectively.

Remuneration Committee

The remuneration committee is a sub-committee of the trust Board and agrees the salaries of the chief executive and the executive directors. The committee comprises of the trust chairman and all the non executive directors. The chief executive and director of workforce attend the meeting, but leaves when discussing the salary for their own position.

The remuneration committee met once in 2013/14.

A table of attendees at the Board and its sub committees is attached at Appendix 2.

Board of Directors and Preparation of Accounts

The annual report and accounts have been prepared under a direction issued by Monitor. In support of the chief executive, as accounting officer of the NHS Foundation Trust, the Board of Directors has responsibilities in the preparation of the accounts.

Monitor, the independent regulator of NHS Foundation Trusts, with the approval of HM Treasury, in exercise of powers conferred on it by paragraph 25(1) of Schedule 7 of the National Health Service Act 2006 directs that the accounts give a fair and true view of the Foundation Trust's gains and losses, cash flows and financial state at the end of the financial period.

To this end, the Board of Directors are required to:

- apply on a consistent basis accounting policies laid down by Monitor with approval of the Treasury
- make judgements and estimates that are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts
- keep proper accounting records, which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act
- safeguard the assets of the Foundation Trust and hence take reasonable steps for the prevention and detection of fraud and other irregularities

Internal Auditors

Details of the internal audit function carried out by CEAC is provided in the Annual Governance Statement.

External Auditors

Deloitte LLP have been the Trust's financial auditors for 2013/14, The appointment was made for a 3 year period with an option to extend to 5 years.. Their audit responsibilities include the statutory services as well as the Quality accounts and Value for Money exercise. The total cost recognised in the accounts for this work is £71,000 (excluding VAT).
The trust has also used Deloitte for additional assurance work including the validation of the annual 3-year planning exercise. This was at a cost of £50,000 (excluding VAT).

In order to ensure that independence is maintained, in instances where the external auditors are used for work other than the external audit, the Council of Governors approve this and the audit committee is also informed.

Code of Governance Disclosures

In January 2014, Monitor published the NHS Foundation Trust Code of Governance (replacing September 2006 version). The purpose of the Code of Conduct is to assist NHS foundation trust boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The Code of Governance was reported to the Trust Board and Council of Governors in April 2014.

The Code is issued as best practice advice, but imposes some disclosure requirements which all foundation

Milton Keynes NHS Foundation Trust uses the Code of Governance to ensure that its governance is in line with best practice. Except in the two special circumstances described below, the Trust applies both the main and supporting principles of the code to its governance practices. The table below explains the two points where the trust does not comply with the code of governance, together with an explanation of why it does not.

Provision	Explanation for non-compliance
A.5.6 The Council should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns.	The Council of Governors raise concerns at their regular meetings which members of the Board of Directors attend. In addition, the lead Governor meets with the Chairman and can raise issues on behalf of the Council. The Senior Independent Director also meets informally with Governors to discuss issues and Governors can raise concerns through these meetings.
B2.4 The chairman or an independent non-executive director should chair the Nominations Committee.	The Nominations Committee believes that the committee should be chaired by a member of the Council of Governors as the Members' Council carried responsibility for its functions. This has been in effect since 2008/9.

Additional and Public Interest Disclosures

Health and Safety Performance 2013/2014

During 2013/2014, 337 staff incidents (including violence and abuse incidents) were recorded compared to 376 in 2012/13. This represents a 10% decrease from the previous year.

Incident	2010/11	2011/12	2012/13	2013/14
Slips / trips / falls **	57	48	47	**38**
Collision / contact	36	30	23	**24**
Violence / abuse	197	165	139	**153**
Sharps / needlesticks	70	78	90	**54**
Manual handling	19	29	26	**12**
Cut with sharp object	7	9	6	**8**
Exposure to substances	10	10	7	**3**
Burns / scalds	7	4	3	**3**
Musculoskeletal	27	17	27	**31**
Struck by moving object	12	12	8	**4**
Near Miss	2	1	0	**3**
Totals	**444**	**402**	**376**	**337**

Figure 1: A Comparison of Type of Incidents Reported by Year from 2010-2013.

The categories with the highest incident rates are violence and abuse, sharps/needle stick injuries, slip, trips and falls and musculoskeletal incidents. Details on actions taken to minimise incident rate for these categories is given below.

Any health and safety incidents that resulted in major injury were reported to the Health and Safety Executive as required under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 1995 (RIDDOR). Out of the 376 staff incidents reported only 15 where classified as either major injuries or resulted in more than 7 days absence from work. The table below gives details of the type of incidents reported as RIDDORS in the Trust.

Incident	Total
Slip, Trip, Fall	5
Manual Handling	6
Violence and Assault	2
Struck by object	2

Actions Taken

Actions taken to minimise incident rates are as follows:

Violence and abuse

The security and car park manager is to lead on a poster campaign to encourage staff to report violence and abuse incidents in particular. Staff are also reminded of the importance of reporting during the induction and refresher training for risk management and health and safety.

Sharps/Needlestick Injuries

The Trust has started using needles that incorporate a protection mechanism in accordance with the EU Council Directive 2010/32/EU on the prevention of sharps injuries in the hospital and healthcare sector. This implementation has reduced the incident rate of needlestick related injuries by 40% (54 sharps related incidents in 2013/14 compared with 90 in 2012/2013)

Slip, Trips and Falls

There has been a 19% decrease in the number of slips, trips and falls reported on Datix (38 in 2013/2014 compared to 47 in 2012/2013). This is due to a campaign led by the chief operating officer to keep corridors clear and tidy and repair work on protruding metal plates that hide the door closing mechanisms of fire doors to minimise their risk as trip hazards. There is also a plan to include a message in the chief executive's weekly message when we have snowy weather reminding staff to take extra care for their own health and safety.

Eye care Vouchers

The display screen equipment (DSE) policy has been updated and uploaded onto the intranet. Staff who are DSE users are encouraged to complete the DSE E-learning program which gives guidance on the appropriate set up of work area to minimise chance of musculoskeletal injuries. All staff have also been made aware via the chief executive's weekly newsletter that they can request eye care vouchers through the Health and Safety Advisor.

Improvements to Health and Safety Management

The following improvements have been made to manage health and safety:

- The health and safety advisor has commenced electing departmental health and safety representatives who will carry out health and safety audits for their area.
- Employers have a legal duty under the Health and Safety Information for Employees Regulations (HSIER) to display the approved poster in a prominent position in each workplace or to provide each worker with a copy of the approved leaflet. The health and safety advisor checks to ensure the 2009 health and safety law poster is displayed appropriately.
- The health and safety advisor attends peer meetings with local NHS health and safety advisors/managers to obtain benchmarking data and learn how they are handling issues such as trying to improve training compliance rates.

Countering fraud and corruption

The Board of Directors has established policies and procedures to minimise the risk of fraud and corruption, along with a procedure to be followed in the event of any reported fraud. Members of staff with reasonable suspicions are encouraged to report them, and the trust's policy is that no employee will suffer as a result of reporting reasonably-held suspicions.

The reporting procedure is detailed in Appendix A of the trust's Standing Financial Instructions. The guidance also includes contact details for the Trust's local counter-fraud specialist (LCFS) and the NHS Fraud and Corruption Reporting Line.

The trust raises awareness of fraud and corruption in many ways, by regular messages on staff payslips, fraud awareness posters, fraud awareness days, intranet articles including fraud alerts, and the trust whistle blowing policy.

Reported concerns are investigated by the trust's local counter-fraud specialist who reports to the director of finance and liaises with NHS Protect and police as necessary. If the reported concerns are substantiated the matter will be pursued in accordance with criminal, civil or disciplinary proceedings, or a combination of these. The trust works hard to create an anti-fraud culture and to prevent and detect fraud and corruption. The local counter-fraud specialist produces a written report to the audit committee.

The Trust partakes in the National Fraud Initiative (NFI). The NFI is the Audit Commission's data matching exercise. It is designed to help participating bodies detect fraudulent and erroneous payments from the public purse. The exercise is run every two years and it works by matching data provided by the Trust against data provided by other participating public bodies, such as payroll, pension payrolls and housing benefits.

Counter Fraud Qualitative Assessments

At the end of each financial year, NHS organisations are required to make a declaration of the counter fraud work they have completed. Using the information captured on the qualitative assessment (QA) declaration an assessment of counter fraud arrangements is made by the NHS Protect. NHS organisations are assessed on their compliance with instructions and guidance outlined by NHS policy. NHS policy is supported by the NHS counter fraud and corruption manual, the risk assessment tool (RAT) and work plan templates that are issued by the LCFS prior to the start of the financial year.

As a result of participating in the 2013/14 exercise utilising the new, revised version of QAs which focused on areas of the counter fraud measures in place, MKHFT has been advised that NHS Protect will not be undertaking a full or focused assessment before 30th June 2014. However, it was stated that the trust may be selected for a thematic assessment or for a triggered assessment. If this happens, NHS Protect will make contact in due course, giving at least four weeks' notice of any assessment. At the time of writing, no such communication had been issued.

Further advice and guidance on the quality assessment programme can be found in the Standards for Providers 2013/14. The Standards are available at http://www.nhsbsa.nhs.uk/3577.aspx.

Information Governance and Data Security

The IGSG oversees the trust's Information Governance Toolkit annual assessment and action plan. Through this governance structure the Trust's Information Governance Statement of Compliance (IGSoC) is assessed on an ongoing and annual basis to ensure connection to the NHS National Network (N3) and the use of the NHS Care Records Service applications. The controls exercised by the trust are compliant with the IGSoC control requirements.

Data security risks are managed via an Information governance framework, which comprises an information governance policy, related policies and guidance and the information governance group (IGSG). In particular, the trust's risk management policy sets out a structured approach to information risk management. This includes the appointment of the senior information risk officer (SIRO), information asset owners (IAOs) and information asset administrators (IAAs). Information risk identification is supported by the maintenance of an information asset register and regular information mapping exercises. Any significant risks identified from these processes are included in the trust's risk register and will therefore be subject to the formal management attention commensurate with the assessed risk.

The trust completes the Information Governance Toolkit (IGT) to demonstrate adequate practice and provide assurance that all aspects of information risk management are appropriately managed. The IGT assessment is externally reviewed by the Trust's Internal Auditors. The SIRO, Caldicott Guardian and IGSG monitor progress and compliance with the IGT on an on-going basis. The SIRO and Caldicott Guardian sit on the Management and trust boards.

The Trust continues to achieve good percentages on the Information Governance Toolkit (IGT) (version 11). In 2012/2103 the Trust achieved 85%, compared with this year 2013/2014 which is currently at 88%.

The trust operates in a complex environment and exchanges data with a number of organisations. The trust therefore continues to prioritise activities to reduce the risk of data loss or accidental disclosure of personal data. information governance policy and guidance is continually reviewed and training and awareness raising programmes target all Trust staff. Information Governance Training includes an assessment of understanding of key aspects of policy and assessment scores will indicate the success of awareness raising activities. Strengthened technical controls will result in a reduction of risk of specific types of data loss, for example preventing the use of unencrypted memory sticks.
The trust has comprehensive and relevant policies covering information governance and security, data quality and records management.

During 2013/14 we had two information governance serious incidents which related to:

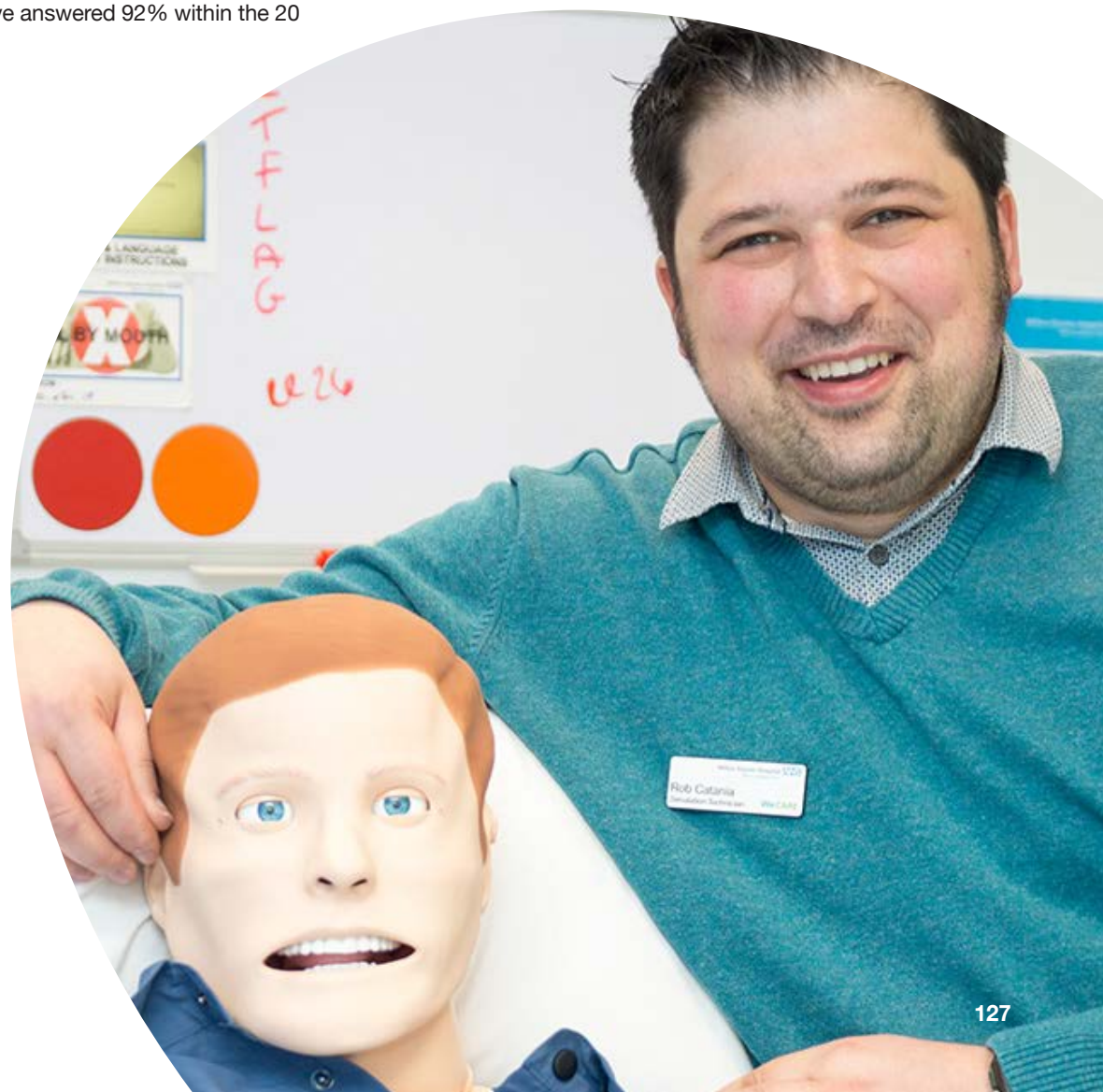
1. Locum doctor in Paediatrics took patient information off site to place of residence. When vacating the premises this was left behind. This breach involved six trusts and was reported to the Information Commissioners office and relevant governing bodies.
2. Two field analysers went missing from the eye clinic, presumed stolen. The analysers were awaiting a data deletion and therefore these contained details of thousands of patients. This breach was reported to the Information Commissioner's Office and other relevant governing bodies including the police.

Cost Allocation and charging requirements

The trust has complied with the cost allocation and charging requirements set out in HM Treasury and Cabinet Office public sector information guidance.

Freedom of Information

Freedom of Information requests have more than doubled this year, the trust received 476 in 2013/14, which included 2956 questions compared to 2012/2013 where 207 requests were received which included 1057 questions. These continue to increase in complexity. The trust continues to deliver an effective service and have answered 92% within the 20 working day deadline.



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 Milton Keynes Hospital 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 Milton Keynes Hospital NHS Foundation Trust for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

Risk management arrangements

- The Board of Directors (Board) has overall responsibility for the effective management of strategic risks identified through the Board Assurance Framework (BAF);
- The audit committee of the Board tests the robustness of the systems and processes surrounding the management of risk throughout the organisation and assures the Board on their adequacy.
- The trust has a systemic process for the identification, recording and management of risk through its specialty, divisional and corporate risk registers and BAF.
- The Board has approved a delegated governance structure through which risks are monitored and managed. This is described in the Board approved risk management strategy and risk management policy.
- Board assurance committees provide the Board with assurance in relation to all aspects of governance, performance and risk management. Each committee reviews relevant risks scored 12 and above on a quarterly basis and if necessary, escalates risks or risk management issues to the Board. The Board considers all risks that are scored 15 and above on the BAF.
- The Board committee structure is shown opposite:

In-year review of risk management arrangements

- The Trust commissioned Price Waterhouse Coopers (PwC) to review its risk management arrangements during 2013/14;
- This independent report made a number of recommendations, including the strengthening of risk reporting, the introduction of a trust-wide corporate risk register, the continued development of the BAF and risk management structures; and
- The Board has adopted the recommendations in full, with implementation on-going into 2014/15 to address residual weaknesses in risk management.

Development of the Board Assurance Framework (BAF)

- The BAF has continued to develop and is used as the principle reporting mechanism for the monitoring and management of strategic risks against the trust's ten objectives;
- The trust revised the BAF following feedback from the internal and external auditors, aligned each risk to strategic objectives and changed the reporting template to enable the trust Board to clearly identify any changes in the risk profile;
- The BAF continues to develop as an active Board management and assurance tool, with presentation and discussion at Board meetings, plus dedicated risk seminars once per quarter.

Risk management structures

Following the in-year independent review of risk management arrangements, the trust revised its risk management structures and director-level responsibility for risk oversight and management. The risk management structure in effect up to 31 March 2014 is described below:

- Until March 2014, the medical director was the executive lead for risk management and clinical governance (day to day responsibility was delegated to the chief compliance officer).
- In March 2014 this function was separated, moving the responsibility for governance assurance to the director of performance and delivery. The medical director retains responsibility for risk management (which includes litigation, complaints and PAL, Datix incident and risk reporting and health and safety).
- Until March 2014 the chief operating officer was the designated executive director lead for health, safety and security, supported by the health and safety advisor, accredited local security management specialist and the trust's fire advisor. This executive lead function is now the responsibility of the director of performance and delivery (from March 2014).
- The Trust's Senior Information Risk Owner is the director of performance and delivery, who is responsible for, and oversees all information risk within the Trust and has undertaken the required training to discharge these responsibilities.
- The Trust's Caldicott Guardian (the medical director) is ultimately responsible for the correct use of patient identifiable information

Staff training on and awareness of risk and risk management

- The trust's mandatory training programme includes responsibilities and processes relating to risk management encompassing fire safety, health and safety and clinical risk. These are included in the induction programme and regular updates are provided for staff. The trust Board receives regular reports regarding mandatory training compliance as part of the monthly performance dashboard.
- Guidance on risk management issues is disseminated to staff through briefing systems (electronically and via meetings) and via the intranet. Good practice and learning is shared through routine communications, training and meetings/committees.
- All directors and divisional managers have a leadership responsibility for risk management within their own areas and are accountable to the Trust Board via general and specific reports

The Risk and Control Framework

The trust's risk management strategy, policy and procedures provide a systematic approach to the anticipation, prevention, mitigation and management of risk across all areas of the trust's business. It is based upon the principles laid down in legislation, government guidance and industry best practice. It is reviewed and audited annually for compliance with legal requirements and with a view to defining areas for further improvement.

The risk management strategy describes the trust's commitment and approach to effective risk management and the systems that the trust has in place or is further developing at a strategic, corporate and operational level to ensure that assurance is provided to the trust Board and to external bodies that risk is being managed effectively within the trust and that the trust promotes a culture of proactive risk management.

Risk management is recognised as a fundamental part of the trust's culture, and an integral part of good practice. It is integrated into the trust's philosophy, practices and business plans. Risk management is the business of everyone in the organisation.

The trust's risk assessment process, investigating incidents, complaints and claims procedures are the principle sources of risk identification. The risk assessment identifies the criteria for risk scoring both likelihood and consequence on a scale of 1 to 5, with the highest risk being accorded a score of 25 (5x5). The risk assessment process also requires an appropriate risk management plan.

The risk assessment process, as described in the risk management strategy, clearly states the escalation of management seniority to monitor management and mitigation of the risk according to its overall likelihood and consequence. The risk assessment process is applied to all types of risk, clinical, financial, operational, capital and strategic.

The corporate risk register procedure requires divisions to maintain and monitor their own risk registers. All divisional risks with a score of 15 or above are reviewed by the management board, finance and investment committee, quality committee and audit committee with a view to being placed on the board assurance framework.

Following the internal audit carried out in May 2013 which highlighted that not all business cases had a risk assessment, the trust has put in a process which included a revised template and now all "business cases" have to be supported with a risk assessment. The scored risk rating strongly influences priorities within the trust capital programme.

The board assurance framework helps provide assurance to internal and external stakeholders in relation to meeting the trust objectives. Assurance of the system is also supported by independent assurance processes – internal and external, and achievement of satisfactory outcomes or results. The audit committee examined the system of risk management at service level by reviewing service risk registers at its meeting in December 2013 and was assured that the processes in the risk management strategy were being adhered to.

The trust commissioned Price Waterhouse Coopers (PwC) to undertake a review of clinical risk management. Considerable progress has been made in strengthening quality governance, including clinical risk management arrangements at the trust over the last few months. The Board has increased the profile and ownership of quality performance and taken steps to strengthen governance arrangements at all levels of the organisation. The recommendations of the review have been incorporated in an action plan which is being implemented and the medical director, Martin Wetherill is responsible for the outcomes. The review of clinical risk management was a requirement of Monitor's provider licence and regular updates are provided to Monitor on progress against the action plan.

The BAF identifies Milton Keynes Hospital NHS Foundation Trust's strategic objectives and principal risks and is developed in consultation with the executive team. The control systems which are used to manage risks are identified together with the evidence for assurance that these are effective. Lead managers and directors are identified to deal with gaps in control and assurance and are responsible for developing action plans to address the gaps.

The Board ensures effective communication and consultation at all levels within the organisation and with external stakeholders. Engagement with stakeholders at various forums such as the Council of Governor's Meetings and Healthwatch meetings provides an opportunity for risk related issues to be raised and discussed.

Key organisational risks 2013/2014

The organisation's key risks are recorded in the Board Assurance Framework and Corporate Risk Register. Forward risks and mitigation plans are also considered in the Trust's Annual Plan submission.

1. Capacity in Emergency Department

The trust's Emergency department, originally built to take a footfall of 17,000 is now servicing more than four times this number of patients. This is putting a strain on the system which is regularly coping with delayed discharges that amount to in excess of a ward's worth of patients. The Trust is planning to provide additional capacity as an interim measure for the winter in 2014/15, but has plans for a longer term solution. The expansion of the emergency department and the longer term solution is dependent on external funding and the trust is working with Monitor to ensure that this funding is secured.

2. Failure to sustain Emergency Department targets

Capacity in the emergency department is the key element to achieving the 95% target of admitting or discharging a patient within 4 hours. Achievement of the target is also dependent on the demand for the service, the acuity of the patients and having appropriate staffing. The trust has invested in medical and nursing staff in emergency department to provide appropriate care for the increasing number of patients.

3. Infection control

Depending on the national target there is a risk of failing to meet the Clostridium Difficile target, recognised in the Targets & Indicators. Following the 2013/14 performance the Trust has commissioned an independent review of cases. It is recognised that there was no cross-contamination and the priority now is on anti-microbial stewardship with the introduction of a new drug chart to assist with the review of medication. The trust has commissioned an external review of the Clostridium Difficile cases to make recommendations to the trust on improvement.

4. Achievement of financial targets

The trust delivered its financial plan in 2013/14 with a £17m deficit against a plan of £17.1m deficit. The trust also delivered cost reduction of £7.4m against a target of £8m. The trust has submitted its two year plan to Monitor and £24.9m deficit is planned for 2014/15. In order to achieve this, the trust must deliver a cost improvement programme of 4% (circa £7.4m, in line with the national tariff adjustment) plus £1m of full-year-effect from 2013/14 schemes. The delivery total of £8.4m equates to just over 4.5% for 2014/15. Monitor recognises the clinical and financial sustainability challenges the trust faces and, with the Trust Development Authority and NHS England, has commissioned a review of Healthcare services for Milton Keynes and Bedford.

5. Electronic Patient Record procurement

The Department of Health has no plans to extend the contract or continue to fund the current Electronic Patient Records services. National guidance and specific legal advice (taken by Department of Health, London trusts, Oxford University Hospitals and others) has all clearly indicated that trusts need to undertake an EU compliant procurement process for software and services provision post October 2015. The project timescales is to secure business continuity beyond the expiry of the current contract in October 2015. The new system should also form a platform for future benefits delivery including both improved clinical safety and clinical effectiveness. Indeed informatics is the key enabler for the trust to meet its strategic clinical and operational goals, and underpins much of the transformation required to deliver the Quality, Innovation, Productivity and Prevention (QIPP) agenda. The risk to the trust is both in terms of timescale for implementation and the cost of the system.

Risk Appetite

The trust is committed to not taking risks that affect would affect care quality or that would place the organisation in breach of regulatory requirements. The Board recognises the need for clearly defined risk appetite against its strategic objectives, as part of its risk management process.

The Board is receiving risk management training, including on risk appetite and will be using the Good Governance Institute risk appetite matrix to develop its risk appetite statement in the first quarter of 2014/15.
This work was not completed in 2013/14 due to the external (PwC) review of risk management arrangements and the subsequent development of the BAF particularly.

The Board will self-certify the validity of its Corporate Governance Statement. A number of compliance assessments review the adequacy of the governance arrangements. These are undertaken by the director of finance who provides assurance on financial performance and the relevant executive director on other areas of governance in relation to the trust's regulations. Assurance on compliance with relevant regulations, internal policies and procedures is undertaken through the trust's Board assurance committee structure; for example CQC registration via the quality committee and fire regulations through the health and safety committee. Compliance assessments are also undertaken by internal audit, which has provided assurances in relation to aspects of the trust's governance arrangements.

The trust was required to commission external assurance on the clinical risk management of the organisation as part of the undertakings of Monitor's Licence Conditions. Price Waterhouse Coopers (PwC) undertook a review and concluded that "considerable progress has been made in strengthening quality governance, including clinical risk management arrangements at the trust over the last few months". PwC recommended further improvements and an action plan have been developed to address these.

Stakeholder Involvement in Risk Management

In order to ensure that risk management is not seen only as an issue that needs to be addressed within the organisation alone there are arrangements in place for working with stakeholders and partner organisations, including close working with Milton Keynes NHS Hospital Foundation Trust.

These cover both operational and strategic issues such as service planning and commissioning, performance management, research, education and clinical governance. Issues arising are fed into the trust's risk capture process and are subject to risk action plans if the risk is graded sufficiently highly on the risk grading matrix referred to above.

Stakeholders attend meetings and are involved with the trust which gives them opportunities to raise issues relating to risks which impact upon them. These stakeholders include for example:

A. Patients and Public

- Patient Experience team
- 15 steps (an assessment of patient areas by patients and Governors
- Local health and Wellbeing Board
- Annual Members Meeting
- Healthwatch
- PLACE survey
- Representatives from local authority, Healthwatch MK, MK CCG and Youth representatives on Council of Governors

B. Staff

- Staff survey
- Staff roadshows
- Monthly 2 way communication CASCADE
- ASK Joe – questions can be submitted to the Chief Executive and are responded to via the intranet
- Whistleblowing policy – which was reviewed and updated in 2013/14

C. Health partners

- There are regular performance review meetings with CCG, GPs and Ambulance Trusts
- Stakeholder membership of working groups
- Involvement in the strategic review of healthcare provision for the residents of Milton Keynes and Bedford.

Governance

Since 2010, the trust has been rated by Monitor, NHS Independent Regulator as at '1' for financial management and 'Red' for quality governance, due to the financial deficit of the trust and the CQC conditions placed on it. This ranked the trust as one of the poorest performing Foundation Trusts in the country. The trust has been monitored on a monthly basis by Monitor and has made some progress in both areas.

The trust Board has continued to receive monthly quality performance and safety reports to provide assurance on quality governance. It includes the high level CQC Essential Standards Dashboard and is discussed at CSU Clinical Improvement Groups (CIG).

There have been changes to the Board of Directors during 2013/14.

Executive Directors

Following the departure of the Kathy Renacre, director of workforce on 31 March 2013, Norma French joined the trust as an interim director of workforce. The director of workforce post has been recruited to substantively, with Ogechi Emeadi commencing with the trust on 31 March 2014.

Duncan Smith changed portfolio from director of finance to director of performance and planning in January 2013 and Robert Toole joined as the interim director of finance. Robert Toole left the trust in June 2013 and Jonathan Dunk became the acting director of finance from his role as deputy director of finance. In March 2014, Jonathan Dunk became the substantive director of finance following an open recruitment process.

John Blakesley joined the trust as interim director of performance and planning on 31 March 2013 and has appointed substantively to the director's post. From 1 April 2014 he trust has a fully substantive executive director team.

Non-Executive Directors

Graham Anderson's term of office came to an end on 28 February 2014. A recruitment campaign was commenced in late 2013 and Tony Nolan was appointed as a non-executive director from 1 March 2014. During the process of recruitment it was acknowledged by the nominations committee that Kate Robinson's term of office was coming to an end in October 2014, and, if there was a suitable candidate, it would be prudent to appoint in an associate non-executive director role until Kate's departure. Dr Jean-Jacques DeGorter was appointed as an associate non-executive director from 1 March 2014. Kate Robinson has tendered her resignation from 30 April 2014.

The trust Board meetings continued to be bi-monthly public meetings with strategic Board of director days during the intervening months which enable more proactive planning of the strategic direction for the trust and to discuss business planning and service delivery issues fully. Deloitte LLP undertook a board development review in 2012/13 and a series of workshops with the Board and the Council of Governors have led to board development plan being agreed. A non-executive director and executive director have been identified to progress each action and a timescale for reporting to Board.

Key issues from the Board of director meetings are cascaded to all staff following these meetings. The visibility of executive directors has been enhanced with the medical director, director of patient care and chief nurse and chief operating officer formally visiting clinical and non clinical areas on a weekly basis. The non-executive directors have undertaken visits to the following areas of the hospital prior to Board meetings:

- Stroke Ward
- A&E
- Outpatients
- Imaging
- Cook and Chill
- Mortuary
- Paediatrics

A programme of NED visits has been developed for 2014/15.

Following the success of the leadership development programme in 2012/13, a second cohort of staff from corporate and clinical areas has embarked on the same programme.

Each month the divisional triumvirates for surgery, medicine and core clinical have a performance review meeting where the director of performance and delivery, director of finance and director of workforce scrutinise the performance of the CSUs and the division as a whole. The divisions have corresponding meetings with each of the CSUs, to ensure that information is being disseminated throughout the organisational structure.

The Board of Directors continue to monitor the improvements in the Children's Services and appointed Kate Robinson (NED) as the as Children's Champions with the support of Darren Leech (director of strategy and estates).

Francis report

The Government required trust's to publish by 31 December 2013 what actions it had taken in response to the Francis report. The trust's response was as follows:

1. Public engagement and patient experience - we will further develop and build on our existing channels for engaging, involving and communicating with patients, the public and staff so we listen to what they are telling us and use their feedback and suggestions to help us continually improve quality. This year we have run our first patient panels where we are getting feedback on the care that we are delivering. In addition we are undertaking 15 Steps walk around with our governors and the public so that they can give us feedback on the ward environment and how welcoming it is.

2. Effective complaints handling procedures - there is currently a national review of the way the NHS handles complaints. We will continue the work we have already begun to review and revise the way we handle and learn from complaints to ensure that issues are addressed in an appropriate and effective manner and that the same problems do not keep re-occurring. We will move the Patient Advice and Liaison Services office so that it is more accessible for our patients and the public. In early 2014 we will be conducting an external review of complaints and looking at both the root cause analysis process and how to better involve patients in the process. Despite the number of complaints reducing the trust is meeting with more families than ever to better resolve their issues and to learn and improve the care that we give.

3. Quality assurance – a review of approaches to assuring on the quality of service provision is already underway which has been externally validated.

4. Risk and incident management - building on existing risk profiling and learning lessons from risk data and incidents. The trust is strengthening its governance team to ensure that all risks are understood and appropriate management actions are in place.

5. Workforce - we will further develop the education and training of our staff to ensure they have the right knowledge and skills, understand the priorities and expectations of them and demonstrate the right values. This includes partnering with the Open University in a number of areas particularly targeted towards Health Care Assistants. The trust has invested more than £2m in medical nursing staff this is to ensure that minimum staffing are met or exceeded and we are working towards the recommendation within the Keogh report on 24x7 working.

6. Organisational Culture - based around the trust's existing culture and values programme, WeCARE, and the external view of the trust's culture. This programme was put together following engagement and consultation with both staff and patients.

7. Rewarding and recognising good practice - we will further develop our systems for this, whether it's by individual staff, a team/department or the whole trust and we will continue to tackle any areas of poor practice and hold people accountable for their actions. We have developed ways of measuring care at ward level which is reviewed monthly by the Board and on available to the public on every ward. At the end of the financial year we plan to celebrate high performing ward areas. All members of staff that have been recognised by the public as having provided exceptional service are written to by the CEO to celebrate their achievement.

The trust will also look at additional ways of incorporating patient stories, staff stories and other personal feedback into quality reporting to the trust Board, Council of Governors and other similar forums.

Incident Reporting

The trust has an online incident reporting system (Datix) which is available for any member of staff to report an incident. A proactive reporting culture has promoted reporting and incidents are monitored and trends identified, including those relating to the same staff members and teams and learning from incidents is shared. An analysis of serious incidents is carried out periodically. Incident reporting is an integral part of induction training which every member of staff has to attend within eight weeks of commencing work with the trust. It also forms part of the risk management training which is mandatory for all staff on a three-yearly basis.

A comparison of incidents and serious incidents for 2012/13 and 2013/14 is given below:

Incident	2012/13	2013/14
Serious Incidents	124 *	**140***
Clinical Incident	3463	**4008**
Non-Clinical Incident	757	**733**
Statement of Concern	570	**540**
Totals	**4914**	**5421**

* To date, 11 of the 2012/13 and 26 of the 2013/14 serious incidents have subsequently been downgraded by the CCG.

There has been a continual increase in the numbers of Serious Incidents over the past five years; however, this should be taken in context with relevant denominators and the openness of reporting.

The trust has a designated person to manage National Patient Safety Agency (NPSA) issues. The Datix manager has responsibility for leading on ensuring compliance with safety alerts as well as reporting applicable incidents to the National Reporting and Learning System (NRLS). These are then analysed by the NHS England (this was previously undertaken by the National Patient Safety Agency (NPSA) and national benchmarking is completed.

The trust encourages staff to report incidents as evidence has shown that organisations who are high incident reporters with low severities are known to have a better and more effective safety culture. It is this culture that helps trusts' assess the quality of the care it is providing and improve safety for both patients and staff. Serious incidents are copied to the risk manager who in consultation with the head of governance and deputy chief nurse ensures that the appropriate level of investigation and root cause analysis is undertaken. The level of investigation is dependent upon the seriousness of the incident and the timeframes set by the Clinical Commissioning Group (CCG), and this is in line with the trust incident reporting policy using a common template. All serious incidents reports are approved by the medical director/ chief nurse and chief executive officer before being reported externally on the STEIS data base.

It is the responsibility of the Clinical Service Units (CSU) to monitor the action plans, lead on implementing improvements and disseminate any lessons learnt from RCA investigations. This is to ensure that the organisation is learning from incidents and minimising recurrence. The CCG randomly selects a number of action plans to review. Part of this process includes the review of evidence to demonstrate completion, improvement and dissemination of learning.

The Trust reported no Never events in 2013/14 compared to two in the previous year.

Care Quality Commission

The quality committee receives reports on quality safety and effectiveness which include information on how the Trust complies with the Care Quality Commission (CQC) essential standards dashboard and the Care Quality Committee (CQC) Quality and Risk Profile (QRP).

The CQC undertook an inspection on 28th February to 1st March 2013 (Inspection against Outcome 14 - Supporting Workers and Outcome 16 -Assessing and monitoring the service quality and provision.) The CQC reported two moderate concerns regarding the outcome of the second CQC inspection. Action plans have been developed and actions monitored. The CQC have not re-inspected the trust on these two outcomes.

The CQC carried out a follow up inspection in June 2013 on 5 Outcomes relating to dignity and nutrition which the Trust had been found non-compliant with in 2012. The standards were met in 3 areas:

- Outcome 1 – People treated with respect
- Outcome 3 – Food and drink to meet people's needs
- Outcome 7 – People should be protected from abuse and their human rights should be protected

Action was required relating to:

- Outcome 13 - Staffing levels
- Outcome 21 – People's personal records should be accurate, kept safe and confidential

MKHFT is fully compliant with the registration requirements of the Care Quality Commission.

Financial governance

Over the last 12 months the trust has delivered material improvements in its internal financial governance which, despite the overall financial position remaining a challenge until a system wide strategic solution is agreed, have led to clear and measurable benefits in performance. For the first time in many years the trust delivered across the range of finance metrics, in a manner consistent with its original planning assumptions, enhancing credibility and building confidence that the financial picture at the trust is clearly understood.

This has been achieved through a number of key actions:

- There has been a focus on implementing and adhering to enhanced governance controls, with clear requirements on all levels of budget management to adhere to updated SFI's.

- The performance management regime has been enhanced with increasing attention on ensuring a clear understanding of variances to financial plans, and development of recovery proposals when deviations have occurred.

- Cash management has been an absolute priority with comprehensive processes established allowing the trust to robustly forecast cash positions and deliver upon external regulatory requirements.

- The manner in which the trust budgets has been fully reviewed, which now means that all budgets are built bottom up, with a clear understanding of the linkages between capacity and what it costs, what levels of activity this can facilitate and therefore the true levels of trust income. Divisions are now required to sign off budgets in advance of plan year commencing, with clear commitment that all aspects of their budgets are consistent and deliverable.

- The trust fully implemented a new activity income monitoring system during the financial year (Civica) which now allows the organisation to understand its billable activity at the most granular of levels, and also to ensure that income from billing to commissioners is far more accurate.

- In conjunction with Monitor an external validation of the 2013/14 annual plan was commissioned early in the financial to ensure it was robust and deliverable. This review, undertaken by trust external auditors Deloitte, found the process, by which the plan had been produced, to be robust, and did not identify any issues with respect to the trust's assumptions, that were considered to be material by the trust or Monitor.

In addition to the above, the trust implemented a clinically led process of investment prioritisation during 2013/14 whereby both capital and revenue investment needs are now determined by a representative board of clinical leaders. This, coupled with requirement to adhere to a revised enhanced process of business case approvals with proper management board sign off, now assures that the organisation is not only following good practice in terms of financial governance but equally at the same time is ensuring all funds are targeted in the most clinically appropriate manner.

In July of 2013, the existing external interim director of finance (DOF) departed the trust and the previous deputy director of finance was acted up into the role. This arrangement continued until April 2014 where these acting arrangements were made permanent following a competitive external process. Thus for the first time in 15 months the trust has a substantive DOF in place which, when coupled with the completion of the permanent director appointment processes in workforce, corporate affairs and performance and delivery, now gives the trust a far greater degree of continuity, assurance and effective governance than has been possible whilst a range of interim arrangements were in place over a number of years.

The trust's transformation programme was fully overhauled during 2013/14 under the externally commissioned leadership of EY. This commission, on a non-recurrent basis, was required to introduce best practice in the way in which savings schemes were identified, planned and then delivered and tracked. This has delivered material improvements in both governance and the outcomes resulting from the transformation programme, with a level of savings delivered in 2013/14 of £7.4m a significant increase on prior years. Furthermore, schemes were tracked in such a way to ensure all savings were absolutely robust and linked to tangible financial savings, meaning comparison with numbers delivered from prior periods sees even more marked improvement.

The external support from EY has also overseen the development of a new substantive internal trust transformation team, who have been grounded in the best practice disciplines introduced during 2013/14. The transition to internal programme leadership is taking place into early 2014/15 and will see EY move into a reduced interim role as providers of governance and assurance to the programme. This will allow the trust to assure that the programme office is sustaining the delivered improvements before any conclusion of the external relationship with EY. The development of the 2014/15 savings programme commenced significantly earlier than in prior years with robust plans for a significant proportion of required savings in place by April 2014.

Information Governance and Data Security

The IGSG oversees the trust's Information Governance Toolkit annual assessment and action plan. Through this governance structure the trust's Information Governance Statement of Compliance (IGSoC) is assessed on an ongoing and annual basis to ensure connection to the NHS National Network (N3) and the use of the NHS Care Records Service applications. The controls exercised by the Trust are compliant with the IGSoC control requirements.

Data security risks are managed via an information governance framework, which comprises an information governance policy, related policies and guidance and the information governance group (IGSG). In particular, the trust's risk management policy sets out a structured approach to information risk management. This includes the appointment of the Senior Information Risk Officer (SIRO), Information Asset Owners (IAOs) and Information Asset Administrators (IAAs). Information risk identification is supported by the maintenance of an information asset register and regular information mapping exercises. Any significant risks identified from these processes are included in the trust's Risk Register and will therefore be subject to the formal management attention commensurate with the assessed risk.

The trust completes the information governance toolkit (IGT) to demonstrate adequate practice and provide assurance that all aspects of information risk management are appropriately managed. The IGT assessment is reviewed by the trust's internal auditors. The SIRO, Caldicott Guardian and IGSG monitor progress and compliance with the IGT on an on-going basis. The SIRO and Caldicott Guardian sit on the management and trust Boards.
The trust continues to achieve good percentages on the information governance toolkit (IGT) (version 11). In 2012/2103 the trust achieved 85%, compared with this year 2013/2014 which is currently at 88%.

The trust operates in a complex environment and exchanges data with a number of organisations. The trust therefore continues to prioritise activities to reduce the risk of data loss or accidental disclosure of personal data. Information governance policy and guidance is continually reviewed and training and awareness raising programmes target all Trust staff. Information governance training includes an assessment of understanding of key aspects of policy and assessment scores will indicate the success of awareness raising activities. Strengthened technical controls will result in a reduction of risk of specific types of data loss, for example preventing the use of unencrypted memory sticks.

The trust has comprehensive and relevant policies covering information governance and security, data quality and records management.

During 2013/14 the trust reported two information governance serious incidents which related to:

1. Locum Doctor in paediatrics took patient information off site to place of residence. When vacating the premises this was left behind. This breach involved six trusts and was reported to the Information Commissioners Office and relevant governing bodies.
2. Two field analysers went missing from the Eye Clinic, presumed stolen. The analysers were awaiting a data deletion and therefore these contained details of thousands of patients. This breach was reported to the Information Commissioners Office and other relevant governing bodies including the Police.

Data Quality

The trust relies on robust information and data to make informed decisions. It is actively engaged with the Milton Keynes Clinical Commissioning Group and management of data quality contract challenges under Schedule 5. The trust actively monitors its national key performance indicators relevant to data quality through the national data quality dashboard produced by the NHS Information Centre.

62 day Cancer indicator

During testing of the 62 day Cancer indicator by the external auditor, it has been found that the written evidence returned from the tertiary centre to the trust's the cancer team has not been timely to align the local system prior to the national system upload via the tertiary centre.

All individual patient records have been reviewed and the cancer team are currently using the evidence in the national database to realign the local data base to reflect the patient pathways. Additional capacity and revised processes are being established to ensure that data is accurately recorded in both systems.

The report to the board uses the data from the national so this will not change our final position, but will ensure that our records are in line on our local system The trust is putting in processes to ensure this issue is resolved going forward and that communications between local and tertiary centres are improved.

Pensions

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure that all employer obligations contained within the scheme regulations are in compliance. 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 and Diversity

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

Sustainability

The trust's 2007 carbon baseline assessment was 12,747 tonnes per annum, with a target to reduce carbon to 9,559 tonnes by 2014/15.

The following table shows Co2 performance per annum to date:

2010/11	11,808 Tonnes
2011/12	11,108 Tonnes
2012/13	11,183 Tonnes
2013/14	10,508 Tonnes

The decrease in carbon from last year will be due in large part to a mild winter with decreased heating requirements and for the first time the use of the trust's medium voltage generators to export electricity to the mains network reducing the reliance on mains voltage as well participation in government backed STOR and Falcon energy saving programs. This combined with a trust initiative to only buy replacement or additional highly rated energy saving appliances wherever possible and on-going staff awareness initiatives to reduce consumption has produced a substantial fall in carbon over the last financial year.

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

Review of Economy, Efficiency and Effectiveness of the Use of Resources

The management board, finance and investment committee and Board of Directors receive and consider reports on the latest financial position of the trust from the director of finance at each of their ordinary meetings. A similar report is circulated to Board members at Board strategy days. This is supported by a "Board dashboard" (again, produced each month) that allows the Board to monitor a set of key indicators including productivity and efficiency measures. The Board dashboard includes comparative benchmarking data primarily from Dr Foster. The Board also reviews its Standing Financial Instructions and Scheme of Delegation annually.

The audit committee is the sub-committee of the Board that supplements the checks of the Board. In particular, it ensures that the work of internal audit is tailored according to the risks and issues facing the organisation; acts as a route by which both internal and external auditors can raise financial and other concerns; and acts as a conduit between the auditors and the non-executive directors. The chair of the audit committee meets with the auditors with no officers present, so that the auditors can informally raise any issues they have. The audit committee also receives quarterly reports from counter fraud and approves the annual counter-fraud plan.

Benchmarking data is obtained for comparison in performance and is reported to the trust Board. An example of this is the Hospital Standard Mortality Rate (HMSR), where the trust used Dr Foster information for benchmarking. Business cases for service development and improvement are robustly challenged during consideration by the management board, following clinical prioritisation and benchmarking data is used as part of the consideration.

Ernst and Young (EY) have continued to support the trust in delivering the We Care transformation programme. In 2013/14 the savings target was £8.4m and £7.4m was delivered. EY has assisted in establishing robust processes for the creation of plans for each project, project management and monitoring of delivery. The transformation board meets on a monthly basis to review progress of the programme and reports to the trust's management board.

The planning process for 2014/15 We Care transformation programme began in December 2013. There have been weekly challenge meetings to challenge progress in the development of the schemes and the trust is significantly further forward in the planning process than at the same point in 2013/14.

Managing Public Money

An explanation of how the trust manages public money is contained in the governance section of the annual report (section 5). It details the governance framework of the organisation, including information about the board's committee structure, attendance at meetings, key areas of work covered at the meetings and an account of corporate governance, including the board's assessment of its compliance with the Monitor's Code of Governance and the departures from it.

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 the 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 following steps have been put in place to assure the Board that the quality report presents a balanced view and there are appropriate controls in place to ensure that the data produced is accurate.

These steps cover areas such as:

- The quality committee overseeing the production of the Quality Accounts to ensure that they reflect the trust's priorities
- The Council of Governors being consulted on the Quality Account and having an opportunity to comment on the quality priorities
- Presenting the Quality Account to the management board giving an opportunity to comment on the content
- Reviewing policies to ensure they are in line with national guidance. Improving systems and processes in response to clinical audit to improve timely prescribing medication to minimise delays in discharge
- Monitoring key quality metrics at the management board and Board of Directors
- Developing the nursing metrics which are reported to management board and Board of Directors. These have showed an improvement of performance across 6 months since the introduction on adult wards. Nursing metrics for maternity and pediatrics are being piloted and will be rolled out in 2014/15
- Monitoring its national key performance indicators relevant to data quality through the national data quality dashboard produced by the NHS Information Centre

The Trust Board monitors performance against key quality indicators and there are two areas which the Trust was not compliant in 2013/14:

1. Clostridium Difficile Infections

The trust was set a challenging target of 12 cases of Clostridium Difficile Infections (C-Diff) for 2013/14. (There were 19 cases in 2012/13 against a target of 14). There has been a significant increase in the number of cases of C-Diff in 2013/14 both nationally and at the Trust, with the total being 37. Each case was tested to ensure that there had been no cross contamination between patients and it was proven that cross contamination had not taken place. The Director of Patient Care, who has the responsibility for Infection Control has commissioned an external review of each case. The report is expected in Q1 of 2014/15 and will be reported to the Trust Board.

2. Referral To Treat (RTT) Performance

There are two national RTT indicators and the Trust's performance is given below:

The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways.	90%	88.8%	**Not Achieved**
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed non-admitted pathways.	95%	97.6%	**Achieved**

In order to reduce the waiting list, the Trust has, with the agreement of Milton Keynes Clinical Commissioning Group, targeted patients on the waiting list who have breached the 18 week RTT deadline. The Trust will be compliant from Q2 of 2014/15 and will enable the Waiting list to be in a sustainable position going forward.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee, quality committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review of the effectiveness of the system of internal control has been informed by advice from the Board, audit committee, external audit, internal audit, local counter fraud specialist, local security management specialist and the independent assurance commissioned in year.

Significant internal control weaknesses of gaps in control

Issue	Process by which identified	Actions being taken
Risk management systems	Internally and through an external assessment by Price Waterhouse Coopers (commissioned by the Trust)	Assessment recommendations being adopted in full Strengthened senior management team
CQC compliance issues	External inspection	Action plans being monitored by Quality Committee. CQC inspection project team being appointed and action plan being developed.
Clostridium difficile infections	Internal performance reporting	Review being undertaken by Health Protection Agency
Capital investment policy	Internal audit	Risk assessments and benefits realisation included as part of the business case process; with oversight at Audit and Finance and Investment Committees
Data Quality – Cancer indicators reported in Quality Account	External audit in assessment of Quality Account	Improved reporting process at the Trust and with tertiary centre and additional internal capacity and revised processes.
Monitor Licence conditions	Monitor	Action taken against Licence conditions for 2013/14 which are being reviewed by Monitor.

Board of Directors

The Board of Directors places reliance upon the audit committee for assurance that the system of internal control is sound. The Board continued to monitor and review the Board Assurance Framework (BAF) and corporate risk register on a quarterly basis. Both these documents are reported to the audit committee at its quarterly meetings. As stated earlier, the interim head of governance is undertaking a review of the corporate risk register and BAF. The revised format of the BAF was considered at the audit committee on 10 March 2014 and was approved trust Board on 2 April 2014.

The trust Board is undertaking a workshop in May 2014 on risk management and evaluation of the risk appetite for each strategic risk on the BAF.

At each meeting the Board reviews the performance of the trust against national and local performance indicators. In tracking the performance of the trust the Board raised concern during the autumn that both in terms of quality and financially the performance of the trust was declining. In particular the Board recognised that correlation in declining performance of indicators that related to increased emergency admissions, emergency department 4 hour maximum wait from arrival to admission/transfer or discharge, length of stay, occupancy rates and cancelled elective procedures.

The governance framework of the trust is defined in the information on the trust Board and its sub-committees and the Council of Governors in Section 5 of the annual report. It explains the scope of each committee and the issues reported to it. The attendance of non-executive directors and executive directors at Board and committee meetings is detailed in Appendix 2 of the annual report.

Monitor's Code of Governance

In January 2014, Monitor published the NHS Foundation Trust Code of Governance (replacing September 2006 version). The purpose of the Code of Conduct is to assist NHS foundation trust boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The Code is issued as best practice advice, but imposes some disclosure requirements which all foundation trusts must comply or explain why they do not comply.

Milton Keynes NHS Foundation Trust uses the Code of Governance to ensure that its governance is in line with best practice. Except in the two special circumstances described below, the trust applies both the main and supporting principles of the code to its governance practices. The table below explains the two points where the trust does not comply with the code of governance, together with an explanation of why it does not.

Provision	Explanation for non-compliance
A.5.6 The Council should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns.	The Council of Governors raise concerns at their regular meetings which members of the Board of Directors attend. In addition, the lead governor meets with the chairman and can raise issues on behalf of the Council. The senior independent director also meets informally with governors to discuss issues and governors can raise concerns through these meetings.
B2.4 The chairman or an independent non-executive director should chair the nominations committee.	The nominations committee believes that the committee should be chaired by a member of the Council of Governors as the Members' Council carried responsibility for its functions. This has been in effect since 2008/9.

The Audit Committee

The audit committee provides assurance to the Board on:

- the effectiveness of the organisation's governance, risk management and internal control systems;
- the integrity of the trust's financial statements, the trust's annual report and in particular the statement on internal control;
- the work of internal and external audit and any actions arising from their work.

The audit committee has oversight of the internal and external audit functions and makes recommendations to the Board and to the nominations committee of the Council of Governors on their reappointment.

The audit committee reviews the findings of other assurance functions such as external regulators and scrutiny bodies and other committees of the Board.

The executive directors have provided all the information contained in the annual report and accounts. The non-executive directors have had an opportunity to comment on the draft document and the audit committee reviews the report and considers it fair, balanced and understandable.

The Finance and Investment Committee

The finance and investment committee focuses on financial and investment issues and takes an overview of operational activity and performance against national and local targets.

Internal Audit

The audit committee agrees an annual risk based internal audit plan and receives reports on the outcomes of the reviews of the system of internal control during the course of the financial year.

In 2013/14 the Head of Internal Audit's opinion states that "Satisfactory assurance can be given as a generally sound system of internal control is in place, designed to meet the organisation's objectives, and controls are generally being applied consistently and effectively. However, some areas for improvement were identified."

The following table contains the Head of Internal Audit opinion of the work carried out by Internal Audit during the year on the effectiveness of the management of those principal risks identified within the organisation's Assurance Framework. The Head of Internal Audit states: "On this basis it is my opinion that for the identified principal risks covered by Internal Audit work the Board has the following assurance":

Principal Objective	Assurance
Become well governed and financially viable.	**Good assurance** Source: Internal Audit report on Finance. **Satisfactory assurance** Source: Internal Audit report on Integrated Governance.
Improve patient safety.	**Satisfactory assurance** Source: Internal Audit report on Complaints and Claims.
Improve clinical effectiveness	**Satisfactory assurance** Source: Internal Audit report on Pharmacy

There were 17 internal audits undertaken in 2013/14 of which 8 final reports have been agreed. Of these 1 was good assurance, 6 satisfactory assurance and 1 was advisory. There were 9 draft internal audit reports of which 3 had good assurance, 3 satisfactory and 3 limited. The draft reports with limited assurance were with regard to CQC compliance, resilience planning and information management and technology (IM&T) - radiology information system (RIS). The trust has supplied evidence for the CQC compliance internal audit at the beginning of 2014/15 and the final report has been received with a satisfactory assurance rating. The IM&T – RIS report was challenged by the trust and the internal auditors have agreed to undertake the audit again

The trust has action plans in place for CQC compliance and resilience planning to implement the recommendations. There has been an improvement in assurance rating for the Board Assurance Framework from limited in 2012/13 to good in 2013/14 and for integrated governance from limited in 2012/13 to satisfactory.

At the end of 2013/14, the trust gave notice to leave the CEAC consortium, the provider of internal audit service for the trust. Some of the consortium had already given notice on the service and the contract was constructed so that the remaining members would have increasing costs. The trust is undergoing a procurement process for the internal audit service.

External Audit

Deloitte LLP, the external auditor provides assurance to the trust on an ongoing basis by regularly attending audit committee and by undertaking the annual audit of the accounts and annual report and a limited assurance review of the Quality Account. The external auditor report is outlined in the annual accounts.

Board Committee Structure review

The new committee structure strengthens the accountability framework by ensuring operational accountability is exercised through the management board before the reports are considered by the Board committee's where the executive are held to account. The workforce assurance committee has been established and has considered the draft workforce strategy which will be consulted upon during the summer for adoption in autumn 2014. The quality board monitors and if required takes action on the quality of care being provided. This will be an internal mechanism for the trust to manage performance and ensure national and local targets are achieved and the requirements of the CQC are met in full.

Going Concern

IAS 1 requires management to undertake an assessment of the NHS Foundation's Trusts ability to continue as a going concern. These accounts have been prepared on a going concern basis as there has been no application to the Secretary of State for the dissolution of the NHS Foundation Trust and the Directors currently believe there is a realistic alternative to doing so. The Directors have therefore prepared these financial statements on a going concern basis.

The trust has prepared its financial plans and cash flow forecasts on the assumption that adequate funding will be received from Milton Keynes Clinical Commissioning Group ("MKCCG") (contractual income), and through the Department of Health (DOH) and Monitor (Public Dividend Capital). These are expected to be sufficient to prevent the trust from failing to meet its obligations as they fall due and to continue until adequate plans are in place to achieve financial sustainability for the trust. However, the directors have identified that there is material uncertainties that casts significant doubt over whether the trust will continue to exist in its current form, and over its ability to discharge its liabilities in the normal course of business.

The current economic environment for all NHS Trusts and NHS Foundation Trusts is challenging with on-going internal efficiency gains necessary due to annual tariff (price) reductions; cost pressures in respect of national pay structures; non-pay and drug cost inflation; as well as nationally set contract penalties for contract performance deviations, combined with commissioner (CCG) expectations to reduce activity through ensuring care can be better provided within the community, i.e. managed outside the hospital.

The trust has incurred a deficit of (£17.0m) for the year ended 31 March 2014. The directors consider that the outlook presents significant challenges in terms of cash-flow for the reasons outlined above, including planned reductions in activity commissioned from the Trust and the need to reduce the underlying cost base of the Trust to continuously align capacity and demand.

The trust is in the process of securing £25.3m of (Public Dividend Capital "PDC") funding to support both the Trust's revenue position for working capital and £7.2m for its capital projects for 2014/15, with discussions with Monitor/DoH on-going. This funding will be required for the duration of the financial year whilst the internal savings plan is embedded and organisational realignment discussions are concluded. Provided the trust is in receipt of these funds the trust should continue to remain a going concern.

The trust is facing a period of unprecedented change over the coming years. During 2013 Monitor, NHS England, along with both Milton Keynes and Bedfordshire CCGs commissioned the 'Milton Keynes and Bedford Healthcare Review'. The first draft of recommendations from that review is expected during the summer of 2014. This could see fundamental economy-wide change to the way that health services are delivered across both areas. The planning undertaken by the trust has recognised that without significant change, the trust will remain in deficit during the foreseeable future.

Positive cash balances are likely to be maintained throughout the period through successfully securing commitments to necessary funding from external bodies (DoH/Monitor) and a contract with the lead commissioner MKCCG that gives assurance of income flows.

The significant risks facing the trust are summarised as follows:

1. The trust has prepared a cash flow forecast which shows a minimum level of headroom of £0.5m. There is a level of uncertainty over whether the trust will receive an additional £32.5m of PDC required to meet its financial obligations. The trust has however developed its financial plan assuming that it will receive this funding and thus continue on a going concern basis.

2. There is uncertainty over whether the trust will achieve its efficiency savings plan of £8.4m which has been assumed in its financial plan. This is a level of savings which is extremely challenging and must be supported with adequate clinical focus and engagement in quality process improvement against agreed and appropriately detailed and delivery plans.

3. There is uncertainty over the level of income that the trust will receive through its national NHS Acute contract with its Commissioners. This is because there is currently a gap between the trust's assumed income and that currently offered by MK CCG. The principal variance is between the trust's plan and the Commissioner intentions, predicated principally on the delivery of admission avoidance schemes in the community. Although, the trust recognises the plan by the MKCCG to implement these schemes, past experience is that the implementation has had limited impact on hospital demand and in thus avoiding patient admissions.

4. The level of financial benefit from the transformation programme in 2014/15 and 2015/16 reduces. This will likely lead to a further challenge to the trust financial position without structural change. The future for Milton Keynes Hospital NHS Foundation Trust is likely to be influenced by the outcome of the jointly commissioned activity (NHS England, Monitor, Milton Keynes CCG and Bedfordshire CCG) currently being undertaken by McKinsey, in respect of the Milton Keynes and Bedford Healthcare Review. This is due to deliver an options appraisal during 2014/15

There is thus, material uncertainties which may cast significant doubt as to the trust's ability to continue as a going concern and therefore it may be unable to realise its assets and discharge its liabilities in the normal course of business. The financial statements do not include any adjustments that would result if the going concern basis were not appropriate.

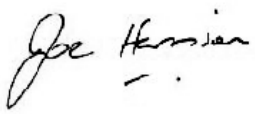
Monitor's Quality Governance Framework

The trust Board is required to evaluate on a quarterly basis the performance of the Trust against Monitor's Quality Governance Framework. In view that the trust could not achieve a financial risk rating of 3 for the next 12 months and that the performance of emergency department in treating patients within 4 hours was not achieved except in Q2, therefore the governance statement has been signed as Not Compliant in all quarters.

The trust Board and assurance committees have regard to Monitor's Quality Governance Assurance Framework in evaluating the performance, internal control and the Board Assurance Framework. Action plans regarding the CQC reports following inspections have been reported to the quality committee to ensure actions are implemented to improve quality on a sustainable basis. The action plan from the PWC also recommended improvements to the governance arrangements of the Trust and progress against the actions is reviewed by Monitor on a monthly basis.

Conclusion

Based on my review, I am aware of significant ongoing internal control challenges that are being addressed by the engagement of external support and expertise to assist with the transformation programme, changes to the committee structure and governance arrangements.



Joe Harrison
CHIEF EXECUTIVE

Section 6

Remuneration Report

Remuneration Report

For the purposes of this report, the disclosure of the remuneration to senior managers in limited to the executive and non-executive directors of the trust. The trust does not link director pay progression to individual performance or award performance related bonuses.

The chair and non-executive directors are responsible for setting the remuneration of the chief executive and executive/ associate directors, while the Council of Governors is responsible for approving the remuneration of the chair and non-executive directors and associate non-executive directors.

In accordance with the constitution, the trust has two committees for this purpose.

The remuneration and expenses for the trust chairman and non-executive directors are determined by the Council of Governors, taking account of the guidance issued by organisations such as the NHS Confederation and Monitor. Remuneration of Trust's most senior managers (executive directors who are members of the trust Board) is determined by the remuneration committee, which consists of the chairman and all the non executive directors.

The remuneration committee is provided with benchmarking information provided by IDS – Executive Compensation on comparable roles in other NHS Trusts when considering the remuneration of executive director positions.

The trust will review the remuneration policy relating to executive directors during 2014/15 and agree a remuneration strategy. Until the remuneration strategy is agreed, the current policy of not link director pay progression to individual performance and of not having performance related bonuses will continue. Both local and national benchmarking information regarding remuneration will continue to be provided to the Remuneration committee.

The table in Appendix 2 sets out the membership and attendance of the remuneration committee for 2013/14. No other party, who was not a member of the committee advised or assisted the remuneration committee in 2013/14.

The remuneration committee took the decision to freeze pay for executives for the period 2013/14, in line with recommendations on national agreements. Details of remuneration, including salaries and pension entitlements of the Board of directors are published in section 4.5 in the annual accounts. Details on the median/mid point and highest paid director are included in Section 4.4 of the annual accounts.

The details of other remuneration, travel and assistance for directors and non executive directors are attached in Table 1.

The only non-cash element of the senior managers' remuneration packages are pension related benefits accrued under the NHS Pensions Scheme. Contributions are made by both the employer and employee in accordance with the rules of the national scheme which applies to all NHS staff.

Senior manager employed on contracts of service are substantive employees of the Trust. Their contracts are open ended which can be terminated by either party with six months notice. The trust's normal disciplinary policies apply to senior managers, including the sanction of instant dismissal for gross misconduct. The trust redundancy policy is consistent with NHS redundancy terms for all staff

For the period until 31 March 2014 there were four trust Board members employed via non payroll engagement: Chris Mellor, Norma French, John Blakesley and Robert Toole.

The chairman's post became vacant due to the resignation of David Wakefield in August 2013 and after discussions with Monitor, the Council of Governors were advised to appoint an interim chair until the position could be filled substantively.

Chris Mellor's contract is due to end at the end of June 2014 and the recruitment process for a replacement chair is underway.

Due to Duncan Smith, director of performance and planning, and Kathy Renacre, director of workforce, leaving the trust at the end of March 2013, it was necessary to contract interim directors to these roles until substantive appointments could be made.

John Blakesley became the substantive director of performance and delivery on 1 April 2014. Previously John Blakesley was employed on a contractual basis from 4 April 2013 to 31 March 2014 in the role of director of performance and planning. The contract specified that 28 days' notice of termination was required by either party.

Norma French joined the trust on a contractual basis from 15 April 2013 to 30 March 2014, as the interim director of workforce. The terms of the contract specified that 1 month's notice by either party and there was no termination payment in the contract. Ogechi Emeadi was appointed as the substantive director of workforce from 31 March 2014 and Norma French was contracted for a handover period of one month and will leave the Trust on 30 April 2014.

Duncan Smith changed executive director portfolio from the role of director of finance to the director of performance and planning in January 2013. It was necessary to contract an interim director of finance to this statutory post until substantive appointments could be made.

Robert Toole was employed on a contractual basis as the interim director of finance from 8 January 2013 to 5 July 2013. The terms of the contract specified that one month's notice by either party and there was no termination payment in the contract.

The trust has made no provision for compensation for early termination and no payment for loss of office for senior managers.

There has been no payments to past senior managers.

In response to the Treasury recommendation, the trust has incorporated into its standard contractual terms and conditions the requirement to allow the Trust to seek assurance around tax obligations.

Table 1: For all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last for longer than six months

No. of existing engagements as of 31 March 2014	5
Of which:	
No. that have existed for less than one year at time of reporting.	1
No. that have existed for between one and two years at time of reporting.	4
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014, for more than £220 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	1
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	1
No. for whom assurance has been requested	1
Of which:	
No. for whom assurance has been received	1
No. for whom assurance has not been received	0
No. that have been terminated as a result of assurance not being received.	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2013 and 31 March 2014

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	6
No. of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements.	0

Reasons for off payroll contracts

Board of Directors

Interim Director of Finance
Robert Toole

Due to a change in executive director portfolios January 2013. It was necessary to contract an interim director to this statutory post until substantive appointments could be made.

Director of Workforce
Norma French

The interim director of workforce was required to fill a vacancy urgently and a successful recruitment campaign has taken place with a substantive appointment made on 31 March 2014.

Chairman
Chris Mellor

The interim chairman was appointed following a recommendation by Monitor to fill the vacancy. A recruitment campaign underway with a commencement date expected of June 2014.

Senior Officials with Significant financial responsibility

Director of Performance and Planning, John Blakesley (Non voting member of the Board)

The interim director of performance and planning was required to fill a vacancy urgently and from April 2014 will be on the payroll.

Chief Pharmacist

The interim chief pharmacist was required to fill a vacancy urgently and a successful recruitment campaign has taken place. The appointed chief pharmacist will commence in June 2014.

Transformation Lead

A transformation lead was required for a specific project with a specific skill set. The contract for this post is due to be reviewed in April 2014

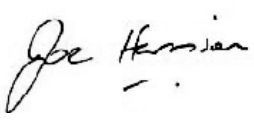
Governor Expenses

Governors are permitted to claim an allowance of £10 for any meeting of the Council of Governors they attend or an external meeting that they attend on behalf of the Trust e.g. Healthwatch:MK Executive. Details of the claims made in 2013/14 are attached at table 2.

As part of the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, the Trust is required to publish the following:

a. off payroll engagements at a cost of over £58,200 per annum
b. Off-payroll engagements between 2013/14 for more than £220 per day and more than six months.

Details of these payments are included in the Remuneration Statement below.



Joe Harrison
CHIEF EXECUTIVE

Salaries & Expenses- Directors Remuneration Statement 2013/14

Name and title	Year Ended 31 March 2014				
	Salary (Bands of £5,000) £	Other Remuneration (Bands of £5,000) £	Travel & Subsistence (Bands of £5,000) £	Pension Benefits (Bands of £2,500) £	Total (Bands of £5,000) £
Joe Harrison- started Feb 2013 Chief Executive Officer	165-170	0	0-5	17.5-20	**190-195**
Jonathan Dunk - started July 2013 Director of Finance	80-85	0	0-5	N/A	**80-85**
Robert Toole (Penna PLC) - started Jan 2013, left June 2013 * Interim Director of Finance	95-100	0	0-5	N/A	**95-100**
Duncan Smith- left April 2013 Director of Finance until Dec 2012 Director of Commercial Development from Dec 2012, left April 2013	N/A N/A	0 0	0 0-5	N/A 0-2.5	**0** **0-5**
Lisa Knight - started Oct 2012 Director of Patient Care / Chief Nurse	100-105	0	0	17.5-20	**115-120**
John Blakesley started April 2013 * Interim Director of Planning & Performance - from April 2013 to March 2014 Interim Director of Performance & Delivery - from March 2014	265-270 5-10	0-5 0	0-5 0	N/A N/A	**270-275** **5-10**
Darren Leech - Started Dec 2011 Chief Operating Officer to March 2014 Director of Strategy & Estates from March 2014	100-105 5-10	0 0	0-5 0	5-7.5 0-2.5	**105-110** **5-10**
Ogechi Emeadi - started 31st March 2014 Director of HR & Workforce Development	0-5	0	0	N/A	**0-5**
Norma French started April 13, left March 2014 * Interim Director of HR & Workforce Development	130-135	0	0	N/A	**130-135**
Kathy Renacre - left April 2013 Director of HR & Workforce Development	N/A	0	0-5	0-5	**0-5**
Martin Wetherill from June 2011 Medical Director	175-180	0	0-5	7.5-10	**180-185**
Chris Mellor- started October 2013 * Interim Chairman	115-120	0-5	5-10	N/A	**120-125**
David Wakefield - Started April 2011, left Sept 2013 Chairman	15-20	0	0-5	N/A	**15-20**
Kate Robinson Non executive director	10-15	0	0	N/A	**10-15**
Tony Nolan - Started March 2014 Non executive director	0-5	0	0	N/A	**0-5**
Dr Jean-Jaques De Gorter- Started March 2014 Non executive director	0-5	0	0	N/A	**0-5**
Robert Green - Started Jan 2013 Non executive director	10-15	0	0-5	N/A	**10-15**
David Moore - Started Feb 2012 Non executive director	10-15	0	0-5	N/A	**10-15**
Frank Burdett - Started Feb 2012 Non executive director	10-15	0	0-5	N/A	**10-15**
Penny Emerson - Started Feb 2012 Non executive director	10-15	0	0	N/A	**10-15**
Graham Anderson - left Feb 2014 Non executive director	10-15	0	0	N/A	**10-15**

Notes* The costs associated with these Directors are the total cost, inclusive of VAT, of the professional service provided and includes other costs associated with providing the service.

Salaries & Expenses- Directors Remuneration Statement 2012/13

Name and title	Year Ended 31 March 2013 Salary (Bands of £5,000) £	Other Remuneration (Bands of £5,000) £	Travel & Subsistence (Bands of £5,000) £	Pension Benefits (Bands of £2,500) £	Total (Bands of £5,000) £
Joe Harrison- started Feb 2013 Chief Executive Officer	25-30	0	0	12.5-15	**40-45**
Mark Millar (Millar Management Associates part time) - left Jan 2013 * Interim Chief Executive Officer	215-220	0	15-20	N/A	**235-240**
Robert Toole (Penna PLC) - started Jan 2013, left June 2013 * Interim Director of Finance	70-75	0	0-5	N/A	**70-75**
Duncan Smith- left April 2013 Director of Finance until Dec 2012 Director of Commercial Development from Dec 2012, left April 2013	95-100 30-35	0-5 0-5	0-5 0	5-7.5 0-2.5	**105-110** **35-40**
Lisa Knight - started Oct 2012 Director of Patient Care / Chief Nurse	40-45	0	0	N/A	**40-45**
Gillian Prager (Gemp Associates) - started Aug 2012 & left Oct 2012 * Interim Director of Nursing	30-35	0	0-5	N/A	**30-35**
Tony Halton - left Sept 2012 Director of Nursing	40-45	0-5	0-5	0-5	**50-55**
Maria Wogan (part time) - left Dec 2012 Director of Corporate Services	35-40	5	0	0-5	**40-45**
Louise Watson (Secondment West Sussex PCT) started Oct 2011 & left Nov 2012* Director of Commercial Development	75-80	0	0-5	5-10	**80-85**
Darren Leech - Started Dec 2011 Chief Operating Officer to March 2014	110-115	0	0-5	12.5-15	**125-130**
Kathy Renacre - left April 2013 Director of HR & Workforce Development	90-95	0-5	0-5	2.5-5	**100-105**
Martin Wetherill from June 2011 Medical Director	175-180	0	0-5	75.5-77	**255-260**
David Wakefield - Started April 2011, left Sept 2013 Chairman	45-50	0	0-5	N/A	**50-55**
Kate Robinson Non executive director	10-15	0	0	N/A	**10-15**
Robert Green - Started Jan 2013 Non executive director	0-5	0	0-5	N/A	**0-5**
David Moore - Started Feb 2012 Non executive director	10-15	0	0-5	N/A	**10-15**
Frank Burdett - Started Feb 2012 Non executive director	10-15	0	0-5	N/A	**10-15**
Penny Emerson - Started Feb 2012 Non executive director	10-15	0	0	N/A	**10-15**
Graham Anderson - left Feb 2014 Non executive director	10-15	0	0	N/A	**10-15**
Ian Mackie - Started Feb 2012 and left Dec 2012 Non executive director	5-10	0	0	N/A	**5-10**

Notes* The costs associated with these Directors are the total cost, inclusive of VAT, of the professional service provided and includes other costs associated with providing the service.

Allowances - Directors Remuneration Statement

Name and title	Year ended 31 March 2013 Other (Bands of £5,000) £	Year ended 31 March 2013 Travel & Subsistence (Bands of £5,000) £	Year Ended 31 March 2014 Other (Bands of £5,000) £	Year Ended 31 March 2014 Travel & Subsistence (Bands of £5,000) £
Joe Harrison- started Feb 2013 Chief Executive Officer	0	0	**0-5**	**0-5**
Mark Millar (Millar Management Associates) - left Jan 2013 * Interim Chief Executive Officer	0	15-20	**0**	**0**
Jonathan Dunk - started July 2013 Director of Finance	N/A	N/A	**0-5**	**0-5**
Robert Toole (Penna PLC) - started Jan 2013 * Interim Director of Finance	0	0-5	**0**	**0-5**
Duncan Smith- left April 2014 Director of Finance until Dec 2012 Director of Commercial Development from Dec 2012, left April 2014	 0-5 0-5	 0-5 0	 **0** **0**	 **0** **0-5**
Lisa Knight - started Oct 2012 Director of Patient Care / Chief Nurse	0	0	**0**	**0**
Gillian Prager (Gemp Associates) - started Aug 2012 & left Oct 2012 * Interim Director of Nursing	0	0-5	**0**	**0**
Tony Halton - left Sept 2012 Director of Nursing - left	0-5	0-5	**0**	**0**
John Blakesley started April 2013 * Interim Director of Commercial Development - started April 2013, left March 2014 Director of Performance & Delivery - started March 2014	 N/A N/A	 N/A N/A	 **0-5** **0**	 **0-5** **0**
Maria Wogan - left Dec 2012 Director of Corporate Services	0-5	0	**0**	**0**
Louise Watson (Secondment West Sussex PCT) - started 17th Oct 2011 and left Nov 2012* Director of Commercial Development	0	0-5	**N/A**	**N/A**
Darren Leech - Started Dec 2011 Chief Operating Officer to March 2014 Director of Strategy & Estates from March 2014	 0 0	 0-5 0	 **0** **0**	 **0-5** **0**
Ogechi Emeadi - started 31st March 2014 Director of HR & Workforce Development	N/A	N/A	**0**	**0**
Norma French started April 2013, left March 2014 * Interim Director of HR & Workforce Development	N/A	N/A	**0**	**0**
Kathy Renacre - left April 2014 Director of HR & Workforce Development	0-5	0-5	**0**	**0-5**
Martin Wetherill from June 2011 Medical Director	0	0-5	**0**	**0-5**
Chris Mellor- started October 2013 * Interim Chairman	N/A	N/A	**0-5**	**5-10**
David Wakefield - Started April 2011, left Sept 2013 Chairman	0	0-5	**0**	**0-5**
Kate Robinson Non executive director	0	0	**0**	**0**
Tony Nolan - Started March 2014 Non executive director	N/A	N/A	**0**	**0**
Dr Jean-Jacques De Gorter- Started March 2014 Non executive director	N/A	N/A	**0**	**0**
Robert Green - Started Jan 2013 Non executive director	0	0-5	**0**	**0-5**
David Moore - Started 21st Feb 2012 Non executive director	0	0-5	**0**	**0-5**
Frank Burdett - Started 21st Feb 2012 Non executive director	0	0-5	**0**	**0-5**
Penny Emerson - Started 21st Feb 2012, left Feb 2014 Non executive director	0	0	**0**	**0**
Graham Anderson - left Feb 2014 Non executive director	0	0	**0**	**0**
Ian Mackie - Started Feb 2012 and left Dec 2012 Non executive director	0	0	**N/A**	**N/A**

Table 2
Governor Expenses 2013/14

Governor	Amount £
Barbara Senior	60.00
Lesley Bell (To May 2013)	100.00
Arun Nathan (Oct 2013	9.40
Lesley Bell (May to Nov 2013)	100.00
Lesley Bell (Nov – Jan 2013)	100.00
Arun Nathan (Feb 2014)	8.00
Arun Nathan (Dec 2013)	10.40

Governor Expenses 2012/13

Governor	Amount £
Bob Collard	140.00
Lesley Bell	200.00
Bob Collard (Feb – Nov 2012)	100.00
Barbara Senior (2011 – May 2013)	357.75
Lesley Bell (Oct – Dec 2012)	100.00

Section 7

Membership Report

Membership Report

Milton Keynes NHS Foundation Trust is committed to establishing and growing an effective membership and during 2013/14, a number of steps have been taken to improve engagement and increase membership.

Although public membership figures have remained fairly static, we are confident that our membership is active, that all members are informed about the benefits of membership and are empowered to have an input into the development of the trust. An audit of the membership database in 2013/14 resulted in a number of members being removed, for various reasons e.g. moved out of area.

The trust has continued to providing members with news about the hospital, information, dates for their diaries and 'members only' incentives and discounts negotiated by the trust with local companies.

Number and analysis of members

	2012/13	2013/14
Public constituency		
At year start 1 April	6,192	**6,177**
New members	196	**83**
Members leaving	211	**307**
At year end 31 March	6,177	**5953**
Staff constituency		
At year start (1 April)	3,352	**2,948**
At year end (31 March)	2,948	**3,016**
Public constituency Age (years)	**Number of members**	**(% of total)**
0-16	17 (0.28%)	**7 (0.11%)**
17-21	211 (3.4%)	**165 (2.77%)**
22+	1912 (30.95%)	**1919 (32.23%)**
Not declared	4,037 (65.35%)	**3865 (64.92%)**
Ethnicity		
White	4891	**4711**
Mixed	79	**98**
Asian or Asian British	285	**350**
Black or Black British	278	**249**
Other	168	**74**
Not declared	482	**471**
Gender		
Male	2,456	**2,367**
Female	3,721	**3,586**

Our governors

Governors have been or are currently involved in various groups and committees, these include:

- Engagement group
- Nominations committee
- PLACE inspection team
- 15 Steps initiative which evaluates the environment of hospital areas from the patient's perspective on the first 15 steps made.

Membership constituencies

The trust has staff and public constituencies, and also has nominated governors representing local stakeholders in partnership constituencies.

Public Constituencies	Membership
Bletchley & Fenny Stratford, Denbigh, Eaton Manor, Whaddon	2
Emerson Valley, Furzton, Loughton Park	2
Linford South, Bradwell, Campbell Park	2
Hanslope Park, Olney, Sherington, Linford North, Newport Pagnell North and NP South	2
Walton Park, Danesborough, Middleton, Woughton	2
Stantonbury, Stony Stratford, Wolverton	2
Outer catchment area (including Parishes in the areas of Buckingham, Winslow, Leighton Buzzard, Linslade, Woburn Sands, Hanslope, Old Stratford, Beachampton, The Horwoods, The Brickhills, Woburn)	2
Extended area	1

Staff Constituencies	Membership
Doctors and Dentists	1
Nurses and Midwives	2
Scientists, Technicians & Allied Health Professionals	1
Non-clinical staff groups, e.g. Admin & Clerical, Estates, Finance, HR & Management	3

Partnership	Membership
MK CCG	1
Milton Keynes Business Leaders	1
MK Council for Voluntary Organisations	1
MK Youth Council Representatives	2
Local Authority	1
Healthwatch MK	1

Staff constituency

Within the terms of the Constitution, all staff are automatically members unless they decide to opt out of membership, providing they have been appointed to a post for a minimum period of twelve months. Staff membership has increased over the last 12 months due to an increase in the number of staff.

Public constituency

Members of the public living within the trust's catchment area who are over the age of 14 and not employed by the trust are entitled to become public members. To be a representative on the Council of Governors, applicants should be aged 16 years or over.

The areas of the public constituency and the number of current members are shown below:

Public Constituencies	Members
Bletchley and Fenny Stratford, Denbigh, Eaton Manor and Whaddon	1189
Emerson Valley, Furzton, Loughton Park	853
Linford South, Bradwell, Campbell Park	902
Hanslope Park, Olney, Sherington, Newport Pagnell North, Newport Pagnell South, Linford North	712
Walton Park, Danesborough, Middleton, Woughton	905
Stantonbury, Stony Stratford and Wolverton	839
Outer catchment area: - (Buckingham, Winslow, Leighton Buzzard, Linslade, Woburn Sands, Hanslope, Old Stratford, Beachampton, The Horwoods, The Brickhills, Woburn)	461
Extended catchment area	92
Total	**5953**

The trust currently has 5,953 public members 3,016 staff members on its membership register. The total membership is therefore 8,969.

The ethnicity of the membership broadly matches the ethnic composition of the local population. The trust has been reaching out to engage with groups typically perceived as 'hard-to-reach', such as those of diverse ethnic origin and social backgrounds. The gender balance is currently skewed towards women. This may be because women are generally more actively involved in their healthcare, and are more likely to come into contact with health-related organisations as women traditionally – and still today – are more likely to take on the role of care giver for their family.

Membership recruitment and engagement

The trust's membership continues to be developed by the communications team and trust secretary. Additionally, some of the trust's governors have been very active in assisting to recruit new members. Initiatives undertaken during 2013/14 include:

- Membership promotion at local public events e.g. Here's Healthwatch event November 2013
- Procedures in place for dealing with applications for membership - including freepost address, dedicated membership office telephone number, email and web links
- Trust website and local media
- Improved communications for members.
- Established two-way feedback systems, so that staff and community members have appropriate channels to feedback their ideas concerns, raise issues and ask questions
- Securing discounts for members on a wide range of goods and services that are offered to NHS staff
- Negotiating with local businesses for discounts for staff, volunteers and members.
- Demonstrating the value of membership through publicising events for members
- Encouraging members to bring their friends and family to events and becoming members too
- Articles about membership and opportunities to engage with the trust have been published in newsletters for stakeholders and in publications sent out to various local organisations
- Membership promoted at designated points throughout the trust, including reception areas (though leaflets and posters), patient experience team and voluntary services.

Engaging young people

Historically the trust has struggled to recruit young members, with 172 members aged 21 or younger. The MK Youth Council has appointed two representatives to sit on the Council of Governors, to give their views on the services provided for young people. One of the representatives is actively involved in paediatric service improvements.

Partner and external organisations

Trust staff and governors continue to talk with partner and external organisations, the trust secretary and governors were also involved in the Here's Healthwatch event and other local events.

The engagement group have also developed a leaflet for the residents in their constituency and the local community council providing information on their role and how they can be contacted. This will be distributed in early 2014/15.

Seldom heard, minority groups and people with disabilities

It is important that the trust fairly reflects the community it provides services for, because representative membership ensures the trust reaches everyone and provides them with the services they require. The trust is committed to engage with individuals or groups who find joining the membership difficult, unappealing, or who are unaware of hospital membership.

In 2013/14 a sensory loss group undertook a visit to the hospital with staff, governors and a non executive director to give their recommendations on how improvements could be made to the environment which would assist visually impaired people. Actions are being taken to address these recommendations and will be considered as part of any proposed changes to the environment.

Contacting Council of Governors

Anyone wishing to contact our Council of Governors or directors, or enquire about becoming a member, can do so in writing or by using a dedicated membership email address (foundation.members@mkhospital.nhs.uk). Contact can also be made directly by telephoning the Membership Office on 01908 243300.

Anyone wishing to contact a governor can do so via email or writing to the trust secretary (Michelle.evans-riches@mkhospital.nhs.uk). Guidance on this is provided on membership application leaflets, in the membership magazine, on the letters that are sent out in the membership packs and on the website.

The following freepost address is specifically for use by members to facilitate communication. Freepost RLXB-TUUR-JCLS, c/o Membership Officer, Oak House, Milton Keynes Hospital NHS Foundation Trust, Standing Way, Eaglestone, Milton Keynes, Buckinghamshire, MK6 5LD.

Section 8

Financial Review

Going Concern Statement
Annual Accounts

Financial Review

Regulatory Ratings

Milton Keynes Hospital NHS Foundation Trust is regulated by Monitor, the sector regulator for health services in England. During 2013/14 Monitor have changed the way that they measure financial risk. Historically this had involved a weighted average of five metrics which provided a 'Financial Risk Rating' where '4' represented least risk and '1' represented most risk. In 2013/14 a measure of 'Continuity of Services rating' has been established where '4' represents least risk and '1' most risk. Details of how 'Continuity of Services ratings' are calculated can be found on the Monitor website: **www.monitor-nhsft.gov.uk**

The Trust continues to measure performance on a monthly basis and taking additional actions where required, with quarterly self-declarations submitted to Monitor, which are shown below. These recognise that the Trust remains subject to Enforcement Action whilst improving services and performance.

	2012/13 Actual				2013/14				
					Annual Plan	Actual			
	Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4
Under the Compliance Framework									
Financial risk rating	1	2	1	2	1	1	1		
Governance risk rating	R	R	R	G	Amber / Red	R	R		
Under the Risk Assessment Framework									
Continuity of Services rating								2	1
Governance rating								R	R

Income Disclosures are Included in the Notes to the Accounts

The trust can confirm that the income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purpose. This is in accordance with Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

Principle Financial Risks and Uncertainties

Milton Keynes Hospital NHS Foundation Trust is facing a period of unprecedented change over the coming years. During 2013 Monitor, NHS England, along with both Milton Keynes and Bedfordshire CCGs commissioned the 'Milton Keynes and Bedford Healthcare Review'. The first draft of recommendations from that review is expected during the summer of 2014. This could see fundamental economy-wide change to the way that health services are delivered across both areas.

The planning undertaken by the trust has recognised that without significant change, the Trust will remain in deficit during the foreseeable future. A deficit of £24.9m is anticipated for 2014/15, which recognises sizeable and essential investment in meeting and maintaining quality standards, and the fact that the organisation lacks the economies of scale enjoyed by other larger trusts. Ongoing deficits of this magnitude come with increasing cash pressures and the trust has been, and continues to be, funded by public dividend capital injections from the Department of Health.

The need for system wide change reflects not only the trust financial position, but also the increasing challenge of maintaining financial sustainability in the local commissioning environment. It is recognised that without change the Milton Keynes (and neighbouring Bedford) systems will be financially unviable and commissioners will be unable to finance the volumes of activity being undertaken across provider functions. This presents real challenges and concerns for the trust with regard to ongoing ability of local commissioners to be able to fund patient activity which is being undertaken.

As with all NHS Trusts, Milton Keynes Hospital NHS Foundation Trust is required to achieve c.4% (approx. £8.0m) savings year-on-year which have historically been delivered from internally focused opportunities. A critical reason for a wider healthcare solution is that individual single-site organisations increasingly find it more difficult to identify this level of savings without external collaboration.

Operationally and financially perhaps the biggest single challenge facing the trust in the immediate sense is its ability to recruit and retain staff at levels which are necessary to deliver high quality and effective services. Increasingly this is not due to any perceived lack of attractiveness of Milton Keynes hospital as a place to work, in fact quite the opposite with tangible evidence that the focus on improving quality, alongside developments such as the academic centre, is making the trust a popular choice for employees to select when deciding between NHS employers. However the lack of suitable nursing or medical candidates across the health system means it is an extremely competitive market and in addition many such staff now choose to work flexibly as locums or via agency. This carries significant premium costs, with Agency spend at the trust at unsustainably high levels, reflecting an average premium of 50% on regular costs for such staff. The Trust are placing huge focus on addressing this issue in its planning for 2014/15 through sustainable, and sometimes innovative, recruitment and retention solutions.

The risks for the trust are included in the Going Concern Statement as detailed below.

Financial Risk management

The Trust's financial instruments, and risk thereof, are described on page 216 of the Financial Statements (note 23 Financial Instruments). The trust continued to only use the Government Banking Service account for its deposits.

The key financial risks facing the NHS Foundation Trust are outlined below:

- The Milton Keynes Clinical Commissioning Group has a programme of service pathway changes and other demand management initiatives that, if delivered, would significantly reduce activity in the hospital and the financial sustainability of the Trust, unless costs could be taken out in full. The trust will continue to work closely with commissioners over the coming year to mitigate these risks.
- The transformation programme is core to the success of the trust, while improving the quality of services and the safety of patients paramount. This programme requires a challenging but realistic financial saving to be realised, and performance improvement delivered.
- The Department of Health, with support from Monitor, has provided public dividend capital to fund the trust's working capital position whilst the future strategic solution for the trust is finalised. This support is integral to the short-term viability of the trust.

Further information regarding the principal risks facing the organisation are given throughout the report as well as in the Statement of Accounting Officer's Responsibilities (page 182, Financial Statements) and Annual Governance Statement (page 74)

Development of the Business During the Year

The trust's emergency department, originally built to take a footfall of 17,000 is now servicing more than four times this number. This has put a strain on the system which is regularly coping with delayed discharges that amount to in excess of a ward's worth of patients. Working in conjunction with Emergency Care Intensive Support Team (ECIST), the trust has undertaken a review of emergency services within the Trust and their associated pathways and during 2013/14 implemented an ambulatory emergency care unit to treat and discharge emergency Care patients in one day where clinically appropriate to do so. This is just one of the measures that has enabled the organisation to improve its performance in respect of the emergency department 95% target.

Recognition of the volumes of patients currently being seen within the emergency department has led to a commitment from both Monitor and Milton Keynes CCG (MKCCG) to support the Trust with implementing a short-term interim emergency department solution to expand capacity as well as continuing to develop plans for a longer term solution, the common front door.

For the first time in a number of years, the trust has fully committed its Capital programme and this has enabled a number of investments across the trust which have, and will continue to make, a real improvement to patient care, these include;

- Redevelopment of the paediatric areas to enable additional capacity and parent facilities
- Relocation and development of a patient discharge unit for patients ready to be discharged to avoid bed-blocking and unnecessary time on acute wards
- Improvements to safety across the site including the provision of new crossings from car parks, speed bumps and improved lighting
- Digital replacement of our radiology / imaging equipment within emergency department
- The provision of a dedicated paediatric imaging area within emergency department

The trust has also seen improved relationships with its main Commissioner this year, MKCCG, which has led to active partnerships in a number of initiatives, including focussing on avoiding admissions for certain cohorts of elderly patients. This has also lead to the organisations having a signed contract for activity for 2014/15 by 31st March 2014. The CCG is committed to reducing demand in the acute setting and the trust continues to work closely with them on this.

Key Financial Performance Indicators March 2014

Area	Metric	Measure	Plan	Actual	Status	Comment
Achievement of plan	Achievement of Plan	<50% (FRR 1) of plan	£2.9m	(£5.5m)	Not Achieved	This variance is due to £4.0m of transformational support being funded as PDC which has no I&E benefit, whereas the plan included this as an income stream.
	Capital spend against plan (accruals basis)	+/- 15% of plan for the year to date. Actual % determined by current Monitor capital plan	between 85% - 115% of plan	100.0%	Achieved	This Trust achieved the capital expenditure plan by the end of March.
	Workforce	YTD WTE against planned trajectories	2704	2821	Not Achieved	Revised Plan now reflects ongoing funded establishment inc. approved business cases. Plan assumed 31 WTE reduction in workforce from Oct 13. Workforce expected to remain above plan following investment in Nursing.
Underlying performance	Underlying Performance	FY14 (FRR 1) <1%	YTD: 1.8%	-3.2%	Not Achieved	This is due to £4.0m of transformational support not having an I&E benefit as planned.
	Patient income variance to plan	YTD performance against plan	£147.9m	£158.4m	Achieved	
	Delivery against Tx Performance target	YTD performance against planned trajectories	£8.0m	£7.4m	Not Achieved	Slipped behind plan at the end of year. Higher than planned levels of activity prevented the Trust from achieving its target. Draft figures still subject to approval by the Transformation Programme Board.
Financial efficiency	Return on assets after financing*	FY14 > -2% (FRR 1)	YTD: -8.1%	-12.0%	Not Achieved	This is due to the lower EBITDA driven mainly by the £3.4m transformational support not having an I&E benefit.
	I&E surplus margin*	FY14 -2.0% (FRR1) or greater	YTD: -6.9%	-9.6%	Not Achieved	This is due to the lower EBITDA driven mainly by the £3.4m transformational support not having an I&E benefit.
	National reference cost index		100.0	101.1	Not Achieved	Reference Cost Index for FY13 now updated. Despite the Trust's financial position it is only just starting to creep beyond the national averages on cost of delivery.
Working Capital	Liquidity ratio	>10 days (FRR 1) cover - Cash plus trade debtors plus unused WCF less trade creditors expressed as the number of days operating expenses that could be covered	YTD: -26.3	-22.6	Achieved	Working Capital Facility (WCF) is not in place. This is better than plan due to lower creditors and higher debtors for expected over performance income.
	Cash variance to plan		1.6	0.5	Not Achieved	The Trust's year end cash forecast was revisited during the year and as per DoH reles on PDC support, the Trust's Year End Cash position was revised to £0.5m.
	Debtors	90 days past due account for more than 5% of total debtor balances	< 5.0%	9.7%	Not Achieved	This is due to invoice for Clinical Navigator support from the CCG which is out standing and over seas and private patient invoices.
	Creditors	90 days past due account for more than 5% of total creditor balances	< 5.0%	3.1%	Achieved	This is due to a continuation clear down of invoices on hold.
Continuity of service	Liquidity ratio	< -14 days (FRR 1) cover - Cash plus trade debtors less trade creditors expressed as the number of days operating expenses that could be covered		-22.5		This ratio now exludes any recognition of a Trust having a Working Captial Facility.
	Capital Service Ratio	<1.25x (FRR 1), it's the degree to which the Trust's operating surplus, excluding depreciation, covers its financing obligations i.e. PDC, loan interest & Finance lease costs		-1.06 times		This is a negative as the Trust has an operating deficit.

Impending developments and Future Development Trends

The level of general population growth has added approx. 9% to the emergency demand but extra growth in Milton Keynes has increased that to 17% partly due to size of population and partly due to the population ageing twice as fast at the national average. The marginal rate emergency threshold has remained at 2008/09 levels which has created a financial pressure on the trust. Milton Keynes CCG is actively trying to manage activity growth through interventions such as a referral management service to support its QIPP agenda. The trust is hopeful of some success in this area in supporting referral to treat times.

The better care agenda will also have a significant impact on the trust as funding is transferred from the NHS and into social care. The trust is working with its commissioners and local council to understand the likely impact and strategies that can be put in place to ensure stability during these changes and the likely success of initiatives put forward.

Milton Keynes Hospital NHS Foundation Trust is approaching a very exciting time in respect of site developments with a number of initiatives impacting on the estates strategy of the organisation and likely to create longer-term improvements to the organisation;

- Buckingham University have partnered with the Trust to create a academic centre on the site. The first cohort of students are due to arrive during 2017.
- The trust continues to develop its plans for a common front door, integrating both emergency and urgent care services in one area. This is in recognition of both the increase in population in the area, that we have a growing town and changes in the health requirements of an aging population.
- The trust is in discussions with both another NHS trust and a private provider with a view to having Linac bunkers on site for the provision of radiotherapy services to the patients of Milton Keynes. Previously patients have had to travel to Oxford and Northampton for these services.
- In line with the nationwide commitment to remove support for the patient administration system, MKHFT is currently undertaking a procurement exercise to purchase a new electronic patient record system, go-live due October 2015.
- The trust procured a new network and telephony system during 2013/14 which will be implemented during 2014/15 to create significant improvements in stability and flexibility of IT infrastructure.

Final financial position

Income and expenditure

The Trust's financial position and end of year accounts are detailed in the Financial Statements on pages 186-189 of the annual accounts. The accounts are prepared under International Financial Reporting Standards and Monitor's Annual Reporting Manual.

Financial headlines for 2013-14 were:

- Total income of £173.1m, an increase of £10.6m, 6.5%, increase on the previous year
- Income from clinical activities was up by £9.7m, 6.4%, at £160.8m
- Retained deficit for year increased to £17.0m from £8.8m the prior year
- Against Monitor's Continuity of Services Rating the Trust scored '1', in a scale of '1'-'4', where '5' is the highest performance rating, indicating the lowest level of financial risk.

Statement of Comprehensive Income

The table below summarises the trust's actual performance for 2013/14 against plan and the previous year. The Trust recorded a retained deficit of £17.0m for the year ending 31 March 2014.

£m	2012/13 Actual	2013/14 Plan	2013/14 Actual	2013/14 Variance
Income	162.5	163.4	173.1	9.7
Expenses	(166.4)	(171.4.)	(185.5)	(14.1)
Operating surplus	**(3.9)**	**(8.0)**	**(12.4)**	**(4.4)**
Finance costs	(4.9)	(5.1)	(4.6)	0.5
Retained surplus/(deficit)	**(8.8)**	**(13.1)**	**(17.0)**	**(3.9)**

2013/14 Statement of Comprehensive Income Summary

The key movement against plan during the year was due to £4m transformational funding that was initially anticipated to be received as 'income' through the statement of comprehensive income (SoCI) but was subsequently funded via public dividend capital and direct to the statement of financial position (SoFP) through cash.

Total income was £173.1m, an increase of £10.6m (6.5%) on the prior year and £9.7m above planned levels:

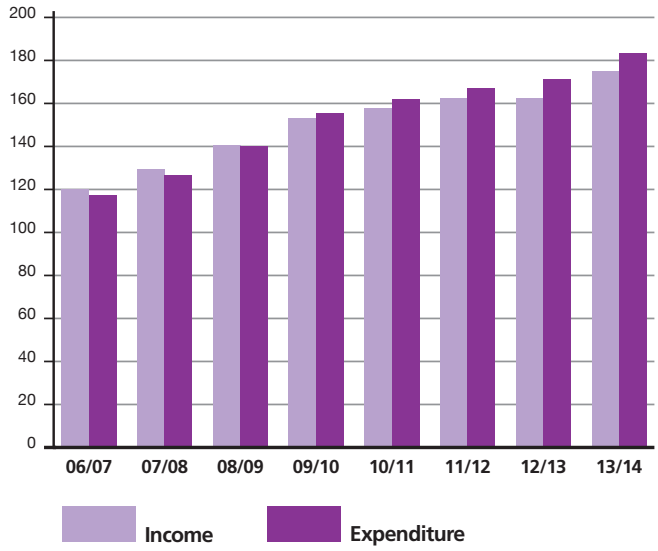
- Income from clinical activities was £160.8m, a year on year increase of £9.7m principally driven by:
  - Outpatient activity and emergency activity (combined £5.7m above planned levels) highlighting that both elective and non-elective activity is increasing.

Operating expenses rose by £19.1m (11.5%) on the previous year at £185.5m, a £14.1m adverse variance against plan. The principal drivers of the adverse performance to plan were:

- £6.4m in respect of pay due to the high utilisation of agency staffing. The plan also assumed significant levels of pay savings that, due to the continuing increasing levels of activity during the year, could not be achieved. Consequently, financing costs also did not see a related increase in transformational costs associated with capacity reductions that had expected.
- £7.7m of non-pay related additional spend was mainly due to the increase in activity as all variable costs increased (i.e. drugs and clinical supplies). Again, this is an area where savings were expected at the start of the year but were not achieved due to activity levels. The Trust has also included a bad-debt provision which has previously not been required.

The chart below shows the income and expenditure over the seven year period from April 2007 to March 2014.

Income & Expenditure £m



Cash flow and net debt

The trust's cash and cash equivalents at 31 March 2014 was £0.5m, in line with the previous year:

- The in year deficit of £17.0m was offset by
- £2.2m improvement in working capital
- £13.7m of PDC funding

Total assets employed

Total assets employed increased by £1.3m (1.0%) to £128.2m. This is predominately due to the increased capital investment in the year within non-current assets offset by an increase in accruals within current liabilities (so invoices not yet received or due for payment).

Total Assets Employed:

£m	2012/13	2013/14
Non-Current Assets	142.5	**146.2**
Current Assets	10.4	**11.7**
Current Liabilities	(15.9)	**(20.4)**
Non-Current Liabilities	(10.1)	**(9.3)**
Total Net Assets Employed	**126.9**	**128.2**

Capital Expenditure

The trust invested £8.7m in capital schemes during 2013/14 and this included a grant for £0.3m in respect of a combined heat and power plant. Further details of significant schemes included above in 'development of the business during the year'.

Asset Valuations

In accordance with International Accounting Standards, a full valuation is carried out on the trust's land and buildings every five years, with an interim valuation after three years. The valuations are performed by members of the Royal Institute of Chartered Surveyors. A full revaluation has been completed by the district valuer as at 31st March 2014 and has resulted in a £2.8m impairment of assets which related to plant property and equipment. Of this, £2.6m related to buildings and was charged to the revaluation reserve and the balance which related to donated assets was charged to operating expenses.

Accounts Preparation

The financial statements have been prepared in accordance with the 2013/14 FT Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FREM) 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.

Going Concern

A statement of Going Concern is included in Section 1 Accounting policies and other information within the Annual Accounts, an excerpt included below;

IAS 1 requires management to undertake an assessment of the NHS Foundation's Trusts ability to continue as a going concern. These accounts have been prepared on a going concern basis as there has been no application to the Secretary of State for the dissolution of the NHS Foundation Trust and the Directors currently believe there is a realistic alternative to doing so. The Directors have therefore prepared these financial statements on a going concern basis.

The trust has prepared its financial plans and cash flow forecasts on the assumption that adequate funding will be received from Milton Keynes Clinical Commissioning Group ("MKCCG") (contractual income), and through the Department of Health/Monitor (Public Dividend Capital). These are expected to be sufficient to prevent the Trust from failing to meet its obligations as they fall due and to continue until adequate plans are in place to achieve financial sustainability for the trust. However, the directors have identified that there is material uncertainties that casts significant doubt over whether the trust will continue to exist in its current form, and over its ability to discharge its liabilities in the normal course of business.

The current economic environment for all NHS Trusts and NHS Foundation Trusts is challenging with on-going internal efficiency gains necessary due to annual tariff (price) reductions; cost pressures in respect of national pay structures; non-pay and drug cost inflation; as well as nationally set contract penalties for contract performance deviations, combined with commissioner (CCG) expectations to reduce activity through ensuring care can be better provided within the community, i.e. managed outside the hospital.

The trust has incurred a deficit of (£17.0m) for the year ended 31 March 2014. The directors consider that the outlook presents significant challenges in terms of cash-flow for the reasons outlined above, including planned reductions in activity commissioned from the Trust and the need to reduce the underlying cost base of the trust to continuously align capacity and demand.

The trust is in the process of securing £25.3m of (public dividend capital "PDC") funding to support both the Trust's revenue position for working capital and £7.2m for its capital projects, with discussions with Monitor/DoH on-going. This funding will be required for the duration of the financial year whilst the internal savings plan is embedded and organisational realignment discussions are concluded. Provided the trust is in receipt of these funds the trust should continue to remain a going concern.

The trust is facing a period of unprecedented change over the coming years. During 2013 Monitor, NHS England, along with both Milton Keynes and Bedfordshire CCGs commissioned the 'Milton Keynes and Bedford Healthcare Review'. The first draft of recommendations from that review is expected during the summer of 2014. This could see fundamental economy-wide change to the way that health services are delivered across both areas. The planning undertaken by the Trust has recognised that without significant change, the Trust will remain in deficit during the foreseeable future.

Positive cash balances are likely to be maintained throughout the period through successfully securing commitments to necessary funding from external bodies (DoH/Monitor) and a contract with the lead commissioner MKCCG that gives assurance of income flows.

The significant risks facing the trust are summarised as follows:

1. The trust has prepared a cash flow forecast which shows a minimum level of headroom of £0.5m. There is a level of uncertainty over whether the trust will receive an additional £32.5m of PDC required to meet its financial obligations. The trust has however developed its financial plan assuming that it will receive this funding and thus continue on a going concern basis.

2. There is uncertainty over whether the trust will achieve its efficiency savings plan of £8.4m which has been assumed in its financial plan. This is a level of savings which is extremely challenging and must be supported with adequate clinical focus and engagement in quality process improvement against agreed and appropriately detailed and delivery plans.

3. There is uncertainty over the level of income that the trust will receive through its national NHS Acute contract with its Commissioners. This is because there is currently a gap between the trust's assumed income and that currently offered by MK CCG. The principal variance is between the trust's plan and the Commissioner intentions, predicated principally on the delivery of admission avoidance schemes in the community. Although, the Trust recognises the plan by the MKCCG to implement these schemes, past experience is that the implementation has had limited impact on hospital demand and in thus avoiding patient admissions.

4. The level of financial benefit from the transformation programme in 2014/15 and 2015/16 reduces. This will likely lead to a further challenge to the Trust financial position without structural change. The future for Milton Keynes Hospital NHS Foundation Trust is likely to be influenced by the outcome of the jointly commissioned activity (NHS England, Monitor, Milton Keynes CCG and Bedfordshire CCG) currently being undertaken by McKinsey, in respect of the Milton Keynes and Bedford Healthcare Review. This is due to deliver an options appraisal during 2014/15

5 There is thus material uncertainties which may cast significant doubt as to the trust's ability to continue as a going concern and therefore it may be unable to realise its assets and discharge its liabilities in the normal course of business. The financial statements do not include any adjustments that would result if the going concern basis were not appropriate.

External Auditors remuneration

Deloitte LLP has been the trust's financial auditors for 2013/14. Their audit responsibilities include the statutory services as well as the Quality accounts and value for money exercise. The total cost recognised in the accounts for this work is £64,000 (excluding VAT).

The Trust has also used Deloitte for additional assurance work including the validation of the annual three year planning exercise. This was at a cost of £50,000 (excluding VAT).

In order to ensure that independence is maintained, in instances where the external auditors are used for work other than the external audit, the Council of Governors approves this and the audit committee is also informed.

Other

Political and Charitable Donations

There have been no political donations made to the NHS foundation trust or charitable donations of the nature specified in the regulations made during the financial year. The trust continues to benefit from charitable donations, and is grateful for the efforts of fundraisers and members of the public for their continued support.

Audit Information

As far as the directors are aware, there is no relevant audit information that the auditors are unaware of. The directors have taken all the steps necessary in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Significant Events Since the Balance Sheet Date

There are no significant events since the balance sheet date that are likely to have a material impact on either the Trust or the financial statements for the year ending 31 March, 2014.

Better Payments Practice Code

The trust uses the Better Payments Practice Code with regards to paying creditors and has improved its year-on-year position from a rate of 24% of invoices in the year ending 31 March 2013 to 37% in the year ending 31 March 2014, which represented 54% in value terms. The Trust also paid £nil in interest charges in respect of late payment of invoices.

Accounting Policies and other retirement benefits

The accounting policies for pensions and other retirement benefits are set out on page 192 of the Financial Statements (note 1.5 Pension costs) and the arrangements for senior employees' remuneration can be found on pages 200 to 204.

Statement on fairness, Balance and Understandable

The Board of Directors are responsible for preparing and agreeing the financial statements contained in the annual report and accounts. The Board confirms that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the NHS foundation trust's performance, business model and strategy.

Milton Keynes Hospital NHS Foundation Trust Accounts Year Ended 31 March 2014

Statement of the chief executive's responsibilities as the Accounting Officer of Milton Keynes Hospital NHS Foundation Trust

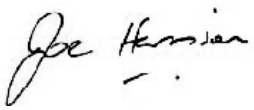
The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Monitor.

Under the National Health Service Act 2006, Monitor has directed Milton Keynes Hospital 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 Milton Keynes Hospital 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;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records, which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.
To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.



Joe Harrison
CHIEF EXECUTIVE

Date: 22nd May 2014

Independent Auditor's Report to the Council of Governors and Board of directors of Milton Keynes Hospital NHS Foundation Trust

We have audited the financial statements of Milton Keynes Hospital NHS Foundation Trust for the year ended 31 March 2014 which comprise of the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 - 25. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

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

Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2014 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

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

In our opinion:

- the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Emphasis of matter – going concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosures made in Note 1 Section 1.1 of the financial statements concerning the material uncertainties as to the continuation of the entity in its present form and the financial risks facing the Trust in the foreseeable future. The matters described in Note 1 Section 1.1 of the financial statements indicate the existence of material uncertainties which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

Matters on which we are required to report by exception

The Trust has described the following matters in its Annual Governance Statement which we consider to be relevant to the Trust's arrangements to secure economy, efficiency and effectiveness:

- The risks to the Trust in respect of its financial performance in 2013/14 and plan for 2014/15 and the Monitor financial risk rating as at 31 March 2014;
- Findings from reviews of the Trust performed in 2013/14 by the Care Quality Commission;
- Residual weaknesses and improvements being made to the Trust's risk management arrangements;
- Weaknesses in the Trust's arrangements to ensure the quality of reported data included in 62 day cancer indicator; and
- The quality indicator breaches reported by the Trust for 2013/14.

As a result of these matters, we have been unable to determine whether Milton Keynes Hospital NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls; or
- proper practices have not been observed in the compilation of the financial statements.

Qualified certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts, except that, as noted above in the section 'matters on which we are required to report by exception', we have been unable to determine whether Milton Keynes Hospital NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Heather Bygrave, FCA
(SENIOR STATUTORY AUDITOR)

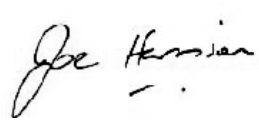
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
St Albans, United Kingdom 29 May 2014

Foreword To The Accounts

Milton Keynes Hospital NHS Foundation Trust

Milton Keynes Hospital NHS Foundation Trust ("the Trust") acts as an acute Hospital for Milton Keynes.

These accounts for the year ended 31 March 2014 have been prepared by Milton Keynes Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the 2006 Act.



Joe Harrison
CHIEF EXECUTIVE

Date: 22nd May 2014

Statement of Comprehensive Income For The Year Ended 31 March 2014

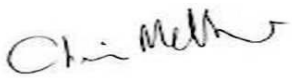
	Note	2013 / 14 £000	2012 / 13 £000
Operating Income from continuing operations	2.2	173,135	162,506
Operating Expenses of continuing operations	3.1	(185,502)	(166,395)
OPERATING (DEFICIT) / SURPLUS		**(12,367)**	**(3,889)**
FINANCE COSTS			
Finance income	6.1	18	20
Finance expense - financial liabilities	6.2	(485)	(582)
Finance expense - unwinding of discount on provisions		(9)	(8)
PDC Dividends payable		(4,113)	(4,380)
NET FINANCE COSTS		**(4,589)**	**(4,950)**
(DEFICIT) FOR THE YEAR		**(16,956)**	**(8,839)**
Other comprehensive income			
Impairment losses property, plant and equipment		(2,645)	0
Finance expense - financial liabilities		4,639	0
Finance expense - unwinding of discount on provisions		45	0
TOTAL COMPREHENSIVE EXPENSE FOR THE YEAR		**(14,917)**	**(8,839)**
Allocation of Losses for the period			
Defecit for the period attributable to:			
Government		**(16,956)**	**(8,839)**
Total Comprehensive Expense for the period attributable to:			
Government		**(14,917)**	**(8,839)**

The notes to the accounts are on page 190

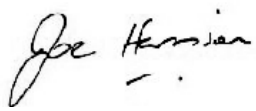
Statement of Financial Position As At 31 March 2014

	Note	31 March 2014 £000	31 March 2013 £000
NON-CURRENT ASSETS			
Intangible assets	7.1	3,589	4,218
Property, plant and equipment	8.1	142,172	137,515
Trade and other receivables	11	476	814
TOTAL NON-CURRENT ASSETS		**146,237**	**142,547**
CURRENT ASSETS			
Inventories	10	2,382	2,229
Trade and other receivables	11	8,790	7,522
Cash and cash equivalents	18	504	640
TOTAL CURRENT ASSETS		**11,676**	**10,391**
CURRENT LIABILITIES			
Trade and other payables	12	(16,762)	(11,937)
Borrowings	13	(810)	(782)
Provisions	16	(353)	(141)
Tax Payable	12.1	(2,348)	(2,422)
Other liabilities	12.2	(159)	(619)
TOTAL CURRENT LIABILITIES		**(20,432)**	**(15,901)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**137,481**	**137,037**
NON-CURRENT LIABILITIES			
Borrowings	13	(8,567)	(9,330)
Provisions	16	(725)	(761)
TOTAL NON-CURRENT LIABILITIES		**(9,292)**	**(10.091)**
TOTAL ASSETS EMPLOYED		**128,189**	**126,946**
FINANCED BY (TAXPAYERS' EQUITY)			
Public Dividend Capital		91,981	75,821
Revaluation reserve	17	57,253	55,214
Income and expenditure reserve		(21,045)	(4,089)
TOTAL (TAXPAYERS' EQUITY)		**128,189**	**126,946**

The financial Statement and notes on pages 182-217 were approved by the Board on 22nd May 2014 and signed on its behalf by:



Chris Mellor
INTERIM CHAIRMAN



Joe Harrison
CHIEF EXECUTIVE

Jonathan Dunk
DIRECTOR OF FINANCE

Statement of Changes in Taxpayers' Equity For The Year Ended 31 March 2014

	Public Dividend Capital	Revaluation Reserve	Income & Expenditure Reserve	Total
	£000	£000	£000	£000
TAXPAYERS' EQUITY AT 1 APRIL 2013	**75,821**	**55,214**	**(4,089)**	**126,946**
Defecit for the year	0	0	(16,956)	(16,956)
Impairments	0	(2,645)	0	(2,645)
Revaluations - property and equipment	0	4,639	0	4,639
Public Dividend Capital received	16,160	0	0	16,160
Other reserve movements	0	45	0	45
TAXPAYERS' EQUITY AT 31 MARCH 2014	**91,981**	**57,253**	**(21,045)**	**128,189**
TAXPAYERS' EQUITY AT 1 APRIL 2012	**71,821**	**55,214**	**4,750**	**131,785**
Defecit for the year	0	0	(8,839)	(8,839)
Transfers between reserves	0	0	0	0
Public Dividend Capital received	4,000	0	0	4,000
Other reserve movements	0	0	0	0
TAXPAYERS' EQUITY AT 31 MARCH 2013	**75,821**	**55,214**	**(4,089)**	**126,946**

Statement of Cash Flows For The Year Ended 31 March 2014

	2013 / 2014 £000	2012 / 2013 £000
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating (deficit) / surplus from continuing operations	(12,366)	(3,889)
OPERATING (DEFICIT) / SURPLUS	**(12,366)**	**(3,889)**
NON-CASH INCOME AND EXPENSE		
Depreciation and amortisation	6,205	6,006
Impairments	197	4
Interest accrued and not paid	0	(5)
Dividends accrued and not paid or received	0	26
(Increase) / Decrease in Trade and Other Receivables	(956)	(623)
(Increase) / Decrease in Inventories	(153)	(541)
(Increase) / Decrease in Trade and Other Payables	5,663	2,290
(Increase) / Decrease in Other Liabilities	(460)	361
(Increase) / Decrease in Provisions	167	356
NET CASH GENERATED FROM / (USED IN) OPERATIONS	**(1,703)**	**3,985**
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	18	20
Purchase of intangible assets	(1,501)	(728)
Sales of intangible assets	461	0
Purchase of Property, Plant and Equipment	(8,276)	(2,459)
NET CASH GENERATED (USED IN) INVESTING ACTIVITIES	**(9,298)**	**(3,167)**
CASH FLOWS FROM FINANCING ACTIVITIES		
PDC received	16,160	4,000
Loans repaid to the Foundation Trust Financing Facility	(445)	(445)
Other capital receipts	0	58
Capital element of finance lease rental payments	(290)	(324)
Interest paid	(89)	(109)
Interest element of finance lease	(396)	(473)
PDC Dividend paid	(4,072)	(4,512)
Cash flows from (used in) other financing activities	(3)	44
NET CASH GENERATED (USED IN) / FROM FINANCING ACTIVITIES	**10,865**	**(1,761)**
(DECREASE) IN CASH AND CASH EQUIVALENTS	**(136)**	**(943)**
CASH AND CASH EQUIVALENTS AT 1 APRIL	**640**	**1,583**
CASH AND CASH EQUIVALENTS AT 31 MARCH	**504**	**640**

Notes to the Accounts

1. Accounting policies and other information

These accounts for the year ended 31 March 2014 have been prepared by the Trust in accordance with the National Health Service Act 2006.

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Financial Reporting Manual (FT ARM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2013/14 FT ARM issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FREM) 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.

The Board of Directors are of the opinion that the Trust's operating activities fall under the single heading of "Healthcare" for the purposes of segmental reporting in accordance with International Financial Reporting Standard 8.

From 1st April 2013, the NHS has had to apply IAS 27' Consolidated and Separate Financial Statements' in respect of consolidating Charitable Funds. The Trust has reviewed the criteria under IAS 27 and it meets the criteria for IAS 27 in respect of having control of MK Hospital NHS charity and it directly benefits from the activities of the charitable funds. However, it has not consolidated the charitable funds into these accounts because the trust does not consider it to be material. The Charitable fund's income and expenditure represents only 0.2% of the Trusts position so they are not material to the accounts of the Trust. Similarly the Trust has chosen not to consolidate the Milton Keynes Urgent Care Services into these accounts due to this position not being material to the Trusts accounts. See Note 9.

Critical Judgements and Key Sources of Estimation Uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates, which only affect that period are recognised in the period in which the estimate is revised. If the revision affects both current and future periods it is recognised in the period of the revision and future periods.

Critical judgements in applying accounting policies:

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

The most significant estimate within the account is the value of land and buildings. The land and buildings have been valued by the district valuer on a modern equivalent asset basis as at 31st March 2014. The district valuer is independent of the Trust and is certified by the Royal institute of Chartered Surveyors. The valuer has extensive knowledge of the physical estate and market factors. The value does not take into account future potential changes in market value which cannot be predicted with any certainty.

In order to report within government guidelines, the value of patient care activity for the year ended 31st March 2014 has been estimated based on data available as at 1st April 2014.

Leases have been reviewed to determine whether they should be classified as finance leases or operating leases. Leases of a similar nature and composition have been grouped together for this purpose. A number of factors are considered in determining the split between finance and operating leases.

Critical judgements include whether ownership transfers at the end of the lease term, whether the lease term is for the major part of the economic life of the asset and whether the present value of the minimum lease payments is substantially all of the fair value of the asset. This classification is made at the inception of the lease. The effect of this judgement is not material to the Accounts.

Assumptions around the timing of cash flows relating to provisions are based on information from the NHS Pensions Agency, external legal advisors regarding when the legal issues may be settled.

Key sources of estimation uncertainty:

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Estimations as to the recoverability of receivables and the valuation of inventories has been made in determining the carrying amounts of these assets, no significant variations are expected.

Clinical Income from activities includes an estimate in respect of income relating to patient care spells that are part-completed at the year end. The number of part completed spells have been apportioned across the financial years on the basis of the number of occupied beds with the actual cost per spell if it is available or an average cost per spell per speciality where the spell cost is not directly available.

1.1 Basis of accounting – going concern

IAS 1 requires management to undertake an assessment of the NHS Foundation's Trusts ability to continue as a going concern. These accounts have been prepared on a going concern basis as there has been no application to the Secretary of State for the dissolution of the NHS Foundation Trust and the Directors currently believe there is a realistic alternative to doing so. The Directors have therefore prepared these financial statements on a going concern basis.

The Trust has prepared its financial plans and cash flow forecasts on the assumption that adequate funding will be received from Milton Keynes Clinical Commissioning Group ("MKCCG") (contractual income), and through the Department of Health/Monitor (Public Dividend Capital). These are expected to be sufficient to prevent the Trust from failing to meet its obligations as they fall due and to continue until adequate plans are in place to achieve financial sustainability for the Trust. However, the Directors have identified that there is a material uncertainty that casts significant doubt over whether the Trust will continue to exist in its current form, and over its ability to discharge its liabilities in the normal course of business.

The current economic environment for all NHS Trusts and NHS Foundation Trusts is challenging with on-going internal efficiency gains necessary due to annual tariff (price) reductions; cost pressures in respect of national pay structures; non-pay and drug cost inflation; as well as nationally set contract penalties for contract performance deviations, combined with commissioner (CCG) expectations to reduce activity through ensuring care can be better provided within the community, i.e. managed outside the Hospital.

The Trust has incurred a deficit of (£17.0m) for the year ended 31 March 2014. The Directors consider that the outlook presents significant challenges in terms of cash-flow for the reasons outlined above, including planned reductions in activity commissioned from the Trust and the need to reduce the underlying cost base of the Trust to continuously align capacity and demand.

The Trust is in the process of securing £25.3m of (Public Dividend Capital "PDC") funding to support both the Trust's revenue position for working capital and £7.2m for its capital projects for 2014/15, with discussions with Monitor/DoH on-going. This funding will be required for the duration of the financial year whilst the internal savings plan is embedded and organisational realignment discussions are concluded. Provided the Trust is in receipt of these funds the Trust should continue to remain a going concern.

The Trust is facing a period of unprecedented change over the coming years. During 2013 Monitor, NHS England, along with both Milton Keynes and Bedfordshire CCGs commissioned the 'Milton Keynes and Bedford Healthcare Review'. The first draft of recommendations from that review is expected during the summer of 2014. This could see fundamental economy-wide change to the way that health services are delivered across both areas. The planning undertaken by the Trust has recognised that without significant change, the Trust will remain in deficit during the foreseeable future.

Positive cash balances are likely to be maintained throughout the period through successfully securing commitments to necessary funding from external bodies (DoH/Monitor) and a contract with the lead commissioner MKCCG that gives assurance of income flows.

The significant risks facing the Trust are summarised as follows:

1. The Trust has prepared a cash flow forecast which shows a minimum level of headroom of £0.5m. There is a level of uncertainty over whether the Trust will receive an additional £32.5m of PDC required to meet its financial obligations. The Trust has however developed its financial plan assuming that it will receive this funding and thus continue on a going concern basis.
2. There is uncertainty over whether the Trust will achieve its efficiency savings plan of £8.4m which has been assumed in its financial plan. This is a level of savings which is extremely challenging and must be supported with adequate clinical focus and engagement in quality process improvement against agreed and appropriately detailed and delivery plans.
3. There is uncertainty over the level of income that the Trust will receive through its national NHS Acute contract with its Commissioners. This is because there is currently a gap between the Trust's assumed income and that currently offered by MK CCG. The principal variance is between the Trust's plan and the Commissioner intentions, predicated principally on the delivery of admission avoidance schemes in the community. Although, the Trust recognises the plan by the MKCCG to implement these schemes, past experience is that the implementation has had limited impact on hospital demand and in thus avoiding patient admissions.
4. The level of financial benefit from the Transformation Programme in 2014/15 and 2015/16 reduces. This will likely lead to a further challenge to the Trust financial position without structural change. The future for Milton Keynes Hospital NHS Foundation Trust is likely to be influenced by the outcome of the jointly commissioned activity (NHS England, Monitor, Milton Keynes CCG and Bedfordshire CCG) currently being undertaken by McKinsey, in respect of the Milton Keynes and Bedford Healthcare Review. This is due to deliver an options appraisal during 2014/15

There is thus a material uncertainty which may cast significant doubt as to the Trust's ability to continue as a going concern and therefore it may be unable to realise its assets and discharge its liabilities in the normal course of business. The financial statements do not include any adjustments that would result if the going concern basis were not appropriate.

1.2 Accounting convention

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

1.3 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.

Income relating to patient care spells that are part-completed at the year end is apportioned across the financial years on the basis of the number of occupied beds, applied to the cost per spell or average cost per spell per speciality where the spell cost was not directly available.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

The Trust receives income under the NHS Injury Cost recovery Scheme. This is designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the Income when it receives notification from the Department of Work and Pension's Compensation recovery unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for the unsuccessful compensation claims and doubtful debts.

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.

1.4 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that, they have been received. It 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 non-current assets such as property, plant and equipment.

1.5 Expenditure on employee benefits

Short –term employee benefits

Salaries, wages and employment-related payments, including termination benefits, are recognised in the period in which the service is received from employees. Annual leave entitlement is actively encouraged to be taken in the year that it is earned, however there are exceptional circumstances when the annual leave entitlement may be carried forward into the following year. Untaken leave is accrued on an average five days carry forward for medical staffing, excluding junior doctors and registrars in training. All other staff are accrued based on annual data collection of untaken hours applied to their hourly rate of pay. The cost of this annual leave entitlement earned but not taken at the end of the financial period is recognised in the financial statements.

Pension costs-NHS Pension Scheme

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.nhsba.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme (which prepares its own scheme statements) that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying assets and liabilities. As a consequence it is not possible for the Trust to identify its share of the underlying scheme 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 equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FREM requires that the "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilised an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability, as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

The last full actuarial (funding) valuation for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes 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 due in 2015.

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

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

The liabilities of the pension scheme as at 31st March 2013 were £284.2 billion. The national deficit of the scheme was £3.3 billion as per the last scheme valuation by the Government Actuary for the period 1 April 1999 to 31 March 2004. The conclusion of the valuation was that the scheme continues to operate on a sound financial basis. Employer contribution rates are reviewed every four years following the scheme valuation, on advice from the actuary. At the last valuation, it was recommended that employer contribution rates should continue at 14% of pensionable pay. From 1st April 2012, the tier contributions have changed, for 1st April 2013 the lower limit remains at 5% whilst the upper limit has increased to 13.3% of pensionable pay. 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.

Pension costs-NEST Pension Scheme

From the 1st October 2013 the Trust has participated in the Government's Auto Enrolment Pension scheme. It has auto-enrolled those employees who are not eligible for the NHS Pensions scheme into an alternative pension scheme run by National Employers Savings Trust (NEST).

The employer's contributions for all staff eligible are 1% in the first year, rising to 3% by 2018. For employees who are eligible for the NHS Pensions scheme the Trust has a transitional date of 2017 which has been agreed with the Pensions Regulator. The Trust currently has, at the 31st March 2014,10 employees enrolled into NEST and the employers contributions for the current financial year have been £300.

1.6 Property, Plant and Equipment

Recognition

Property, Plant and Equipment (PPE) 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 will be supplied to the Trust;
- it is expected to be used for more than one financial year; and
- The cost of the item can be measured reliably.

The Trust capitalises assets that individually have a cost of at least £5,000 or form a group of assets which individually have a cost of more than £250 and collectively have a cost of at least £5,000, where the assets are functionally interdependent, have broadly simultaneous purchase dates and anticipated to have simultaneous disposal dated and are under single managerial control.

Assets will also be capitalised if they form part of the initial set-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost. In accordance with IAS23, borrowing costs directly attributable to the financing of PPE are also capitalised up until all the activities necessary to prepare the asset for its intended use are complete.

Valuation

All property, plant and equipment assets are measured initially at cost, representing the cost 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.

The carrying value of fixtures and equipment are written off over the 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.

Land and buildings are re-valued where a movement in fair values is considered to be material. Fair values are determined as follows: Land and no specialised buildings – modern equivalent asset basis. Specialised buildings – depreciated replacement cost.

HM Treasury adopted a standard approach to depreciated replacement cost valuations on a modern equivalent asset where it would meet the location requirements of the service being provided, an alternative site can be valued. HM Treasury has agreed that NHS Trusts must apply these new valuations techniques by 1 April 2010 at the latest.

In any event, professional valuations are carried out every five years, together with a three year interim/desk top valuations. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RCIS) Appraisal and Valuation Standards Manual.

The Trust has undertaken a full asset valuation as at 31st March 2014 which was carried out by a RCIS qualified valuer from District Valuer Services (DVS), South East Valuation Office Agency. The DVS is the commercial arm of the Valuation Office Agency, which is an executive agency of HM Revenue & Customs (HMRC). It provides professional property advice across the public sector in England, Wales and Scotland.

DVS valued the underlying land as at 31March 2014, with regard to prevailing land values in the vicinity of the existing site and in a manner consistent with the Trust's occupational requirements and current land ownership. This increased the value of the land by 11% on previous valuations. Buildings were valued at depreciated replacement cost on a modern equivalent asset basis (no alternative site) for buildings which qualify as a specialised operational property asset which is consistent with IAS16. The DVS gave regard to the RICS Build Cost Indices in consulting with their own surveyor.

Non specialised operational property, including land, is assessed at existing use value whilst non-operational property, including surplus land is valued on the basis of market value. The valuation was undertaken by a Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Until 31 March 2008, plant, machinery, vehicles, furniture and fittings were carried at replacement costs, based on indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over the remaining useful economic life and new assets carried at depreciated historic cost, unless this is considered to be materially different from fair value due to significant volatility in asset values.

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. 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 over their remaining economic lives in a manner consistent with the consumption of economic or service delivery benefits. 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 or reverts to the Trust, respectively.

Buildings, dwellings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset based on assessments by the Trust's professional valuers. Leasehold buildings are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the following estimated lives: Asset lives fall into the following ranges;

Asset Category	Estimated life (in years)
Plant and Machinery	5 to 20 years
Transport Equipment	7 years
Information Technology	2 to 8 years
Furniture and Fittings	5 to 10 years

Where a large asset, for example a building, includes a number of components with significantly different lives e.g. plant and equipment, then these components are treated as separate assets and are depreciated over their own useful economic lives.

Revaluation

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has been previously recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent there is an available balance for the asset concerned and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to the 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 as operating income to the extent that the asset is restored to its carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reverse. 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 loses. Reversals of 'other impairments' are treated as revaluation gains.
Where impairment arises from a clear consumption of economic value, this is taken in full to operating expenses.

De-recognition

Assets intended for disposal, are reclassified as 'Held for sale' once all of the following criteria are met:

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

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

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

1.7 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential will be provided to the Trust where the cost of the asset can be measured reliably.

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised and recognised as an operating expense in the period that it is incurred.

Software that is integral to the operating of hardware, for example, an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Intangible assets are amortised over the following estimated lives:

Asset Category	Estimated life (in years)
Purchased computer software	2 to 8 years
Internally Generated IT	2 to 8 years

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at fair value by reference to an active market or, where no active market exists, at amortised replacement cost (modern equivalent asset basis), indexed for relevant price increases a proxy for fair value. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment. Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.8 Donated, government grant and other grant funded assets

Government grants are grants from Government bodies other than income from CCG's or NHS Trusts for the provisions of services. 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.

1.9 Inventories

Inventories comprise mainly of drugs and consumable medical products which are held at the lower of cost or net realisable value. The cost formula is determined by using the latest cost price from suppliers. Due to the high turnover of inventories and the low value held, the Trust considers this method to be an appropriate basis of measurement. Net realisable value is the estimated selling price less estimated costs to achieve a sale.

1.10 Financial Assets

Recognition

Financial assets are recognised on the Statement of Financial Position when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered.

De-recognition

Financial assets are derecognised when the rights to received cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Classification

The Trust has the following categories of financial assets;

- Receivables

The classification depends on the nature and purpose of the financial asset which is determined at the time of initial recognition.

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 receivables comprise of; cash and cash equivalents, trade and other receivables, accrued income and prepayments.
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

Measurement

Financial assets are initially recognised at fair value, net of transaction costs and are measured subsequently at amortised costs 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.

At the Statement of Financial Position date, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses 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. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

If in a subsequent period, the amount of the impairment loss decreased and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Statement of Comprehensive Income. This is to the extent that the carrying amount of the receivable, at the date of the impairment, is reversed does not exceed the amortised cost had the impairment not been recognised.

1.11 Financial Liabilities

Recognition

Financial liabilities are recognised on the Statement of Financial Position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received.

De-recognition

Financial liabilities are de-recognised when the obligations are discharged, cancelled or expire.

Measurement

Financial liabilities are initially recognised at fair value, net of transaction costs incurred, and measured subsequently at amortised costs 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 balance sheet date, which are classified as non-current liabilities.

The Trust's other financial liabilities comprise of FTFF Loan, trade and other payables, accruals and provisions.

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 on finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

1.12 Liquidity Risk

The Trust's net operating costs are mainly incurred under legally binding contracts with local CCG's, which are financed from resources voted annually by Parliament. Under Payment by Results the Trust is paid for activity on the basis on nationally set tariffs. For contracted activity the trust is paid in 12 monthly instalments through the year which has in the latter part of the year included monthly payments for activity over contracted levels. This has reduced the liquidity risk. However the fact that the Trust does not have working capital facility due to its current risk rating increases the Trusts liquidity risk. In addition the Trust recognises the issues around Going Concern which are outlined in note 1.1

1.13 Market Risk

Interest –rate risk

All of the Trusts financial liabilities carry nil or fixed rates of interest. Therefore the Trust is not, exposed to significant interest rate risk.

Foreign currency risk

The Trust has no foreign currency income and negligible foreign currency 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 obligation with the other. Disputes can arise, however, around how the amounts owed are calculated, particularly due to the complex nature of the Payment by Results regime. The Trust does not hold any collateral as security.

1.14 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 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 periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease, thereafter the asset is accounted for as an item of plant and equipment and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income. Leases are assessed using IAS17 as a basis for qualitative and quantitative assessment.

Operating Leases

Other leases are regarded as operating leases and the rentals are charged to the operating expenses on a straight-line basis over the term of the lease. Operating lease incentives are added to the lease rentals and charged to the 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 if it is considered to be material and the classification for each is assessed separately.

1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount at the balance sheet date, for which it is probable that there will be a future outflow of cash or other resources and a reliable estimate of the expenditure can be made. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk adjusted cash flows are discounted using HM Treasury's discount rate. The rate for injury benefit provisions and pensions is at a rate of 2.35 % in real terms is applied.

1.16 Clinical Negligence

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 at note 16 but is not recognised in the trust's accounts.

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 NHSLA 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.

1.17 Contingencies

Recognition

Contingent assets are assets arising from past events whose existence will only be confirmed by one or more future vents not wholly within the entity's control. They are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

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.

1.18 Public Dividend Capital

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

A charge, reflecting the forecast cost of capital utilised by the Trust, is paid over as Public Dividend Capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) average daily cash held with Government Banking Service excluding cash balances held in GBS account that relate to a short-term working capital facility and any (iii) PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health, 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 of the audit of the annual accounts. Average relevant net assets are calculated as a simple means of opening and closing relevant net assets.

1.19 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.

1.20 Corporation Tax

The Trust does not foresee that it will have any material commercial activities on which corporate tax liability will arise under the guidance issues by HM Revenue and Customs.

1.21 Foreign Exchange

The functional and presentational currencies of the trust are sterling. A transaction which is denominated in a foreign currency is translated into sterling at the exchange rate ruling on the dates of the transaction. Resulting exchange gains and losses are taken to the Statement of Comprehensive Income.

1.22 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 does not have any beneficial interest in them.

1.23 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 that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure. The information for losses and special payments is compiled directly from the losses and special payments register.

1.24 Accounting Standards that have been issued but have not yet been adopted

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted.

IFRS 9 Financial Instruments is a replacement of IAS 39 Financial Instruments: Recognition and Measurement. The impact of this is to provide a clearer definition for the recognition of financial assets and liabilities. The standard is allowing financial assets to be recognised at amortised cost if it meets both the business model test and the cash flow characteristics test; otherwise the assets are to be measured at fair. It is expected that the Trust's Financial Assets will remain to be valued at fair value. The effective date is uncertain as it is not likely to be adopted by the EU until the IASB has finished the rest of its financial instrument project.

IFRS 10 Consolidated Financial Statements replaces parts of IAS 27 that address how and when an investor should prepare consolidated financial statements and replaces SIC 12 in its entirety. The objective of IFRS 10 is to have a single basis for consolidation for all entities, regardless of the nature of the investee, and that basis is control. The impact of this standard is consistency on consolidation decisions. This standard could have an impact if the Trust in the future takes controls of another entity. It will need to ensure that it complies with all the requirements of this standard and produces consolidated statements. The EU adopted effective date is 2014/15.

IFRS 11 Joint Arrangements replaces IAS 31 – Interests in Joint Ventures and SIC 13 – Jointly Controlled Entities. The core principle of IFRS 11 is that a party to a joint arrangement determines the type of joint arrangement in which it is involved by assessing its rights and obligations and accounts for those rights and obligations in accordance with that type of joint arrangement. The impact of this standard is that the trust will need to consider if the arrangement with the Milton Keynes Urgent Care Services is a joint venture or a joint operation to ensure correct accounting treatment for these different types of arrangements. The EU adopted effective date is 2014/15.

IFRS 12 Disclosure of Interests in Other Entities. The new standard sets out the disclosure requirements for all forms of interests in other entities, including subsidiaries, joint arrangements, associates and unconsolidated structured entities. The impact of this new statement is that the Trust will need to disclose additional information relating to any joint arrangements such as the Milton Keynes Urgent Care Services that will enable users of financial statements to evaluate the nature of, and risks associated with, its interests in other entities and the effects of those interests on its financial position, financial performance and cash flows. The EU adopted effective date is 2014/15.

IFRS 13 Fair Value Measurement This standard defines fair value, provides guidance on its determination and introduces consistent requirements for its disclosures on fair value measurements. The standard does not include requirements on when fair value measurement is required; it prescribes how fair value is to be measured if another standard requires it. The impact of the standard is to increase consistency and comparability in fair value measurements and related disclosures through a 'fair value hierarchy'. The Trust will review its valuation of assets and liabilities to ensure that they comply with this standard. The effective date is 2013/13 but this has not been adopted by HM Treasury.

IAS 27 Separate Financial Statements Consolidation requirements previously forming part of IAS 27 (2008) have been revised and are now contained in IFRS 10 Consolidated Financial Statements. Please refer to IFRS 10 as above for further information. The EU adopted effective date is 2014/15.

IAS 28 Associates and Joint Ventures The objective of IAS 28 (as amended in 2011) is to prescribe the accounting for investments in associates and to set out the requirements for the application of the equity method when accounting for investments in associates and joint ventures. It applies to all entities that are investors with joint control of, or significant influence over, an investee (associate or joint venture). The Trust will review this in light of its arrangements with Milton Keynes Urgent Care Services.

IAS 32 Financial Instruments It outlines the accounting requirements for the presentation of financial instruments, particularly as to the classification of such instruments into financial assets, financial liabilities and equity instruments. The standard also provides guidance on the classification of related interest, dividends and gains/losses, and when financial assets and financial liabilities can be offset. The Trust will review its financial instruments in light of the new classifications. Its effective date is 2014/15.

There are other new standards which exist but these are deemed not to be relevant to the NHS. The directors do not expect that the adoption of these standards and interpretations will have a material impact on the financial statements in future periods. All other revised and new standards have not been listed here as they are not considered to have an impact on the Trust.

2.0 Operating Income

IFRS 8 requires the disclosure of results of significant operating segments; the Trust considers that it only has one operating segment, Healthcare.

2.1 Operating Income

	2013/14 £000	2012/13 £000
Commissioner requested services	**158,424**	148,528
Non Commissioner requested services	**2,362**	2,611
TOTAL INCOME FROM ACTIVITIES	**160,786**	**151,139**

The Trust's Commissioner Requested Services is the total income from activities excluding private patient's income and non–protected clinical income. Non protected income relates to overseas patients, the NHS Injury Scheme and other Non NHS bodies. Commissioner Requested Services are protected from closure without prior agreement from commissioning bodies. This has replaced the heading of mandatory and non-mandatory income.

2.2 Operating Income (by classification)

	2013/14 £000	2012/13 £000
INCOME FROM ACTIVITIES		
Elective income	27,081	24,858
Non elective income	54,731	55,826
Outpatient income	28,555	29,173
A&E income	8,731	7,807
Other NHS clinical income	39,326	30,864
Private patient income	438	779
Other non-protected clinical income	1,924	1,833
TOTAL INCOME FROM ACTIVITIES	**160,786**	**151,139**
OTHER OPERATING INCOME		
Research and development	464	458
Education and training	4,915	3,945
Received from NHS charities : Receipt of grants / donations for capital acquisitions - Donation (ie receipt of dontated asset)	0	59
Received from NHS charities : Receipt of grants / donations for capital acquisitions - Grant	124	0
Non-patient care services to other bodies	2,220	800
Car Parking	1,250	1,211
Staff accommodation rentals	1,022	873
Catering	672	689
Property rentals	67	86
Other	1,615	3,246
TOTAL OTHER OPERATING INCOME	**12,349**	**11,367**
TOTAL OPERATING INCOME	**173,135**	**162,506**

2.3 Private patient income

The Health and Social Care Act from the 1st October 2012 repealed the statutory limitation on private patient income in section 44 of the National Health Services Act 2006.The Trust earned 0.3% of total patient care income from private patients.

2.4 Other operating income (by Type)

	2013/14 £000	2012/13 £000
INCOME FROM ACTIVITIES		
NHS Foundation Trusts	111	(3)
NHS Trusts	654	542
Strategic Health Authorities	0	(63)
CCG's and NHS England	157,767	0
Primary Care Trusts	0	148,495
Local Authorities	217	183
NHS other	20	13
Non NHS : Private patients	438	779
Non NHS : Overseas patients (non-reciprocal)	237	176
NHS Injury Scheme (was RTA)	795	909
Non NHS : Other	547	109
TOTAL INCOME FROM ACTIVITIES	**160,786**	**151,140**

From the 31st March 2013, Primary Care Trusts and Strategic Health Authorities were abolished as part of the Health and Social Care Act 2012. The responsibility for the commissioning of Healthcare services transferred to two new NHS Bodies, Clinical Commissioning Groups (CCG's) and NHS England. The major CCG's for the Trust is MKCCG and this accounts for 73% of the Trusts CCG income.

NHS England commissions nationally for a number of specialist services which includes HIV, Neonatology and Specialist Cancers and screening. The Trust received £17.4m in respect of these services in 2013/14. In the prior year these services were funded by the PCT's.

3.0 Operating expenses

3.1 Operating expenses (by Type)

	2013/14 £000	2012/13 £000
OPERATING EXPENSES COMPRISE :		
Services from NHS Foundation Trusts	1,261	300
Services from NHS Trusts	1,554	1,736
Services from PCTs	0	584
Services from CCG's and NHS England	6	0
Services from other NHS Bodies	124	120
Purchase of healthcare from non NHS Bodies	1,834	1,144
Employee Expenses - Executive directors	851	986
Employee Expenses - Non-executive directors	221	133
Employee Expenses - Staff	119,999	111,296
Supplies and services - clinical (excl drug costs)	14,375	12,911
Supplies and services - general	3,117	2,630
Establishment	1,660	1,170
Transport (Business travel only)	319	78
Transport (other)	206	0
Premises	7,623	5,963
Increase / (decrease) in provision for impairment of receivables	1,495	74
Drugs	12,445	10,126
Rentals under operating leases-minimum lease receipts	511	417
Depreciation on property, plant and equipment	5,360	5,307
Amortisation on intangible assets	845	699
Impairments of property, plant and equipment (6.3)	197	4
Audit fees Statutory	64	86
Other auditors remuneration - other services	50	72
Clinical negligence	4,019	4,870
Legal fees	887	385
Consultancy costs	3,223	1,986
Training, courses and conferences	906	448
Patient travel	9	9
Car parking & Security	89	84
Redundancy (included in employee expenses)	217	809
Hospitality	21	18
Insurance	151	122
Other services, eg external payroll	984	763
Losses, ex gratia & special payments not included in employee expenses	110	123
Other	769	942
TOTAL	**185,502**	**166,395**

3.2 Arrangements containing an operating lease

	2013/14 £000	2012/13 £000
Minimum Lease payments in year	511	417
TOTAL	**511**	**417**

Operating lease includes rentals for a variety of medical equipment as well as photocopiers and lease cars.

	2013/14 £000	2012/13 £000
Future lease payments	1,487	1,615
TOTAL	**1,487**	**1,615**
- not later than one year	559	532
- later than one year and not later than five years	928	1,083
- later than five years	0	0
TOTAL	**1,487**	**1,615**

4.0 Staff costs and numbers

	2013/14 £000	2012/13 £000
Salaries and wages	93,418	87,083
Social security costs	7,781	7,502
Pension costs - defined contribution plan Employers contribution to NHS Pensions	10,387	9,952
Termination benefits	0	809
Agency / contract staff	9,264	7,745
TOTAL	**120,850**	**113,091**

These costs exclude those for Non-Executive Directors' remuneration and benefits in kind.

4.1 Average number of persons employed (WTE basis)

	2013/14 Number	2012/13 Number
Medical and dental	321	312
Administration and estates	743	713
Healthcase assistants and other support staff	283	256
Nursing, midwifery and health visiting staff	774	755
Scientific, therapeutic and technical staff	363	352
Agency and contract staff	79	54
Bank	172	149
TOTAL	**2,735**	**2,591**

All numbers shown are based on average whole time equivalents for the twelve months.

4.2 Employee Benefits

There were no employee benefits paid in the year or in the previous financial year.

4.3 Salary and pension entitlements of Directors

Name and title	Year Ended 31 March 2014 Salary (Bands of £5,000) £	Year Ended 31 March 2013 Salary (Bands of £5,000) £
Joe Harrison- started Feb 2013 Chief Executive Officer	165-170	25-30
Mark Millar - Left Jan 2013 **(Millar Management Associates)** Interim Chief Executive Officer *	N/A	215-220
Jonathan Dunk - started July 2013 Director of Finance	80-85	N/A
Robert Toole (Penna PLC) - **Started Jan 2013, left June 2013 *** Interim Director of Finance	95-100	70-75
Duncan Smith- left April 2013 Director of Finance until Dec 2012 Director of Commercial Development from Dec 2012, left April 2013	N/A N/A	95-100 30-35
Lisa Knight - started Oct 2012 Director of Patient Care / Chief Nurse	100-105	40-45
Gillian Prager - started Aug 2012 & left Oct 2012 * **(Gemp Associates)** Interim Director of Nursing	N/A	30 - 35
Tony Halton - left Sept 2012 Director of Nursing	N/A	40-45
John Blakesley started April 2013 * Interim Director of Planning & Performance - from April 2013 to March 2014 Interim Director of Performance & Delivery - from March 2014	265-270 5-10	N/A N/A
Maria Wogan - left Dec 2012 Director of Corporate Services	N/A	35-40
Louise Watson - started Oct 2011 & left Nov 2012* **(Secondment West Sussex PCT)** Director of Commercial Development	N/A	75-80
Darren Leech - Started Dec 2011 Chief Operating Officer to March 2014 Director of Strategy & Estates from March 2014	100-105 5-10	110-115 N/A

Name and title	Year Ended 31 March 2014 Salary (Bands of £5,000) £	Year Ended 31 March 2013 Salary (Bands of £5,000) £
Ogechi Emeadi - started 31st March 2014 Director of HR & Workforce Development	0-5	N/A
Norma French started April 13, left March 2014 * Interim Director of HR & Workforce Development	130-135	N/A
Kathy Renacre - left April 2013 Director of HR & Workforce Development	N/A	90-95
Martin Wetherill from June 2011 Medical Director	175-180	175-180
Chris Mellor- started October 2013 * Interim Chairman	115-120	N/A
David Wakefield - **Started April 2011, left Sept 2013** Chairman	15-20	45-50
Kate Robinson Non executive director	10-15	10-15
Tony Nolan - Started March 2014 Non executive director	0-5	N/A
Dr Jean-Jaques De Gorter- Started March 2014 Non executive director	0-5	N/A
Robert Green - Started Jan 2013 Non executive director	10-15	0-5
David Moore - Started Feb 2012 Non executive director	10-15	10-15
Frank Burdett - Started Feb 2012 Non executive director	10-15	10-15
Penny Emerson - Started 21st Feb 2012. Non executive director	10-15	10-15
Graham Anderson - left Feb 2014 Non executive director	10-15	10-15
Ian Mackie - Started Feb 2012 and left Dec 2012 Non executive director	N/A	5-10

Notes

* The costs associated with these Directors are the total cost, inclusive of VAT, of the professional service provided and includes other costs associated with providing the service.

4.4 Highest paid Director Analysis

The median remuneration has been calculated using the full time equivalent annualised salary costs taken from the March payroll data, excluding the highest paid director but including agency and bank costs.

	2013/14 £000	2012/13 £000
Band of Highest Paid Director's Total Remuneration	275-280	325-350
Median Remuneration	29.3	30.1
RATIO	**9.4**	**10.9**

The Trust's highest paid Director was the Director of Performance and Delivery and the remuneration costs that have used in the calculation are the banded, full time equivalent annualised total remuneration costs. These costs include a premium relating to Tax, NI and pensions as well as costs associated with providing the professional services of the role.

The ratio remains high due to the number of Interim Directors the Trust had during the majority of 2013/14. In March 2014, there only remained two Interim Directors, one of which was the Chairman and this post is currently being recruited to.

4.5 Pension Benefits

Non executive directors do not receive pensionable remuneration and therefore there are no pension details included. The pension information has been provided by NHS Pensions Agency.

Name and Title	Real increase in pension at aged 60 (Bands of £2.5k) £000	Lump sum at aged 60 related to real increase in pension (Bands of £2.5k) £000	Total accrued pension aged 60 at 31st March 2014 (Bands of £5k) £000	Lump sum at aged 60 accrued pension at 31st March 2014 (Bands of £5k) £000	Cash equivalent transfer value at 31st March 2013 (Bands of £1k) £000	Real increase in Cash equivalent transfer value (Bands of £1k) £000	Cash equivalent transfer value at 31st March 2014 (Bands of £1k) £000
Joe Harrison Chief Executive Officer	2.5-5	12.5-15.0	40-45	120-125	539	87	626
Robert Toole - Left July 2013 Interim Director of Finance	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jonathan Dunk - From July 2013 Director of Finance	N/A	N/A	10-15	40-45	N/A	N/A	175
Duncan Smith - Left April 2013 Director of Commercial Development	0-2.5	0-2.5	55-60	175-180	N/A	N/A	N/A
Lisa Knight Director of Patient Care / Chief Nurse	2.5-5	12.5-15.0	30-35	95-100	441	86	527
Darren Leech Chief Operating Officer and then Direct of Strategic and Estates	0-2.5	2.5-5	20-25	60-65	271	27	298
John Blakesley Interim Director of Commercial Development and then Director of Performance and Delivery	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kathy Renacre - Left April 2013 Director of HR & Workforce Development	0-2.5	0-2.5	40-45	120-125	847	9	856
Norma French Interim Director of HR & Workforce Development	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ogechi Emeadi - From 31st March 2014 Director of HR & Workforce Development	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Martin Wetherill Medical Director	0-2.5	5-7.5	50-55	160-165	N/A	N/A	N/A

Notes

Martin Wetherill and Duncan Smith have left the pension scheme and therefore there is no CETV value.
Robert Toole, John Blakesley and Norma French are self employed and responsible for their own pension arrangements.
Ogechi Emeadi only started with the Trust on the 31st March, there is no pension information available.

4.6 Retirements due to ill-health

During the year ended 31 March 2014 the Trust had four early retirements agreed on the grounds of ill-health, the liability for this is carried by the pension agency and totalled £0.3m. There were no early retirements on the grounds of ill health for the prior year.

4.7 Termination Benefits

During the year the Trust continued with a programme of reviewing its staffing structure and continued to offer a MARS redundancy scheme as it had in the previous year. As a result there were a total of eleven departures agreed during 2013/14 at a cost of £427k during the year. The table below provides a summary of the departures.

2013/14	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	£000	Number	£000	Number	£000
< £10,000	0 (0)	0 (0)	3 (5)	10 (31)	3 (5)	10 (31)
£10,001 - £25,000	0 (1)	0 (23)	0 (5)	0 (86)	0 (6)	0 (109)
£25,001 - £50,000	0 (3)	0 (134)	6 (0)	179 (0)	6 (3)	179 (134)
£50,001 - £100,000	0 (2)	0 (179)	1 (0)	72 (0)	1 (2)	72 (179)
£100,001 - £150,000	0 (3)	0 (356)	0 (0)	0 (0)	0 (3)	0 (356)
£100,001 - £150,000	1 (0)	166 (0)	0 (0)	0 (0)	1 (0)	166 (0)
TOTAL	**1 (9)**	**166 (692)**	**10 (10)**	**261 (117)**	**11 (19)**	**427 (809)**

The Prior Year comparatives are shown in brackets.

There were ten non-compulsory departures agreed in 2013/14 at a cost of £261k and the split of these are detailed below.

Exit package type	Number of Payments agreed	Total Value of agreements
	Number	£000
Mutually agreed resignations (MARS) contractual costs	8 (7)	210 (58)
Contractual payments in lieu of notice	2 (0)	51 (0)
Compromise Agreement	0 (3)	0 (59)
TOTAL	**10 (10)**	**261 (117)**

The Prior Year comparatives are shown in brackets.

4.8 Staff Sickness

	2013/14 Number	2012/13 Number
Days Lost - Long Term*	28,919	31,905
Days Lost - Short Term	17,705	18,164
TOTAL DAYS LOST	**46,624**	**50,069**
Total Staff Employed In Period (Headcount)	3,008	2,934
Total Staff Employed In Period With No Absence(-Headcount)	1,074	1,291
PERCENTAGE STAFF WITH NO SICK LEAVE	**36%**	**44%**

*Over 20 consecutive days

5.0 Better Payment Practice Code

5.1 Better Payment Practice Code - measure of compliance

	2013/14 Number	2013/14 £000	2012/13 Number	2012/13 £000
Total trade invoices paid in the year	59,443	64,729	51,090	55,728
Total trade invoices paid within target	21,982	35,131	12,385	19,017
Percentage of Total trade invoices paid within target	37%	54%	24%	34%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust's improvement is due to the agreed cash support the Trust received in year from the DoH which enabled the Trust to plan the payment of its creditors in a more timely manner. As a result there were no payments made in year in respect of late payment of invoices under the Late Payment of Commercial Interest) Act 1998 (2012/13 £3k)

6. 0 Finance income and expense

6.1 Finance Income

	2013/14 £000	2012/13 £000
Interest on deposits and receivables	18	20
TOTAL	**18**	**20**

6.2 Finance Expenses – interest expense

	2013/14 £000	2012/13 £000
Loan from the Foundation Trust Financing Facility	89	109
Finance leases	396	473
TOTAL	**485**	**582**

6.3 Impairment of Assets (PPE and intangibles)

	2013/14 £000	2012/13 £000
Changes in market price (within Other comprehensive income)	197	4
Charged to the revaluation reserve	2,645	0
TOTAL IMPAIRMENTS	**2,842**	**4**

The Trust had a valuation as at the 31st March 2014 and as a result there were £2.8m impairment of assets which related to Plant Property and Equipment. Of this, £2.6m related to Buildings and was charged to the revaluation reserve and the balance which related to donated assets was charged to operating expenses.

7.1 Intangible Assets

	Software licences (Purchased) £000	Information technology (internally generated) £000	Development expenditure (internally generated) £000	Intangible assets under construction £000	Total £000
GROSS COST AT 1 APRIL 2013	**3,043**	**3,237**	**0**	**676**	**6,956**
Additions - purchased	176	73	359	69	677
Reclassification	14	226	0	(240)	0
Disposals	(200)	0	0	(261)	(461)
GROSS COST AT 31 MARCH 2014	**3,033**	**3,536**	**359**	**244**	**7,172**
AMORTISATION AT 1 APRIL 2013	**1,979**	**759**	**0**	**0**	**2,738**
Provided during the year	278	488	79	0	845
AMORTISATION AT 31 MARCH 2014	**2,257**	**1,247**	**79**	**0**	**3,583**
NET BOOK VALUE					
NBV - Purchased at 31 March 2014	776	2,289	280	244	3,589
NBV TOTAL AT 31 MARCH 2014	**776**	**2,289**	**280**	**244**	**3,589**
GROSS COST AT 1 APRIL 2012	**2,504**	**3,015**	**0**	**709**	**6,228**
Additions - purchased	339	208	0	182	728
Reclassification	200	15	0	(215)	(0)
GROSS COST AT 31 MARCH 2013	**3,043**	**3,237**	**0**	**676**	**6,956**
AMORTISATION AT 1 APRIL 2012	**1,733**	**306**	**0**	**0**	**2,039**
Provided during the year	246	453	0	0	699
Disposals	0	0	0	0	0
AMORTISATION AT 31 MARCH 2013	**1,979**	**759**	**0**	**0**	**2,738**
NET BOOK VALUE					
NBV - Purchased at 31 March 2013	1,064	2,464	0	676	4,204
NBV - Government Granted at 31 March 2013	14	0	0	0	14
NBV - Donated at 31 March 2013	0	0	0	0	0
NBV TOTAL AT 31 MARCH 2013	**1,078**	**2,464**	**0**	**676**	**4,218**

7.2 Economic Life of Intangible Asset

	Min Life Years	Max Life Years
INTANGIBLE ASSETS - INTERNALLY GENERATED		
Information technology	2	8
INTANGIBLE ASSETS - PURCHASED		
Software	2	8
Licences & Trademarks	2	8

8.1 Property, Plant and Equipment

Property, plant and equipment as at 31st March 2014 is broken down in the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & POA	Plant & machinery	Transport equipment	IT	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
COST OR VALUATION AT 1 APRIL 2013	**18,896**	**126,160**	**870**	**286**	**24,988**	**44**	**10,095**	**1,768**	**183,107**
Additions - purchased	0	2,229	0	0	3,347	0	2,580	17	8,173
Assitions - leased	0	0	0	0	47	0	0	0	47
Impairments charged to operating expenses	0	(577)	0	0	0	0	0	0	(577)
Impairments charged to the revaluation reserve	0	(9,659)	(25)	0	0	0	0	0	(9,684)
Reclassification	0	2	0	(2)	235	0	(235)	0	0
Revaluations	1,309	(8,663)	27	0	0	0	0	0	(7,327)
Disposals*	0	0	0	(4)	(12,215)	(18)	(6,355)	(741)	(19,333)
COST OR VALUATION AT 31 MARCH 2014	**20,205**	**109,492**	**872**	**280**	**16,402**	**26**	**6,085**	**1,044**	**154,407**
ACCUMULATED DEPRECIATION AT 1 APRIL 2013	**0**	**16,019**	**58**	**4**	**19,289**	**38**	**9,001**	**1,183**	**45,592**
Provided during the year	0	3,292	16	0	1,560	3	408	81	5,360
Impairments charged to operating expenses	0	(380)	0	0	0	0	0	0	(380)
Impairments charged to the revaluation reserve	0	(7,027)	(12)	0	0	0	0	0	(7,039)
Revaluations	0	(11,904)	(62)	0	0	0	0	0	(11,966)
Disposals*	0	0	0	(4)	(12,215)	(18)	(6,355)	(741)	(19,333)
ACCUMULATED DEPRECIATION AT 31 MARCH 2014	**0**	**0**	**0**	**0**	**8,634**	**23**	**3,054**	**523**	**12,234**
NET BOOK VALUE AS AT MARCH 2014									
NBV - Owned at 31 March 2014	20,205	91,005	207	280	6,927	3	2,905	52	121,584
NBV - Finance lease at 31 March 2014	0	3,566	665	0	539	0	126	469	6,365
NBV - Government Granted at 31 March 2014	0	11,292	0	0	162	0	0	0	11,454
NBV - Donated at 31 March 2014	0	2,629	0	0	140	0	0	0	2,769
NBV TOTAL AT 31 MARCH 2014	**20,205**	**109,492**	**872**	**280**	**7,768**	**3**	**3,031**	**521**	**142,172**

Notes: Disposals * in Cost and Depreciation relates to assets that were fully written down and no longer in use but had not been removed from the Trust Asset registers.

COST OR VALUATION AT 1 APRIL 2012 AS PREVIOUSLY STATED	**18,896**	**125,880**	**917**	**508**	**23,974**	**44**	**9,367**	**1,760**	**181,346**
Prior Period Adjustment	0	(650)	(47)	0	(28)	0	27	0	(698)
COST OR VALUATION AT 1 APRIL 2012 RESTATED	**18,896**	**125,230**	**870**	**508**	**23,946**	**44**	**9,394**	**1,760**	**180,648**
Additions - purchased	0	725	0	226	1,034	0	466	8	2,459
Reclassification	0	205	0	(448)	8	0	235	0	0
COST OR VALUATION AT 1 APRIL 2013	**18,896**	**126,160**	**870**	**286**	**24,988**	**44**	**10,095**	**1,768**	**183,107**
ACCUMULATED DEPRECIATION AT 1 APRIL 2012 AS PREVIOUSLY RESTATED	**0**	**13,358**	**81**	**0**	**17,769**	**34**	**8,640**	**1,097**	**40,979**
Provided during the year	0	(651)	(46)	0	(1)	0	0	0	(698)
ACCUMULATED DEPRECIATION AT 1 APRIL 2012 RESTATED	**0**	**12,707**	**35**	**0**	**17,768**	**34**	**8,640**	**1,097**	**40,281**
Provided during the year	0	3,312	23	0	1,521	4	361	86	5,307
Impairments	0	0	0	4	0	0	0	0	4
ACCUMULATED DEPRECIATION AT 31 MARCH 2013	**0**	**16,019**	**58**	**4**	**19,289**	**38**	**9,001**	**1,183**	**45,592**
NET BOOK VALUE AS AT MARCH 2013 RESTATED									
NBV - Owned at 31 March 2013	18,896	91,229	204	282	5,010	6	640	59	116,326
NBV - Finance lease at 31 March 2013	0	4,350	608	0	599	0	219	526	6,302
NBV - Government Granted at 31 March 2013	0	11,515	0	0	255	0	0	0	11,770
NBV - Donated at 31 March 2013	0	3,047	0	0	70	0	0	0	3,117
NBV TOTAL AT 31 MARCH 2013	**18,896**	**110,141**	**812**	**282**	**5,934**	**6**	**859**	**585**	**137,515**

Notes: The prior period adjustment is amending the prior year's Gross Cost and accumulated depreciation as this was incorrectly stated in the prior year's figures. In addition there was an incorrect classification between the NBV of Plant and machinery and IT relating to the prior year which has been reflected in these figures.

8.2 Analysis of Plant, Property and Equipment

There is no longer a requirement to disclose protected and non protected assets so this disclosure has been removed. The Trust can disclose that there have been no disposals in year of land and building assets used for the delivery of Commissioner Requested Services (CRS). In addition as at 31 March 2014, the Trust had no land and buildings valued at open market value.

8.3 Economic Life of Plant, Property and Equipment

	Min Life Years	Max Life Years
Buildings excluding dwellings	8	90
Dwellings	40	40
Plant & Machinery	5	20
Transport Equipment	7	7
Information Technology	2	8
Furniture & Fittings	5	10

8.4 Capital commitments

There were no commitments under capital expenditure contracts at the Statement of Financial Position date.

9.0 Investments Carrying Amount

Associate entities are those over which the Trust has the power to exercise a significant influence, but not control over the operating and financial management policy decisions. This is generally demonstrated by the Trust holding in excess of 20% but no more than 50% of the voting rights.

With effect from August 2009 the Trust has an associate investment in Milton Keynes Urgent Care Services, a community interest company (CIC) and holds an equity investment of 40% voting rights. The sum of the investment was £40.

The Trust has chosen not to reflect any surplus or deficit from the associate in the Trust accounts as the Trust deems the impact to be immaterial. In the event of any impact becoming material, the Trust will review the position and reflect this as appropriate.

10.0 Inventories

	Drugs	Consumables	Energy	Total
	£000	£000	£000	£000
AS AT 1 APRIL 2013	**590**	**1,577**	**62**	**2,229**
Additions	107	27	19	**153**
AS AT 31 MARCH 2014	**697**	**1,604**	**81**	**2,382**
AS AT 1 APRIL 2012	**445**	**1,231**	**12**	**1,688**
Additions	145	346	50	**541**
AS AT 31 MARCH 2013	**590**	**1,577**	**62**	**2,229**

There is a small movement in inventories as the trust continued to maintain stock balances to minimal levels and operated robust stock control measures continued from the previous year.

11.0 Trade and Other Receivables

	31 March 2014 £000	31 March 2013 £000
CURRENT		
NHS receivables (revenue)	7,192	5,088
Provision for impaired receivables	(2,084)	(615)
Prepayments (non PFI)	904	984
Accrued income	1,423	1,075
PDC Dividend	0	26
VAT receivable	530	120
Other receivables (revenue)	825	844
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**8,790**	**7,522**
NON-CURRENT		
Provision for impaired receivables	(103)	(77)
Other receivables (revenue)	579	891
TOTAL NON-CURRENT TRADE AND OTHER RECEIVABLES	**476**	**814**
	9,266	**8,336**

NHS receivables are mainly considered recoverable because the majority of trade is with CCG's, as commissioners for NHS patient care services. CCG's are funded by the Government to purchase NHS patient care services, therefore no credit scoring of them is considered to be necessary. However, the Trust has recognised an impairment for receivables which relates to CCG income. Similarly other receivables with related parties are with other Government bodies, so no credit scoring is considered necessary.

Trade and Other Receivables includes £1.8m for the value of partially completed patient episodes as at 31st March 2014 (31st March 2013 £1.8m).

At the Statement of Financial Position date there were no material concentrations of risk, the maximum exposure to credit risk being the carrying values of trade receivables.

11.1 Provision For Impairment of receivables

	31 March 2014 £000	31 March 2013 £000
AT 1 APRIL	**692**	**605**
Increase in provision	1,495	74
Amounts Utilised	0	13
Unused amounts reversed	0	0
AT 31 MARCH	**2,187**	**692**

11.2 Analysis For Impairment of receivables

	31 March 2014 £000	31 March 2013 £000
AGEING OF IMPAIRED RECEIVABLES		
0 - 30 days	0	0
30 - 60 days	0	0
60 - 90 days	0	0
90-180 days	1,462	105
over 180 days	725	2,005
TOTAL	**2,187**	**2,110**

Impaired receivables, aged 90 to 180 days in the main relates to payments from CCG's, those aged over 180 days cover payments from the Compensation Recovery Unit in relation to recovering costs arising through road traffic accidents. The irrecoverable debt provision has increased 15.8% to as notified by the Department of Health for debts arising in 2013/14, 12.5% in 2012/13,10.5% in 2011/12 and 7.8% for each year arising from 1999/00 to 2010/11.

	31 March 2014 £000	31 March 2013 £000
AGEING OF NON-IMPAIRED RECEIVABLES PAST THEIR DUE DATE		
0 - 30 days	1,322	1,931
30 - 60 days	180	313
60 - 90 days	225	65
90-180 days	123	40
over 180 days	216	14
TOTAL	**2,066**	**2,363**

12.0 Trade and other payables

	31 March 2014 £000	31 March 2013 £000
CURRENT		
NHS payables revenue	1,785	1,802
Other trade payables - capital	126	1,053
Other trade payables - revenue	4,458	2,874
Other payables	7,647	5,188
Accruals	2,731	1,020
PDC payable	15	0
TOTAL TRADE AND OTHER PAYABLES	**16,762**	**11,937**
Tax and Social Security	2,348	2,422
TOTAL TRADE AND OTHER PAYABLES inc Tax	**19,110**	**14,359**

12.1 Tax Payable

	31 March 2014 £000	31 March 2013 £000
Income Tax	1,207	1,260
National Insurance	1,141	1,162
TOTAL TAX PAYABLE	**2,348**	**2,422**

12.2 Other Liabilities

	31 March 2014 £000	31 March 2013 £000
CURRENT		
Other Deferred Income	159	619
TOTAL OTHER CURRENT LIABILITIES	**159**	**619**
NON-CURRENT		
Deferred Government Grant	0	0
TOTAL OTHER NON-CURRENT LIABILITIES	**0**	**0**
TOTAL OTHER LIABILITIES	**159**	**619**

The Trust has not received any government grant income in year.

13.0 Borrowings

	31 March 2014 £000	31 March 2013 £000
CURRENT		
Loan from Foundation Trust Financing Facility	445	445
Obligations under finance leases	365	337
TOTAL CURRENT BORROWINGS	**810**	**782**
NON-CURRENT		
Loan from Foundation Trust Financing Facility	2,221	2,666
Obligations under finance leases	6,346	6,664
TOTAL NON-CURRENT BORROWINGS	**8,567**	**9,330**
TOTAL BORROWINGS	**9,377**	**10,112**

The trust has a £4m loan from the Foundation Trust Financing Facility which is an unsecured loan which it fully drew down during 2010/11. The loan is to being repaid over a 10 year period at an interest rate of 3%. The first repayment of interest occurred in Dec 2010, with a further interest payment paid in June 2011. Principal and interest repayments have occurred thereafter in August and February, with the final payment being due in February 2020.

14.0 Prudential Borrowing Limit

With effect from 1st April 2013, the Prudential Borrowing Code and Limit is no longer required as they were repealed by the Health and Social Care Act 2012.Therfore these disclosures are no longer contained in the Annual Accounts.

15.0 Finance Lease obligations

The Finance leases cover a number of different items of equipment, but the main items include the Trusts Accommodation Block, Beds, Pharmacy Robot and a Haematology Analyser.

	Minimum lease payments		Present value of minimum lease payments	
	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000
GROSS LEASE LIABILITIES	**12,553**	**13,243**	**6,711**	**6,985**
of which liabilities are due				
- not later than one year;	734	738	365	337
- later than one year and not later than five years;	1,838	2,138	536	720
- later than five years.	9,981	10,367	5,810	5,928
TOTAL	**12,553**	**13,243**	**6,711**	**6,985**
Finance charges allocated to future periods	(5,842)	(6,242)	(6,242)	(6,242)
NET LEASE LIABILITIES	**6,711**	**7,001**	**869**	**742**
- not later than one year;	365	337	(5)	(63)
- later than one year and not later than five years;	536	769	(766)	(650)
- later than five years.	5,810	5,895	1,640	1,455
TOTAL	**6,711**	**7,001**	**869**	**742**

16.0 Provisions

	31 March 2014	31 March 2013
	£000	£000
CURRENT		
Pensions relating to staff	6	6
Other legal claims	308	96
Other	39	39
TOTAL CURRENT PROVISIONS FOR LIABILITIES & CHARGES	**353**	**141**
NON-CURRENT		
Pensions relating to staff	32	37
Other	693	724
TOTAL NON-CURRENT PROVISIONS FOR LIABILITIES & CHARGES	**725**	**761**
TOTAL PROVISIONS FOR LIABILITIES & CHARGES	**1,078**	**902**

	Pensions (other staff)	Other legal claims	Other	Total
	£000	£000	£000	£000
AT 1 APRIL 2013	43	96	763	902
Arising during the year	0	308	0	308
Utilised during the year	(6)	(40)	(39)	(85)
Reversed unused	0	(56)	0	(56)
Unwinding of discount	1	0	8	9
AT 31 MARCH 2014	**38**	**308**	**732**	**1,078**
EXPECTED TIMING OF CASHFLOWS:				
Not later than one year	6	308	39	353
Later than one year and not later than five years	25	0	155	180
Later than five years	7	0	538	545
TOTAL	**38**	**308**	**732**	**1,078**

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event and it is probable that the Trust will be required to settle the obligation and a reliable estimate can be made of the obligation.

The above provision for pension costs relates to additional pension liabilities arising from early retirements. Unless due to ill-heath, these are not funded by the NHS Pension Scheme. As noted within note 1.15 the full amount of such liabilities is charged to the income and expenditure account at the time the Trust commits itself to the retirement. Other includes four injury benefits, one of which amounts to £0.5m

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 2.9% in real terms.

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, and all clinical negligence claims are recognised in the accounts of the NHSLA, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is £27.5m (year ended 31 March 2013 £17.9m). No contingencies or provisions are in the accounts at 31 March 2014 in relation to these cases, even though the legal liability for them remains with the Trust.

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 NHSLA 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.

17.0 Revaluation Reserve

	Property, Plant & Equipment £000	Total £000
REVALUATION RESERVE AT 1 APRIL 2013	55,214	55,214
Impairment losses property, plant and equipment	(2,645)	(2,645)
Impairment gains property, plant and equipment	4,639	4,639
Other reserve movements	45	45
REVALUATION RESERVE AT 31 March 2014	**57,253**	**57,253**
REVALUATION RESERVE AT 1 APRIL 2012	55,214	55,214
Other reserve movements	0	0
REVALUATION RESERVE AT 31 March 2013	**55,214**	**55,214**

18.0 Cash and cash Equivalents

	31 March 2014 £000	31 March 2013 £000
AT 1 APRIL	640	1,583
Net change in year	(136)	(943)
AT 31 MARCH	**504**	**640**
Broken down into :		
Cash and commercial banks and in hand	134	62
Cash with the Government Banking Service	370	578
CASH AND CASH EQUIVALENTS AS IN SOFP	**504**	**640**
CASH AND CASH EQUIVALENTS AS IN SOCF	**504**	**640**

19.0 Liquidity Risk

The Trust's net operating income is mainly incurred under legally binding contracts with the local CCG's, which are financed from resources voted annually by Parliament. Under Payment by Results, the Trust is paid for the activity on the basis of nationally set tariffs. For contracted activity, the Trust is paid in 12 monthly instalments throughout the year, which significantly reduces the liquidity risk. Performance in excess of contracted levels up to the end of December 2013 has been agreed and paid for by with MKCCG at PbR rates. However the Trust is looking for further support to its working capital during 2014/15.

The Trust finance's its capital programme through internally generated resources and external borrowing.

20.0 Post Balance Sheet events

There are no post balance sheet events having a material effect of the accounts

21.0 Contingent Liabilities

The Trust has reviewed its liabilities it does not consider that it has any material contingent liabilities for the forthcoming financial period. The provisions that the trust has made for liabilities and charges are disclosed in note 16 including provisions held by the NHSLA as at 31 March 2014 in respect of clinical negligence liabilities of the NHS Foundation trust.

22.0 Related Party Transactions

The Trust is a body corporate established by the Secretary of State for Health. Government departments and their agencies are considered by HM Treasury as being related parties. During the year, the Trust has had a significant number of material transactions with other NHS bodies and in the ordinary course of its business with other Government departments and other central and local Government bodies. Most of these transactions have been with HMRC in respect of deductions and payment of PAYE, NHS Pensions Agency, Milton Keynes Council in respect of payment of rates and MKCCG which is the Trusts local commissioner of NHS services. There are additional related parties of, Monitor, Milton Keynes NHS Foundation Trust Charitable Funds and the Milton Keynes Urgent Care Service, with which there have been no significant transactions in year.

	2013 / 14				2012 / 13			
	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due to related party	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due to related party
	£000	£000	£000	£000	£000	£000	£000	£000
Department of Health	0	0	15	0	42	0	0	26
NHS Bodies	2,912	9,617	1,438	1,500	2,822	5,270	744	631
Milton Keynes CCG	9	115,523	4	4,132	576	122,348	408	2,559
Bedfordshire CCG	0	10,824	0	691	0	10,843	1	890
NHS England	8	20,287	0	345	0	137	0	9
NHS Aylesbury Vale CCG	0	6,628	0	175	0	7,664	0	400
NHS Nene CCG	0	2,665	0	169	19	2,861	58	186
Bedford Hospital NHS Trust	163	231	34	69	0	1,943	71	146
Northampton Hospital NHS Trust	472	146	58	5	410	68	163	0
Oxford University Hospital NHS Trust	340	1,367	230	100	300	1,353	359	268
NHS Litigation Authority	4,019	0	0	0	5,000	0	1	0
NHS Business Services Authority	10	0	12	0	0	0	0	0
South Central SHA	0	0	0	0	0	2,573	2	0
OTHER								
Other WGA Bodies	304	5	9	5	0	0	0	0
Local Authorities	220	244	0	0	616	183	0	0
HMRC	0	0	0	530	0	0	0	120
Dept of Work & Pension	7,781	0	1,141	0	7,502	0	1,162	0
NHS Pensions	10,387	0	1,207	0	9,952	0	1,260	0
TOTAL	**26,625**	**167,537**	**4,148**	**7,721**	**27,239**	**155,243**	**4,229**	**5,235**

During the year none of the Board members or members of key management staff or parties related to them have undertaken any material transactions with the Trust.

23.0 Financial Instruments

	31 March 2014 £000	31 March 2013 £000
Cash	504	640
Capital	504	640
Total Equity	504	640
Borrowings	9,377	10,112
OVERALL FINANCING	**9,881**	**10,752**
CAPITAL TO OVERALL FINANCING RATIO	**5%**	**6%**

Capital Risk Management

The Trust's capital management objectives are:

- to ensure the Trust's ability to continue as a going concern; and
- to provide an adequate return to reinvest in healthcare services by providing healthcare services commensurately with the level of risk of receiving income for those services provided.

The Trust monitors capital on the basis of the carrying amount of Public Dividend Capital less cash presented on the face of the balance sheet.

The Trust sets the amount of capital in proportion to its overall financing structure, i.e. equity and financial liabilities. The Trust manages the capital structure and makes adjustments to it in light of changes in economic conditions and the risk characteristics of the underlying assets.

Interest Rate Risk

The trust is not exposed to significant interest rate risk as the Borrowings are all at a fixed rate of interest.

23.1 Financial assets by category

	31 March 2014 Receivables £000	31 March 2013 Receivables £000
NHS Trade and other receivables excluding non financial assets	7,192	5,088
Non NHS Trade and other receivables excluding non financial assets	2,062	3,247
Cash and cash equivalents (at bank and in hand)	504	640
TOTAL AT 31 MARCH	**9,758**	**8,975**

23.2 Financial liabilities by category

	31 March 2014 Other financial liabilities £000	31 March 2013 Other financial liabilities £000
Borrowings excluding finance leases	2,666	3,111
Obligations under finance leases	6,711	7,001
NHS Trade and other payables excluding non financial assets	1,913	1,802
Non NHS Trade and other payables excluding non financial assets	17,197	12,557
Provisions	1,078	902
TOTAL AT 31 MARCH	**29,565**	**25,373**

23.3 Fair values of financial assets

	31 March 2014 Book value £000	31 March 2014 Fair value £000
Current Financial Assets *		
Non current trade and other receivables excluding non financial assets	9,282	9,282
Other	476	476
TOTAL	**9,758**	**9,758**

23.4 Fair values of financial liabilities

	31 March 2014 Book value £000	31 March 2014 Fair value £000
Current Financial Liabilities *	19,110	19,110
Provisions under contract	1,078	1,078
Loans	2,666	2,666
Other	6,711	6,711
TOTAL	**29,565**	**29,565**

*For Current Financial Assets and Liabilities Book and Fair values are assumed to be the same values.

23.5 Maturity of Financial Liabilities

	31 March 2014 £000	31 March 2013 £000
In one year or less	20,273	15,282
In more than one year but not more than two years	624	681
In more than two years but not more than five years	2,402	2,191
In more than five years	6,266	7,219
TOTAL	**29,565**	**25,373**

24.0 Third Party assets

The Trust held £0 cash at bank and in hand at 31 March 2014 (£3,000 at 31 March 2013) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figures reported in the accounts.

25.0 Losses and special payments

There were 156 cases at 31 March 2014 of losses and special payments totalling £110k approved during the year ended to 31 March 2014 (166 cases to 31 March 2013 totalling £123,000) These payments are the cash payments made in the year and are not calculated on an accruals basis. There were no compensation payments recovered during the year. Details of the payments are shown in the table below.

	31 March 2014		31 March 2013	
	Number	Value £000	Number	Value £000
1. LOSSES OF CASH DUE TO:				
a. theft, fraud etc	0	0	0	0
b. overpayment of saleries etc	1	0	15	14
c. other causes	1	0	2	0
2. FRUITLESS PAYMENTS	0	0	0	0
3. BAD DEBTS AND CLAIMS ABANDONED IN RELATION TO:				
a. private patients	5	0	16	3
b. overseas visitors	16	39	32	52
c. other	79	2	62	3
4. DAMAGE TO BUILDINGS, PROPERTY ETC. DUE TO:				
a. theft, fraud etc	0	0	0	0
b. stores losses	16	41	0	0
TOTAL LOSSES	**118**	**82**	**127**	**72**
SPECIAL PAYMENTS				
5. COMPENSATION UNDER LEGAL OBLIGATION	0	0	0	0
6. EXTRA CONTRACTUAL TO CONTRACTORS	0	0	0	0
7. EX GRATIA PAYMENTS IN RESPECT OF:				
a. loss of personal effects	25	6	16	5
b. clinical negligence with advice	0	0	0	0
c. personal injury with advice	0	0	3	38
d. other negligence and injury	0	0	0	0
e. other employment payments	1	18	0	0
f. patient referrals outside the UK and EEA Guidelines	12	4	19	8
g. other	0	0	0	0
h. maladministration, no financial loss	0	0	1	0
8. SPECIAL SEVERANCE PAYMENTS	0	0	0	0
9. EXTRA STATUTORY AND REGULATORY	0	0	0	0
TOTAL SPECIAL PAYMENTS	**38**	**28**	**39**	**51**
TOTAL LOSSES AND SPECIAL PAYMENTS	**156**	**110**	**166**	**123**

Appendices

Appendix 1

Constituencies and Governors 2013-14

	Constituency	No	Governors	Term of Office From	Term of Office To
A	Bletchley & Fenny Stratford, Denbigh, Eaton Manor & Whaddon	2	Dr Arun Nathan	14 May 2012	14 May 2015
			Peter Ballantyne	6 Jun 2013	5 Jun 2016
B	Emerson Valley, Furzton, Loughton Park	2	Brian Hobbs	17 Aug 2010	25 Jul 2016
			Vacant	10 April 2013	6 Jun 2013
C	Linford South, Bradwell, Campbell Park	2	Robert Collard	1 Oct 2007	23 Aug 2016
			Chris Phillips	18 Mar 2011	13 Mar 2017
D	Hanslope Park, Olney, Sherington, Newport Pagnell	2	Liz Wogan	12 May 2009	11 May 2015
			Roger Hornblow	13 May 2010	5 Jun 2016
E	Walton Park, Danesborough, Middleton, Woughton	2	Lesley Bell	1 Oct 2007	25 Jul 2016
			Vincent Lieu	6 Jun 2013	5 Jun 2016
F	Stantonbury, Stony Stratford, Wolverton	2	Ann Thomas	11 Oct 2012	10 Oct 2015
			Michael Moutrie	10 Feb 2012	9 Feb 2015
G	Outer catchment area	1	Vacant	6 Apr 2013	10 July 2013
			Adrienne Rutter	10 July 2013	9 July 2016
			Jean Button	21 Mar 2012	20 Mar 2015
H	Extended area	1	Vacant	25 Nov 2011	
STAFF CONSTITUENCY (7)					
I	Doctors and Dentists	1	Dawar Abbas	17 Aug 2010	25 Jul 2016
J	Nurses and Midwives	2	Kim Weston	1 Oct 2007	30 Sep 2016
			Julie Orr	17 Aug 2010	16 Aug 2013
			Vacant	16 Aug 2013	
K	Scientists, technicians and allied health professionals	1	Keith Marfleet	11 Oct 2012	10 Oct 2015
L	Non-clinical staff groups e.g. admin & clerical, estates, finance, HR, management	3	Lesley Dillon	11 Oct 2012	10 Oct 2015
			Paul Williams	11 Oct 2012	1 Aug 2013
			Eszther Pritchard	10 Oct 2013	9 Oct 2016
			Martyn Rollins	10 Feb 2012	9 Feb 2015
N	Milton Keynes Business Leaders	1	Vacant	1 Oct 2010	Not applicable
	Youth participation representative		Anita Dzre	13 Aug 2013	
			Jack Robinson	13 Aug 2013	
O	Healthwatch MK	1	Alan Hastings	25 Oct 2011	Not applicable
P	Milton Keynes Council for Voluntary Organisations	1	Clare Hill	1 Oct 2007	Not applicable
	Local Authority – Milton Keynes Council		Cllr Debbie Brock	1 Jul 2011	Not applicable
	Clinical Commissioning Group		Jeannie Ablett	19 Feb 2013	Not applicable

Appendix 2

Board and Governor Attendance

	Board of Directors	Audit Committee	Charitable funds	Finance & Investment	Quality Committee	Remuneration
Graham Anderson	3/5			11/12	7/8	1/1
Frank Burdett	3/5	3/5	4/4	13/15		1/1
John Blakesley	5/5		3/3			
Jean-Jacques DeGorter (from March 2014)					1/1	
Jonathan Dunk (from July 2013)	4/4	3/3	3/3	8/11		
Penny Emerson	3/5	3/5			3/9	1/1
Norma French	4/5					1/1
Robert Green	4/5	5/5	4/4	9/12*		1/1
Joe Harrison	5/5	1 ex officio		11/15	1 ex officio	1/1
Lisa Knight	3/5				6/9	
Darren Leech	3/5					
Chris Mellor (from Sep 2013)	3/3			7/8	4 ex officio	
David Moore	5/5			15/15		1/1
Tony Nolan (from March 2014)				1/1		
Kate Robinson	5/5	4/5			9/9	1/1
Robert Toole (until June 2013)	1/1	2/2	1/1	4/4		
David Wakefield	2/2	1 ex officio		3/6	1/3	
Martin Wetherill	2/5	3		5	2/9	

* Attended Finance and Investment Committee as Chair of Audit Committee.

Members of the Committee attendance is given above.

Council of Governor attendance

	9 April 2013	11 May 2013	11 June 2013	25 June 2013	13 Aug 2013	8 Oct 2013	10 Dec 2013	11 Feb 2014	All meetings	Nominations Committee
Ablett, Jeannie	✓	A	✗	✗	✗	✓	✓	A	3/8	
Abbas, Dr Dawar	✓	✓	A	✓	A	✓	✓	✓	6/8	0/0
Ballantyne, Peter	✓			✗	✓	✓	✓	✓	5/6	0/0
Bell, Lesley	✓	✓	✓	✓	✓	✓	✓	✓	8/8	1/1
Brock, Cllr Debbie	✓	✓	A	✓	✓	✓	✓	✓	7/8	0/0
Button, Jean	✓	✓	✓	✓	✓	✓	✓	A	7/8	0/0
Collard, Robert	✓	✓	✓	✓	✓	A	✓	✓	7/8	0/1
Dillon, Lesley	✓	✓	A	✓	✓	✓	A	A	5/8	0/0
Dzre, Anita					✓	✓	✗	A	2/4	0/0
Hastings, Alan	✓	✓	✗	✓	✓	✓	✓	✓	7/8	0/0
Hill, Clare	A	✓	A	✓	✓	A	✓	✓	5/8	0/0
Hobbs, Brian	✓	✓	✓	✓	✓	✓	✓	✓	8/8	0/0
Hornblow, Roger	✓	✗	✗	✓	✓	✓	✗	✗	4/8	0/0
Leiu, Vincent				✓	✗	A	A	A	1/5	0/0
Marfleet, Keith	A	✓	✗	✓	A	A	✓	✓	4/8	0/0
Mellor, Chris						✓	✓	✓	3/3	0/0
Moutrie, Michael	✓	✓	✓	✓	✓	✓	A	✓	7/8	0/0
Orr, Julie	✓	A	A	✗	✓				2/5	0/0
Phillips, Chris	✓	A	✓	A	✓	✓	✓	✓	6/8	0/0
Pritchard, Eszther							A	✓	1/2	0/0
Robinson, Jack					✓	✓	✓	✓	4/4	0/0
Rollins, Martyn	✓	A	✗	✓	✓	A	✓	✓	5/8	0/0
Rutter, Adrienne					✓	✓	A	✓	3/4	0/0
Thomas, Ann	✓	✓	✓	✓	✓	✓	A	A	6/8	0/0
Vaidyanathan, Dr Arun	A	✓	✗	✓	A	✓	✓	✓	5/8	0/0
Wakefield, David	✓	✓	A	✓	✓				4/5	0/0
Weston, Kim	A	A	A	✓	✓	✗	A	✓	3/8	0/0
Williams, Paul	✓	✓	✗	✓					3/4	0/0
Wogan, Liz	✓	✓	A	✓	✓	✓	✓	✓	7/8	1/1

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