Patient FIRST

NHS
Medway
NHS Foundation Trust

Annual report 2023-24

Best of care
Best of people

Medway NHS Foundation Trust
Annual Report and Accounts
April 2023 to March 2024

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Contents

Foreword from the Chief Executive

I am immensely proud to lead this Trust, supporting an extraordinary team of highly skilled professionals who come to work every day to put our patients first.

When I look back over 2023-24, there is much to reflect on, including times of significant pressure as we have seen more patients than ever needing our care. Thank you for your patience when waits for care were longer than we would like something we continue to work hard to improve. Thank you also for your understanding when we have needed to take the difficult decision to reschedule appointments and operations during periods of industrial action.

Patient First

There is also much to celebrate and be proud of this year. We have made progress on our Patient First improvement programme priorities – work that drives all that we do, underpinned by our values, and vision to deliver the Best of Care through the Best of People.

We have increased the number of patients treated as day cases in the Sunderland Day Case Unit, which has led to improvements in patient care and satisfaction. We have introduced a new bed management system that is helping us turn beds around more quickly, reducing delays for patients waiting for admission to a ward.

Another Patient First priority – improving the care of deteriorating patients and reducing the number of avoidable cardiac arrest calls – was the South East regional winner at the NHS Parliamentary Awards 2023 in the 'Excellence in Urgent and Emergency Care' category. The project has seen a sustained reduction in avoidable cardiac arrest calls from an average of five calls per month to just one.

Our ear, nose and throat (ENT) surgical team piloted High Intensity Theatre (HIT) lists which are designed to safely reduce the backlog for non-emergency surgery caused by the pandemic by focusing on just one type of routine operation. As a result, they removed the tonsils of 10 children on the same day, double the usual daily number.

More Care Closer to Home

We have continued to expand our services beyond the hospital walls, bringing care closer to home for more patients.

We opened our first Community Diagnostic Centre at Rochester's Healthy Living Centre, with work underway on the second, at Sheppey Community Hospital, which is due to open later in 2024. These centres provide quicker access to diagnostic tests – such as CT, MRI, X-ray and ECG – often closer to people's homes. They also help to free up diagnostic capacity at Medway Maritime Hospital to treat patients sooner.

We are proud of the success of the Sheppey Frailty Unit, which has looked after and discharged more than 600 patients since opening in January 2023. Run by Trust staff, the unit provides acute care closer to home for frail elderly people in Sheppey, Sittingbourne and the surrounding areas.

Regulator Inspections

Our maternity services retained their 'Good' rating following an inspection by the Care Quality Commission. The inspection report commended the range of services offered, including initiatives such as Call the Midwife, which is a 24-hour-a-day triage phone service, answered by experienced midwives, and Team Aurelia, a multi-disciplinary team that focuses on planned Caesarean births.

Harnessing Technology to Improve Care

Here at Medway we know that harnessing technology is key to improving care – both on the frontline and behind the scenes. Investing in a second surgical robot this year is enabling us to expand robotic assisted surgery to more specialties, which will benefit more patients. We have also invested in the latest robotic technology in our Pharmacy department, to speed up the dispensing of thousands of medicines every week.

As part of our ongoing digital transformation, patients can now access their hospital appointments on a new online portal called Patients Know Best. People can use Patients Know Best to view appointments, appointment letters, discharge summaries and more, quickly registering through the NHS app or the dedicated Patients Know Best website for Medway.

Investing In Our Hospital
We have continued to invest in improving our wards with £1.74 million spent transforming Harvey Ward, a 25-bed trauma and orthopaedic ward, which now has a dedicated relatives' room, a day room for patients, new therapy equipment and a dedicated room for patients living with dementia – the Butterfly Room.

The First Rate Café and Shop run by our valued partners, the Medway League of Friends, reopened in the hospital's main entrance following a major refurbishment. The café and shop now offer patients, visitors and staff a greater choice of hot and cold refreshments, a much improved layout and seating, and a new barista-style coffee area.

Serving Our Community
It is a real privilege to serve our local community and sometimes this extends beyond caring for our patients. Our excellent Acute Response and Resuscitation Service teams have been out-reach to teaching vital life-saving skills to local children. Hearing first-hand from NHS staff about what they do can be just the inspiration young people need to spark their interest in a rewarding NHS career.

We are proud to have received our Veteran Aware Accreditation, formally recognising our commitment to the Armed Forces Community. The accreditation, carried out by the Veterans Covenant Healthcare Alliance, recognises the Trust as an exemplar of the best standards of care for the Armed Forces Community.

It was a great honour to have been granted the Freedom of Medway, during the year of the 75th anniversary of the NHS. The honorary freedom of the borough is the highest civic distinction that can be conferred upon individuals or collective bodies and was conferred 'in recognition of the contribution of the staff of Medway Maritime Hospital to the community'.

Looking Ahead
Later this year we will open our new 32-bed cardio-respiratory village for patients needing treatment for heart and lung conditions. This exciting expansion has been possible thanks to additional funding secured by the Trust for urgent and emergency care services.

Finally, thank you to our valued staff, volunteers, governors, charity partners, health and care partners and local community for your ongoing support as we do our best to deliver the very best of care for local people.

……..
Jayne Black
Chief Executive

Foreword from the Chair

I joined the Trust as a Non-Executive Director in 2017, and it is fair to say every single year has been different, bringing its own challenges and also its highpoints.

Demand seems to grow each year, with population growth and new treatments requiring more from the NHS, while at the same time developments in services ensure we are able to deliver improvements to enhance the experience of patients at Medway Maritime Hospital.

During the past few years we have implemented our Patient First improvement programme which has seen colleagues across the Trust identifying areas where changes can be made to benefit patients. Many of these projects are now in place and already making a difference. Schemes range from improvements to the physical environment through ward refurbishments, to life-saving initiatives such as a reduction in the number of avoidable cardiac arrest calls.

We have also seen patient-led improvements. For example feedback from patients through the Friends and Family Test told us that it was difficult for some patients to sleep at night due to noise on wards, so we made changes, which have been well received.

The improvements made over the course of the year are too numerous to list here – many are included elsewhere in this annual report – however, we know we have more to do, and we look forward to more projects coming to fruition over the next 12 months.

I would like to thank members of the Board for their commitment to the Trust. We have seen some Non-Executives move on during the year, while others have joined us. I would particularly like to pay tribute to my predecessor Jo Palmer, who left the role of Chair at the end of October 2023 to take on a new role in the USA. Jo did a great deal to develop the Trust's relationships with partner organisations and was a first class ambassador for the hospital.

Our Governors – representing the communities of Medway and Swale, staff, and partner organisations – play an important role in holding the Non-Executive to account, as well as being a bridge between the Trust and the constituencies they serve, and I thank them for the time and commitment they give.

I would also like to thank our amazing volunteers who give their time so generously to help out around the hospital, on wards and in public areas, and the Medway League of Friends, Hospital Radio and Voluntary Services, who through their shops and donations raise greatly-needed funds for the Trust.

Last, but not least, I am in awe of our colleagues across the Trust, whether in clinical or non-clinical roles, on the frontline or behind the scenes. We are fortunate to have such a fantastic team and I give them our sincere thanks on behalf of the Board.

……
Mark Spragg
Chair

Performance Report

Purpose and Activities

Medway NHS Foundation Trust is a hospital Trust based in Gillingham, Kent serving more than 427,000 people across Medway and Swale.

It provides clinical services to more than half a million patients a year, including approximately 180,000 attendances to the Emergency Department, more than 87,000 admissions, more than 345,000 outpatients' appointments and more than 4,600 babies born last year.

As an NHS Foundation Trust, there are 26 seats on the Council of Governors and more than 6,000 public members. It employs more than 5,000 staff, making it one of Medway's largest employers. In addition, over 300 volunteers provide invaluable support across the Medway League of Friends, Hospital Radio and the Voluntary Services Department.

The Trust is comprised of five divisions – Cancer and Core Clinical Services, Central Operations, Medicine and Emergency Care, Surgery and Anaesthetics, and Women, Children and Young People.

The Board of Directors, led by Trust Chair Mark Spragg, comprises five Executive Directors including Jayne Black, Chief Executive, and six Non-Executive Directors including the Chair.

Brief History

Medway Maritime Hospital was originally a Royal Naval Hospital, opened by King Edward VII in 1905.

In 1961, the NHS acquired the hospital from the Navy. Buildings and facilities were updated as part of a £1.5million modernisation scheme and the hospital reopened again as Medway Hospital in 1965. The hospital changed its name in 1999 to mark the start of a new era. The new name 'Medway Maritime Hospital' reflects the hospital's proud naval origins.

Key Issues and Risks

The principal risks in delivering the Trust's Strategic Objectives are recorded in detail in the Board Assurance Framework and the key operational risks are described in the Corporate Risk Register, which are monitored by directorates, the Executive Group, Committees and the Board.

A summary of significant risks within the Board Assurance Framework is included within the Annual Governance Statement.

Going Concern

After making enquiries, the directors have a reasonable expectation that the services provided by Medway NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

The accounts have been prepared on a going concern basis as the Trust does not intend, nor consider that it will be necessary, to apply to the Secretary of State for the dissolution of the Trust with the transfer of the services to another entity in the foreseeable future.

The Trust considers the future financial performance and traditional going concern risks in the 'Overview of Financial Performance' section of this report.

Summary of Performance

The Trust overperformed against the national standard for the four-hour performance target in 2023/24, finishing the year on 77.4% (all types). This was a 5% increase in performance from 2022/23.

Key Performance Measures

The Trust formally agreed trajectories for the constitutional targets: Emergency Department, Referral to Treatment (RTT), Cancer and Diagnostic (known as DM01). These trajectories were based on demand and capacity work completed for all of the services using the NHS Improvement Tool.

The performance of these areas is monitored at all times and reported on a monthly basis in various different meetings internally and externally to the Trust.

Referral to Treatment (RTT)

The Trust did not meet the Referral to Treatment standard of 92%. It reported a year end position of 50.6%. The total waiting list size has steadily increased over the reporting period ending on 44,646 patients compared to 36,659 at the start of the year. The number of patients waiting more than 52 weeks for treatment is currently 2,159. The National standard was to achieve no patients waiting over 78 weeks which was achieved.

The Trust has identified a number of actions to address this underperformance, including:

- Addressing staffing issues in clinical areas with the largest waiting times and running additional clinics.
- Collaborating with system delivery partners to increase capacity.
- Launching the patient-initiated follow-up approach.

DM01

The Trusts performance against the Diagnostic Waiting Times and Activity standard (DM01) has been below the standard of 99% ending the year at 66.9%. Although factors such as poor capacity within Endoscopy and overall capacity versus demand has impacted negatively on the DMO1 the principal reason is a significant increase in demand for diagnostic modalities including Echocardiography, Endoscopy and MRI. The Trust continues to utilise support from the independent sector and mutual aid from other NHS Trusts to support the improvement plans for DM01.

Cancer

2023/24 Cancer Waiting Times Performance

The Trust performance against the 28-day standard ended the year below the standard for 75% ending the year at 66.6%. The top contributing factor was low capacity within Endoscopy which resulted in lower performance within both upper and lower gastrointestinal (GI) tumour sites. The Trust has been working with partners at NHSE and the ICB to secure additional Endoscopy capacity to support the cancer performance and is currently being supported with mutual aid from a neighbouring Trust. The Trust continues to develop and increase cancer nursing support for the initial 28 days of the pathway to decrease waiting times for initial appointment and diagnostic requests.

The Trust has consistently met the 96% operational standard for 31-day for the full 12 months. Patients with a confirmed diagnosis of cancer are treated with the urgency required to ensure the Trust remains compliant against this Key Performance Indicator (KPI).

The Trust was compliant in five of the twelve months with the 94% operational standard for 31-day subsequent treatment (surgery). This was achieved by continuing to work closely with the theatre and surgery teams to ensure that there was adequate capacity to prioritise treatments for patients with cancer. However, cases of national industrial action have impacted on the Trust's capacity and patient choice.

The Trust was compliant with the 98% operational standard 31-day waits for subsequent treatment (drug treatment) in nine out of 12 months. This represents a huge improvement in performance from the previous year.

The Trust ended the year with a performance of 72.3% against a target of 85% for 62 day waits from urgent GP referrals. This performance was largely driven by the challenges faced within the Upper GI and Lower GI tumour sites to achieve the 28-day performance which lead to delays in the pathway.

Emergency Care Standard

The year 2023/24 saw levels of attendance remain high, with a difficult and challenging winter season, of high attendances. The Emergency Department (ED) team has continued to drive forward with improvements to patient care, safety and delivering gold standard. These improvements saw the Trust achieve the four-hour target in October 2023 being one of only 16 acute Trusts to do this, nationally. There have been fantastic achievements within ED, these include:

- Launch of Single Point of Access Pathway, supporting the reduction of avoidable conveyances from South East Coast Ambulance Service.

- Launch of the direct access 111 pathway, reducing delays in ED and admission avoidance.
- Increased utilisation of Same Day Emergency Care (SDEC) and launch of the Acute Assessment Model, which has reduced length of stay within ED and decreased admissions into the Trust.
- Increase in the number of patients who access the right pathways from ED, for example; Surgical and Maternity.
- Achieving the national performance in March 2024, being the most improved Trust across the South East region.
- Maintained ambulance handover performance as a leading Trust in the country.
- Reduction of length of stay in many specialties to support Emergency Care patient flow.
- Reduced the time an inpatient bed is empty between patients by half, improving access to beds for patients in the ED.
- Reduced ED presentations by people awaiting elective care

The Trusts dedicated, clinically-led Patient First programme gives the tools and the confidence that the Trust will deliver the required improvements in quality, performance and patient and staff experience.

Sustainability Report

The Trust's Carbon Footprint

Medway NHS Foundation Trust continues to recognise that it is not only part of the NHS but that it plays an integral role in the local community.

Sustainability means spending public money intelligently and responsibly, making efficient use of natural resources and taking part in building healthy, resilient communities. By making the most of social, environmental and economic assets the Trust can improve health both in the immediate and long term even in the context of rising costs of natural resources.

Task Force on Climate-Related Financial Disclosures (TFCD)
NHS England's NHS foundation trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance pillar for 2023/24. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications.

Over the past year, the Sustainability Team has successfully secured funding for various decarbonisation projects. In June 2023, the Trust secured £83,000 through the Low Carbon Skills Fund (LCSF), run by the Department for Energy Security and Net Zero and delivered by Salix, to develop the Heat Decarbonisation Plan (HDP). This plan provides a net zero framework, outlining several stages to guide the transition from fossil fuel reliant heating systems to low carbon alternatives.

The initial stage of the HDP, projected to result in 3,500 tonnes of annual carbon savings, is currently underway, thanks to the £25.9million secured through the Public Sector Decarbonisation Scheme (PSDS) which is run by the Department for Energy Security and Net Zero and delivered by Salix. The proposed initiatives for this stage of the HDP include:

- De-steaming part of the hospital with heat pump systems
- Installing roof-mounted solar photovoltaic arrays across multiple buildings
- Replacing single glazed windows with double glazed units

The programme of works is a complex undertaking and will be carried out over two financial years, 2024/25 and 2025/26. The Trust embeds sustainability into its operation through the implementation of its Green Plan. Introduced during the 2020-21 period, and endorsed by the Board, the Green Plan provides an organisation-wide strategy that outlines the Trust's plan of action that is necessary to achieve the targets within the Greener NHS Net Zero Programme.

Progress on delivery of the Green Plan is provided to the Board through an annual summary report. Managements role in assessing and managing climate-related issues and the structure has been approved at Board level.

Throughout this year, significant strides have been made in advancing sustainability objectives through the establishment of a robust governance and assurance framework to facilitate the delivery of the Green Plan. Through the formation of dedicated Green Working Groups, alongside the appointment of individuals in specific sustainability roles, this leadership will play a pivotal role in supporting the Trust's sustainability agenda and driving performance in sustainability initiatives.

Alan Davies, Chief Financial Officer, is overseeing the resourcing and delivery of this Green Plan, and has been appointed as the Trust's Net Zero Lead. Neil McElduff, Director of Estates and Facilities and Senior Responsible Officer (SRO) for the Green Plan, is accountable for leading the Green Plan and reporting into the NHS Kent and Medway Integrated Care Board Environmental Sustainability Steering Group. In collaboration with the NHS Kent and Medway Integrated Care Board, the Trust previously undertook an exercise to assess and improve its carbon footprint methodology. The Trust now calculates this data on a quarterly basis, facilitating ongoing monitoring and evaluation of its environmental impact.

The Green Sustainability Operational Group, convenes bi-monthly with the participation of 10 senior staff members, including Directors and Associate Directors of the Trust. The group is tasked with the implementation of the various workstreams and actions outlined in the Green Plan.

The Green Sustainability Strategic Group, comprising of the Trust's Executive Directors, and chaired by Jayne Black, the Chief Executive, assumes the responsibility of overseeing the activities of the Operational Group and monitors progress against goals and targets for addressing climate-related issues. This entails ensuring alignment with the Trust's strategic objectives. The group meets quarterly and will receive performance updates on the workstreams and action plan of the Operational Group. This group reports into the Board on an annual basis reviewing and approving its Green Plan.

The Green Champion Network, is still in its early stages but already has 25 registered Champions actively involved in championing sustainability initiatives. The Green Champions will identify initiatives at a grass roots level within the Trust and will lead on implementation of the projects that the network is running.

An optimisation study to identify areas of sub-optimal performance and enhance efficiency in the heating system is underway. This initiative has been made possible by securing £23,000 through the Heat Network Efficiency Scheme (HNES). This study is exploring subsequent stages of the HDP and presents an opportunity for the Trust to not only mitigate energy expenditure but also minimise its carbon footprint.

Finally, the Trust also secured £173,000 in January 2024 through the National Energy Efficiency Fund (NEEF). This funding supports the ongoing implementation of LED lighting throughout the Trust. LED lighting offers significant benefits over traditional lighting options, such as reduced energy consumption and carbon emissions.

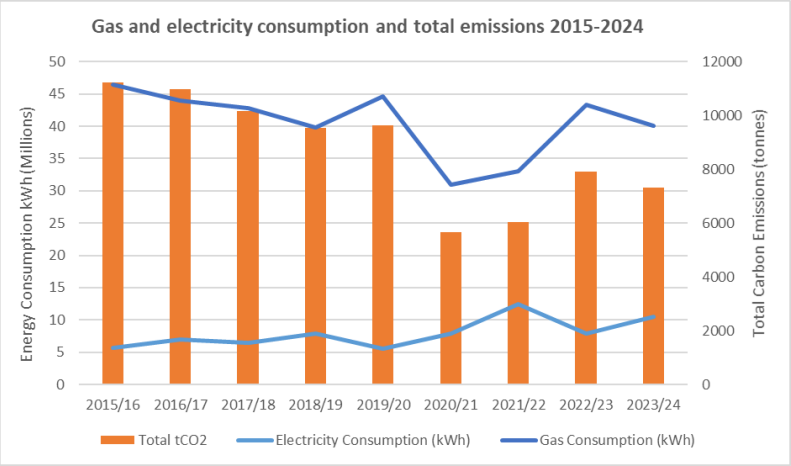
During the most recent year, 2023/24, the Trust spent a total of around £8.2million on electricity and gas. This increase in spending can be attributed to rising energy costs. Supply pressures on gas and generated electricity have directly resulted in significant increases in the unit costs charged by suppliers. The following table shows energy consumption and costs in 2021/22 and 2023/24:

Energy Usage and Costs 2021-22 to 2023-24						
	Consumption			**Costs**		
	21-22	**22-23**	**23-24**	**21-22**	**22-23**	**23-24**
	KWH	**KWH**	**KWH**	**£**	**£**	**£**
Gas	36,491,997	46,214,831	40,064,445	874,698	3,300,348	4,016,482
Electricity	12,558,811	8,565,071	10,473,540	1,924,119	2,344,706	4,174,831
Total	**49,050,809**	**54,779,902**	**50,537,985**	**2,798,817**	**5,645,054**	**8,191,313**

**KWH - A kilowatt-hour is a non-SI unit of energy equal to 3.6 megajoules in SI units which is the energy delivered by one kilowatt of power for one hour.*

The Combined Heat and Power plant (CHP) is approximately 15 years old. While it does provide cost savings, gas yields a degree of unit price efficiency over electricity, as part of the HDP and the move towards decarbonisation, replacing the CHP is necessary in the long term. Since it has only been operating intermittently, a review of the use of the CHP is needed in the short term.

The energy consumption patterns shown below reflect the operational patterns of the CHP. The Trust's emissions directly associated with gas and electricity are also provided below and highlights the switch to carbon neutral electricity in 2020/21, allowing the Trust to report a zero emissions factor for electric.



Community Engagement, Human Rights and Anti Bribery

The Trust strives to undertake meaningful community engagement through actively informing, involving, and inviting feedback about its services. Involvement from the local community is essential in helping shape and influence decision making to improve services and patient experience. The Trust encourages people to get involved and share their views, this will help give us a better understanding of the diverse health needs and what matters to patients, carers, the public, members, stakeholders and the wider community.

The Trust continues to share updates and opportunities for involvement by attending virtual and face-to-face meetings, community events, sharing information, and invitations to events with members and the community, providing updates on the website and through the bi-monthly Community Engagement newsletter.

In the last year, the Trust hosted and attended a variety of public events, including events focusing on Perinatal Mental Health, Therapies and Older People, and Quality Priorities.

In July, the Trust held its second Summer Fun Day following the success of the first, with lots of activities for families to take part in. This was an opportunity for people to find out more about the Trust's charities and volunteering.

The Engagement Team has held stands in a variety of places, including shopping centres, supermarkets, awareness events, colleges and universities. The team took part in engagement sessions in relation to the Sheppey Frailty Unit, and Patient First.

During the first anniversary week of Patient First, the Trust held a variety of engagement activities with staff, stakeholders and public, which helped shape the Clinical Strategy. It raised awareness of Patient First and engaged on "What does Patient First mean to me?".

There was attendance at numerous community events during the year, including; Medway Armed Forces Day, Riverside English Festival, Medway Pride, Swale Pride and two Freshers' Fairs at local universities in September as part of ongoing work to increase engagement with the younger generation.

The Trust held its Annual Members' Meeting in September 2023; the Trust invites the community, alongside Governors, members and staff. The Trust continues to build on community engagement and provides opportunities to engage with the wider community groups in areas that are harder to reach. This will ensure the Trust continues to learn and discover the amazing work that is taking place in the local community, and ensure community voices heard will be at the Trust.

Anti-Bribery and Fraud

During the reporting period, the Trust's local counter fraud services have been provided by RSM UK. The Audit and Risk Committee approved the annual counter fraud work plan. It receives a progress report at each meeting detailing cases of possible fraud and the outcome of any investigations. Progress in respect of proactive work and themed reviews is also reported. The Audit and Risk Committee monitors the implementation of any recommendations made by RSM UK by way of a Management Audit Action Tracker.

The Local Counter Fraud Services Team works closely with the internal audit team (KPMG) to consider how identified fraud risks can be addressed within the scope of their reviews and additional assurance can be provided through this route.

The team also provide a report to the Audit and Risk Committee regarding the Trust's scoring for the Counter Fraud Functional Standard Return, which is continuously monitored throughout the year against the Government Functional Standard 013: Counter Fraud.

Throughout the year RSM UK raised awareness through bespoke training sessions, a refreshing of induction materials for the Trust, Fraud Alerts to Trust staff and communications through events like Fraud Awareness Week.

The team brought two investigations forward from 2022/23 and 11 new referrals of fraud were received during 2023/24, which were investigated and outcomes reported to the Audit and Risk Committee. 11 of these referrals are closed and two remain open.

Equality, Diversity and Human Rights

Control measures are in place to ensure that the organisation's obligations under equality and human rights legislation are complied with. The Trust employs a Head of Equality and Inclusion to provide strategic and practical professional guidance and advice to the Trust.

The Trust's strategic approach to equality and diversity is managed through the Equality Delivery Scheme (EDS). This is reviewed periodically, and the Equality Strategy will be refreshed in 2024. Additionally, the Trust publishes the results and action plans on mandatory equality metrics, such as the Gender Pay Gap and Workforce Race and Disability Equality Standards. These metrics enable the Trust to benchmark with other NHS organisations and partners, to produce and maintain action plans, and review and improve its performance for people with characteristics protected by the Equality Act 2010.

Training on equality and human rights is mandatory for all staff, and management programmes have been developed to improve the Trust's leadership skills around equality, diversity and human rights. The Trust is committed to going beyond that which is mandated and makes equality and inclusion an integral part of everything it does for staff, patients and the local community. The Trust developed and adopted an Anti-Discrimination Statement in 2023, setting out five key commitments to going beyond being non-discriminatory to being anti-discriminatory. The Statement sets a tone for staff, patients and community alike to be able to receive and give respect.

The Trust has also continued to develop its policies and procedures to promote equality of opportunity and outcomes. In this past year this has included strengthening the Trust's approach to Equality Impact Assessments, revising and extending the Reasonable Adjustment and Modified Duties Policy, and developing a comprehensive Anti-bullying, Harassment, Discrimination and Conflict Resolution Policy. The latter policy is supported by the development of a team of Dignity at Work Advisors, drawn from a wide range of job roles and diverse backgrounds. 25 Advisors have been independently trained to support and advise staff who raise concerns about issues of dignity and discrimination at work.

Gender Pay Gap

In March 2024, the Trust published its gender pay gap and supporting statement for 2022/23, as required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. The Trust's mean gender pay gap is 30.5 per cent and the median gender pay gap is 20.9 per cent. This is an improvement from the position in 2021. The gender pay gap relates to gender differentials in the progression to senior roles, particularly in medical roles. There is some evidence that this pattern is repeated in many other Trusts across the NHS and relates to professional career paths.

There is reasonable confidence that, owing to Agenda for Change and medical pay reviews, the NHS is providing equal pay (men and women paid equally to carry out the same jobs, similar jobs or work of equal value). However, it is evident that in medical roles there have been, traditionally, significantly more men progressing to the most senior levels, resulting in a gender pay gap.

While there is little that the Trust can do in the short term to address the gender pay gap, because the issue affects professions that have long term career pathways, action can be taken to encourage the retention and career progression of women into senior roles, particularly in medicine. Therefore, a key focus for 2024 is reviewing and ensuring that opportunities are created for women to develop into leadership within the medical workforce. This approach has been supported by the Trust's Women's Staff Network and Chief Medical Officer and will be progressed with the involvement of women in the medical workforce. The Women's Staff Network is also a key stakeholder and advisor on general to improvements to reduce the gender pay gap.

The Agenda for Change gender pay gap for 2023 was 1.9 percent, down from 3.1 percent in 2022. The data for the 2023/24 reporting period is due by 31 March 2025, but will be published on the Trust's website in the summer of 2024.

Overview of Financial Performance

Although on occasion the quality of the service the Trust offers has not achieved the levels it strives for, this has not been as a result of the removal of resource nor a lack of willingness to ensure managers and clinicians have the manpower and equipment they need to provide those services. Choices have been made and will continue to be made as to how services might develop and change within the funding envelope and the Trust will maintain its close relationships with local commissioners and the Integrated Care System/Board to ensure patients receive the best care for the best value.

The accounts presented in this 2023/24 annual report shows a deficit of £24.0 million; the performance against the Trust's control total is as per the table below:

	Plan £m	Actual £m	Variance £m
Clinical income	393.4	**433.9**	40.5
Other income	27.9	**36.7**	8.8
Pay	(255.3)	**(314.1)**	(58.8)
Non-pay	(159.0)	**(173.0)**	(14.0)
Operating surplus	7.0	**(16.5)**	(23.5)
Non-operating expenses	(7.1)	**(7.5)**	(0.4)
Reported surplus/(deficit)	(0.1)	**(24.0)**	(23.9)
Net impairments	-	**0.2**	0.2
Donated Asset cost/income net	0.1	**0.1**	-
Control total	-	**(23.7)**	(23.7)

During the course of the financial year the Trust began to report an adverse performance. This principally arose from:

- Incomplete and identification and non-delivery of efficiencies.
- Net impact of industrial action.
- Patient acuity and unbudgeted escalation capacity.
- Medical pay award funding shortfall.
- Premium costs of vacancies.
- Costs of covering rota gaps.
- High cost drugs and devices reimbursement.

Income

The majority of the Trust's income is directly related to patient care from commissioning organisations such as Integrated Care Boards and NHS England. The contract in 2023/24 set a fixed income sum based on historically contracted levels, whilst elective activity was paid on a 'cost and volume' using the national tariff. The Trust delivered elective activity over and above plan to a value of £5.3 million in 2023/24 on this basis.

Other operating income included: education and training funding; non-patient care or 'hosted' services to other organisations; car parking income; research and development funding, and; charitable contributions to expenditure.

Expenditure

In 2023/24 the Trust is reporting increased costs of £30.9 million on pay; these arose from: £14.7 million on pay awards, £3.0 million in respect of pension and social security costs, £10.4 million in respect of service developments (including Community Diagnostic Centres and the Sheppey Frailty Unit) and c£4 million in respect of industrial action costs. Non-pay has increased by £25.1 million when compared to 2022/23; this includes: £12.2 million on the purchase of healthcare (supporting the elective recovery activity), £2.9 million relates to higher depreciation charges (from investments made in the current and preceding financial year), £2.4m on drugs costs (activity and inflation), £5.2m on premises (maintenance, repairs and cleaning) and £0.8m on clinical negligence insurance premiums.

Capital Expenditure Plan

During the year, the Trust has invested £28.1m in capital schemes (excluding £2.0m on lease asset additions) in the areas shown in the table below:

	Total in £m
Estates and Site infrastructure	7.2
Fire Safety	1.2
Service Development	8.5
IT	5.5
Equipment	5.7
Total	**28.1**

The total investment is 8.5% higher than the previous year, mainly due to large externally funded projects approved by NHS England. Some of the notable projects in the year have included:

- Development of community diagnostics hubs in Sheppey and Rochester, due to complete in 2024/25
- Continuing implementation of an electronic patient records system
- Ward refurbishments
- Replacement of aged imaging equipment and other medical devices
- Fire safety works

Cash Flow and Balance Sheet

The balance sheet shows £275.6m of net assets at the end of the year, down from £288.2m of net assets at previous year end. This arises principally from the reported deficit.

The Trust ended the year with £21.0m cash in the bank; this is lower than originally planned due to the deficit. An application has been made for a revenue support loan – based on current performance forecasts, the Trust anticipates needing this additional cash support in order to be able to pay its creditors. See below for further information.

Financial Outlook

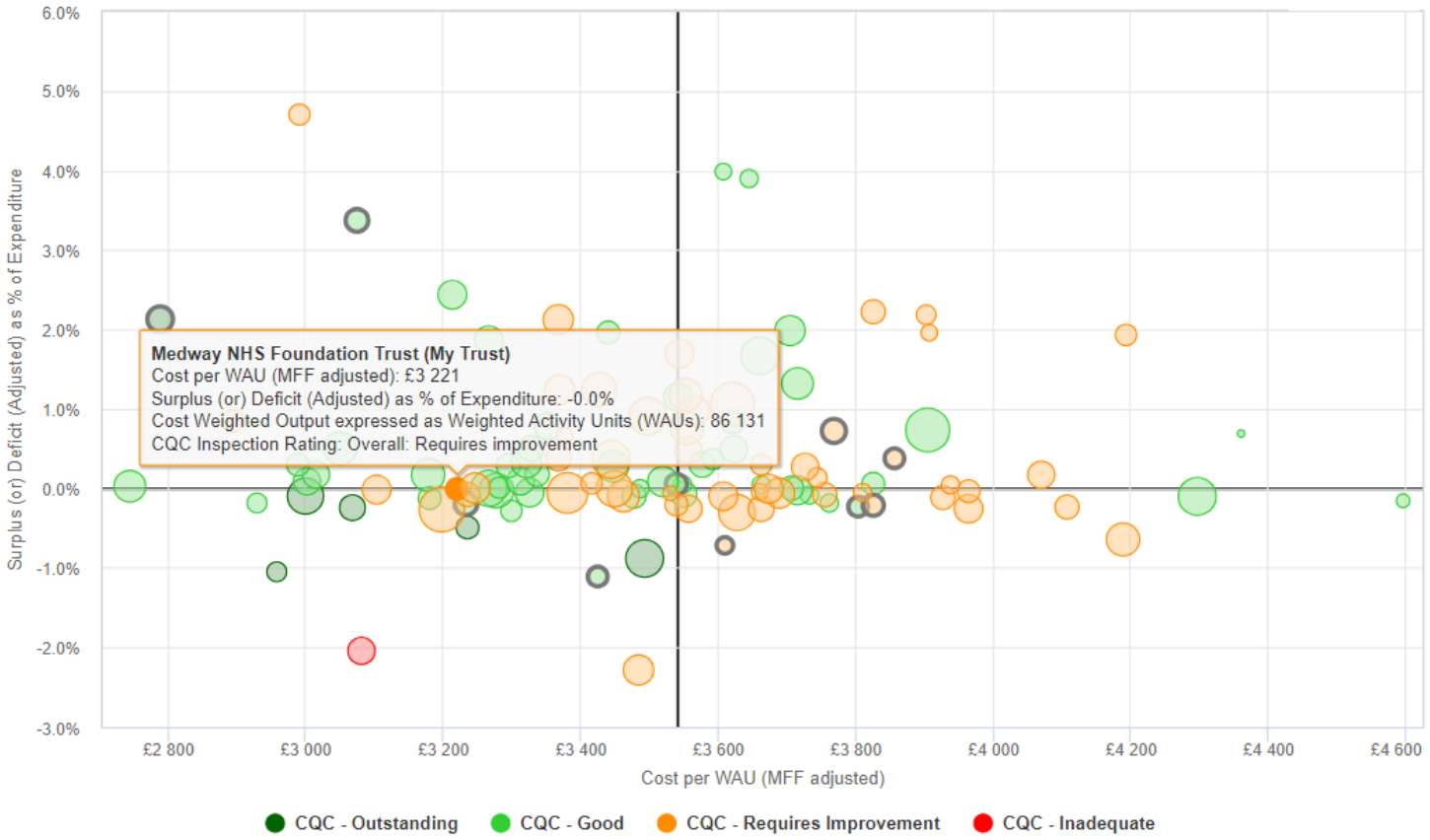
2024/25 will be another challenging year for the Trust. The Trust has submitted a deficit plan for the year of £29m, arising as a consequence of the continuation of those 2023/24 cost pressures.

There are a number of key risks to the overall 2024/25 plan, each of which are high on the agenda of the Board. Specifically:

- Delivery of activity in a capacity constrained hospital
- Mitigation of cost pressures, including inflationary costs over and above tariff
- Delivery of a £21.6m / 4.8% efficiency programme, ensuring no compromise on quality
- Managing investments to a tight capital programme

Based on cash flow projections, and principally driven by a continued deficit, the Trust anticipates it will need cash support during 2024/25. Without sufficient cash reserves the Trust would not be able to pay its staff, its suppliers or meet other liability obligations; this could ultimately affect the availability of human and consumable resources and equipment, with potential impacts thereafter on patient care. An application has consequently been made to NHS England for a revenue support loan.

From nationally collected data it is known that in recent years the Trust has improved its efficiency position relative to Trusts up and down the country. This is represented by the chart below sourced from the national model health system data. The Trust's cost per 'weighted activity unit' has reduced each year from a high of £3,832 in 2016/17 to £3,221 in 2021/22 (the last available period).



It shows the Trust is below the national median for its average costs yet historically it has had a significant deficit. The task as a health economy is to move performance to comfortably within the top left-hand quartile (better than average efficiency; surplus) while ensuring patients receive the care they deserve.

During 2023/24 the Trust revisited and refreshed elements of its Financial Recovery Plan (FRP) that had been agreed by system partners and NHS England in 2022. The Integrated Care System is working with its partner organisations to develop a long-term financial model, looking at financial performance several years into the future to understand where there may be emerging risks and opportunities to improve financial sustainability. The Trust will utilise that work and build this into a further update to its FRP during 2024/25. The Trust still target achieving a recurrent and underlying breakeven position by 2028/29.

Overseas Operations

The Trust does not have any overseas operations.

As Accounting Officer, I am satisfied that this performance report provides a true and accurate summary of the performance of the Trust during the year 2023/24.

Signed

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Jayne Black
Chief Executive
Thursday, 20 June 2024

Accountability Report

Directors' Report

Board of Directors

The following disclosures relate to the Trust's governance arrangements and illustrate the application of the main and supporting principles of the NHS Foundation Trust Code of Governance (the Code). It is the responsibility of the Board of Directors to ensure that the Trust complies with the provisions of the code or, where it does not, to provide an explanation which justifies departure from the code in the particular circumstances.

The Directors' Report has been prepared under direction issued by NHS England, the regulator for foundation trusts, and in accordance with the NHS Foundation Trust Annual Reporting Manual 2023/24.

The Trust Board

Medway NHS Foundation Trust is run by the Board of Directors. The Board is responsible for overseeing the overall strategic and corporate direction of the Trust and ensures the delivery of the Trust's goals and targets. It is also responsible for ensuring its obligations to regulators and stakeholders are met. Strategic priorities are set by the Trust Board annually. The risks to achieving these priorities are monitored through the Board Assurance Framework, which provides the Board with a systematic process of obtaining assurance to support the mitigation of risks. The Trust Board leads the Trust and provides a framework of governance within which high quality, safe services are delivered to the residents of Medway and Swale.

Trust Board Governance

The Board comprises a Non-Executive Chair, five other Non-Executive Directors, one Non-Executive Director (non-voting – ending July 2024), one Associate NED (non-voting – ended 31 March 2024) and one Academic NED (non-voting), five voting Executive Directors, including the Chief Executive, Chief Financial Officer, Chief Nursing Officer, Chief Medical Officer, Chief Operating Officer and Chief People Officer (both sharing a vote).

The Chair is responsible for leadership of the Board of Directors and the Council of Governors and responsible for ensuring that the Board and Council work together effectively. The Senior Independent Director, who is also a Non-Executive Director, provides a sounding-board for the Chair and serves as an intermediary for the other Directors when necessary. They should be available to Governors if they have concerns that contact through the normal channels has failed to resolve, or for which such contact is inappropriate. The Senior Independent Director is also the deputy chair.

The Non-Executive Directors scrutinise the performance of the Executive team in meeting agreed goals and objectives and monitor performance. The Executive Directors are responsible for managing the day-to-day operational and financial performance of the Trust. The Chief Executive leads the Executive team and is accountable to the Board for the operational delivery of the Trust.

Voting Board directors (Executive and Non-Executive) have joint responsibility for Board decisions, the same legal responsibilities and collective responsibility for the performance of the Trust.

Together the Non-Executive Directors and Executive Directors bring a wide range of skills and experience to the Trust, such that the Board achieves balance and completeness. The Board meets monthly with bi-monthly Strategy Deployment Review sessions.

All Non-Executive Directors are eligible for appointment for two three-year terms of office, and in exceptional circumstances a further term of 12 months. The Chair and Non-Executive Directors are appointed by the Council of Governors in accordance with the Trust's Constitution.

The Board has an approved Scheme of Delegation. The Board delegates some of its powers to its committees, all of which have a Non-Executive Chair. The arrangements for delegation are set out in the Trust's Standing Orders and Scheme of Delegation. The Trust's Constitution and Terms of Reference of these committees and their specific powers are approved by the Board of Directors. The Board committees are all assurance committees with the exception of the Nomination and Remuneration Committee.

Board Appointments and Leavers

Non-Executive Directors are appointed through a formal and transparent procedure, managed through the Governors' Nomination and Remuneration Committee, a sub-committee of the Council of Governors. This committee also advises the Council on the remuneration and terms and conditions of the Non-Executive Directors.

The Council of Governors, advised by the Governor Nominations Committee, appointed Gary Lupton and Mojgan Sani as Non-Executive Director for three years from 01 September 2023. The roles were advertised externally through Gatenby Sanderson recruitment agency.

The Council of Governors, advised by the Governor Nomination and Remuneration Committee, were informed that Jo Palmer, Chair tendered her resignation on 03 October 2023 and her last working day would be 31 October 2023, with Mark Spragg, Deputy Chair to be Acting Chair in the interim.

Decisions Delegated to the Executive Group

The Executive Directors meet weekly and the meeting is chaired by the Chief Executive. Its purpose is to ensure that the objectives agreed by the Board are delivered and to analyse the activity and performance of the Trust against the business plan to ensure that duties are appropriately delegated to the senior management team and actions monitored. It also ensures that the key information from external bodies is discussed, actions identified and messages disseminated appropriately across the organisation.

Statement about the Balance, Completeness and Appropriateness of the Board

The members of the Trust Board possess a wide range of skills and bring experience gained from NHS organisations, other public bodies and the private sector. The skills portfolio of the directors, both Executive and Non-Executive are balanced to ensure it meets the requirements of a NHS Foundation Trust.

The Non-Executive Directors are considered to be independent in character and judgement and the Board believes it has the correct balance in its composition to meet the requirements of a NHS Foundation Trust.

The Trust's constitution permits each term of office to be up to three years, to a maximum of seven years' service. Appointments and removals of Non-Executive Directors are determined by the Council of Governors on the advice of the Governors Nomination and Remuneration Committee.

The Constitution was refreshed at the end of April 2023 to ensure it was fully compatible with the amendments to the Health and Care Act 2022 and the revised Code of Governance.

Directors of Medway NHS Foundation Trust 2023/24

Non-Executive Directors

Joanne Palmer - Chair – appointed 22 October 2020 to 31 October 2023
Appointed as Non-Executive Director 01 September 2015
Appointed as Senior Independent Director 22 December 2016
Appointed as Deputy Chair 01 April 2017 Acting Chair from 01 April to 21 October 2020
Term: first as Chair, ending 31 October 2023

Experience and Qualifications
More than 30 years' experience in banking and financial services across a range of disciplines. Member of the national committee for the Group's women's network, Breakthrough.

Membership of Committees
- Council of Governors (Chair)
- Trust Nomination and Remuneration Committee
- Finance Planning and Performance Committee
- Quality Assurance Committee
- Corporate Trustee

Mark Spragg – appointed Acting Chair from 01 November 2023
Non-Executive Director
Deputy Chair and Senior Independent Director.
Appointed 01 April 2017
Term: second term commenced 1 April 2020 (extended for 12 months)

Experience and Qualifications
Qualified solicitor with more than 30 years' experience
Both a civil and criminal litigation specialist with expertise in Financial Services. Involved in a number of notable cases. Involved in charity work.

Membership of Committees*
- Audit and Risk Committee (Chair)
- Finance, Planning and Performance Committee
- Trust Nominations and Remuneration Committee (Chair)
- Governor Nominations and Remuneration Committee (Chair)
- Corporate Trustee (Chair)

**The above listed changed to the Acting Chair commitments from 01 November 2023.*

Adrian Ward
Non-Executive Director (non-voting from 01.09.23)
Non-Executive Director for Freedom to Speak Up
Appointed 01 August 2017
Term: second, ending 31 July 2023 (extended to 31 July 2024)

Experience and Qualifications
Practising Veterinary Surgeon, Graduate of the Royal Veterinary College.
BSc (Hons) in Physiology from King's College, London.
Former Veterinary Advisor for pharmaceutical company – developed an interest in the development of antimicrobial resistance and the strategies that can be used to slow this process.
Case examiner for the Royal College of Veterinary Surgeons Preliminary Investigation Committee from 2015.
Chair, Fitness to Practise Panel for the Nursing and Midwifery Council from 2017
Member - Institute of Chartered Accountants in England and Wales investigating Committee 2018.
Promotes responsible antibiotic use and infection control strategies through his work with the Bella Moss Foundation.
Assists in development of educational resources for the veterinary profession as a volunteer for the British Small Animal Veterinary Association.

Membership of Committees

- Quality Assurance Committee
- Health and Safety Strategy Committee
- Nominations and Remuneration Committee
- Corporate Trustee

Annyes Laheurte
Non-executive Director
Appointed 01 April 2021
Term: first, ending March 2024 (extended to 11 April 2027)

Experience and Qualifications
More than 25 years' experience in financial reporting together with financial planning and analysis for international organisations.
While working at Lloyd's of London, focused on financial controls, process enhancements and safeguarding the Society's assets by mitigating operational risks.
A Chartered Global Management Accountant (1991) and member of the Institute of Risk Management (2007) and was awarded Specialist status (2009).

Membership of Committees

- Finance Planning and Performance Committee (Chair until 01 September 2023)
- Audit and Risk Committee (Chair from 01.09.23)
- Nominations and Remuneration Committee
- Corporate Trustee

Sue Mackenzie
Non-Executive Director
Acting Senior Independent Director from 01 November 2023
Appointed 01 April 2020 to 31 March 2024 (resigned)
Term: second, originally ending 31 March 2026

Experience and Qualifications
Formerly Operations and Business Transformation Director for P&O Ferries.
Operations Director at London Luton Airport
Career in the Army
Chief Executive of the charity Cities in Schools

Membership of Committees

- People Committee (Chair)
- Nomination and Remuneration Committee
- Corporate Trustee

Paulette Lewis
Non-Executive Director
Appointed November 2022.
Term: First, ending October 2025

Experience and Qualifications
Worked more than 35 years in a variety of healthcare settings, gaining wide experience across acute and community services. Held several senior/executive posts, including Director of Midwifery and Children's' Services, Executive Director Nursing and Director of the Pan London Maternity Service Review. A leadership and management consultant and has spent a great deal of time mentoring and coaching individuals to help them reach their full potential.
Received a Silver Award for excellence in healthcare. In 2002, her charitable and leadership work was recognised by her receiving the European Social and Humanitarian award. In October 2022, she received the Zenith Global Healthcare Award as special recognition for global healthcare work. Nominee for Nurse of the Year by the Jamaican Times UK Community Award in 2014.
Awarded an MBE in the Queen's Birthday Honours List in June 2014 for work and contribution to nursing and charity work.

Membership of Committees

- Quality Assurance Committee (Chair)
- People Committee
- Nomination and Remuneration Committee
- Corporate Trustee

Gary Lupton
Non-Executive Director
Appointed 01 September 2023
Term: First, ending 31 August 2026

Experience and Qualifications

Significant level of experience across both the private and public sectors with a clear understanding of the links between financial resources and how this drives quality outcomes and ultimately achieves the objectives of the organisation. Commercial and Board level experience within the NHS constructively challenging and helping colleagues to develop strategies to obtain best practice examples to shape the vision to achieve.

Knowledge and understanding of what good governance looks like, understanding detail and how this links to overall performance. Understanding the requirement to meet standards, targets and compliance with legal regulations, for example meeting environmental and fire standards.

Awarded the Chairman's award for work to improve the patient environment.

Completed the Institute of Directors training. Undertook the procurement of one of the first private hospitals to support the delivery of NHS workloads.

Membership of Committees

- Finance, Planning and Performance Committee (Chair)
- Audit and Risk Committee
- Nomination and Renumeration Committee
- Corporate Trustee
- People Committee

Mojgan Sani
Non-Executive Director
Appointed 01 September 2023
Term: First, ending 31 August 2026

Experience and Qualifications

Accomplished and innovative NHS senior leader with professional background as Corporate Director of Clinical Outcomes and Effectiveness, Chief Pharmacist and Controlled Drugs Accountable Officer. Served the NHS as the lead director for Health Inequalities within an NHS Foundation Trust. Significant experience of working across acute hospitals, primary care, academia, and specialist regional responsibilities feeding into the Integrated Care System (ICS). Achievements in operational, quality and safety transformation initiatives, financial efficiencies, people engagement, service transformation, system wide engagement and bringing the NHS and academia together as a visiting professor for Medicines Optimisation for improved patient care. Other roles include CQC Specialist Advisor, NHS Non-Executive director roles for the subsidiary companies owned by the NHS, Trustees at Charitable organisations, Public Governor for a large mental health Foundation Trust, and Non-Executive Director at acute provider level and Integrated Care Board.

NHS achievements for quality improvement and transformation have led to nominations for Parliamentary award, NICE Fellowship, and appointments as a visiting professor with a number of universities.

Membership of Committees

- Quality Assurance Committee
- Audit and Risk Committee
- Nomination and Renumeration Committee
- Corporate Trustee

Non-voting Associate Non-Executives:

- Jenny Chong, Associate Non-Executive Director
- Rama Thirunamachandran, Academic Non-Executive Director (to 30 September 2023)
- Chris Burton, Academic Non-Executive Director (from 01 February 2024)

Executive Directors

Jayne Black, Chief Executive

Experience and Qualifications
Jayne became the Trust's Chief Executive in August 2022. Jayne originally joined the Trust in November 2021 as Chief Operating Officer before becoming Interim Chief Executive in June 2022.
Jayne has considerable NHS leadership experience and is a trained nurse by background. She has worked across acute, community and the wider system throughout her career, in a variety of roles.

Alan Davies, Chief Financial Officer

Experience and Qualifications
Alan joined the Trust in November 2020 and brings with him extensive Finance experience within the NHS, in acute, clinical commissioning group (CCG) and Strategic settings. His last NHS role was as Chief Finance Officer for Luton CCG and before that Deputy Finance Director at Barking Havering and Redbridge Hospitals.
He has a strong track record in improving financial performance and strengthening governance in NHS organisations in support of improving care for patients. Alan is a Fellow of the Chartered Association of Certified Accountants.

Leon Hinton, Chief People Officer

Experience and Qualifications
Leon brings a wealth of experience, having worked in a number of hospitals in the NHS over the past 23 years. He holds Chartered Fellow status with the Chartered Institute of Personnel and Development; a Master of Chemistry degree from the University of Warwick and postgraduate degrees in Human Resources Management (University of Wolverhampton) and Strategic Workforce Planning (University of West London).
Leon was an integral part of the leadership team at Great Ormond Street Hospital which won the national HPMA award in 2015 for improved HR capability.

Evonne Hunt, Chief Nursing Officer (on secondment)

Experience and Qualifications
Appointed October 2021 to the role of Chief Nursing Officer, Evonne has been a nurse for 24 years and has held director and senior leadership level positions in nursing, quality governance, patient safety, and risk management in acute, mental health and commissioning organisations in the NHS. She has also worked in the Department of Health and the independent/private healthcare sectors.

As Chief Nursing Officer, Evonne has board level responsibility for professional nursing, midwifery and allied health profession workforce to support the delivery of high-quality compassionate care. Evonne is on external secondment from 04 December 2023

Sarah Vaux, Interim Chief Nursing Officer (from 01 January 2024)

Experience and Qualifications
Sarah has worked in the NHS for more than 35 years, starting her career by training as a nurse here at Medway Maritime Hospital. Sarah has worked as a nurse, midwife, health visitor and safeguarding specialist nurse locally and across the south east, before going on to hold a number of nursing executive and leadership positions.

Before joining Medway, Sarah's most recent role was as Director of Nursing for NHS England South East Region.

Alison Davis, Chief Medical Officer (and Caldicott Guardian)

Experience and Qualifications
Appointed January 2022, Alison started her clinical career as a paediatric ophthalmologist and has worked as a consultant at Moorfields Eye Hospital, St George's Hospital Tooting, Croydon University Hospital and as an honorary consultant at Great Ormond Street Hospital.

Recent clinical leadership experience includes Deputy Medical Director at Moorfields and hospital Medical Director at Kent and Canterbury Hospital.

Nick Sinclair, Chief Operating Officer (from April 2023)

Experience and Qualifications
Nick Sinclair was appointed as the Chief Operating Officer in April 2023. Nick trained as a Paramedic in Kent in 1994 and specialised in trauma management and urgent care. He held several operational and educational management roles within the ambulance service. He then moved to the acute sector leading significant improvement in Emergency Care standards and RTT performance and has held various senior leadership roles in operations.
He is a graduate from the Elizabeth Garrett Anderson, Masters in Healthcare Leadership programme and has qualified as a Service Improvement Practitioner.

Gavin MacDonald, Chief Delivery Officer and Senior Independent Risk Owner Officer – Non-Voting (from April 2023 as interim, from June 2023 as substantive)

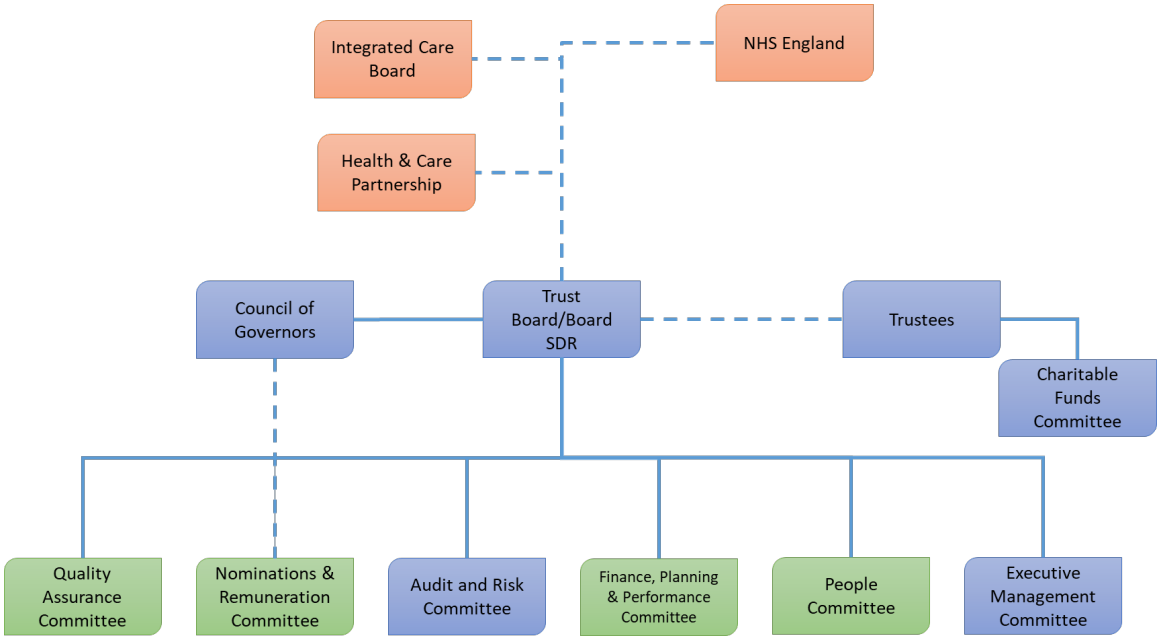
Experience and Qualifications
Gavin trained as a registered nurse in Scotland and specialised in critical care. He has held several senior management positions in England and Wales in acute hospitals, integrated care organisations and with an NHS regulator.
He is a graduate from the national chief operating officer programme and has held several Board roles across England and Wales.
He holds a Masters degree in leadership and management, has a diploma in health emergency planning and is a quality improvement and service redesign practitioner.

Trust Board Meetings
The Trust Board held a total of six public meetings between 01 April 2023 and 31 March 2024, and nine development sessions including Patient First and Strategic Development Review. Trust Board meetings are held in public unless there is confidential or sensitive information to be discussed. This is detailed on the board agenda which is published, together with the meeting papers on the Trust's website.

Director attendance at formal committee and public board meetings is detailed under: *Attendance at Board of Directors and Committee meetings in 2023/24.*

Development of Working Relationships with the Council of Governors
The Board of Directors and the Council of Governors have development/discussion sessions to examine particular areas of interest and concern. With the challenges facing the Trust, these sessions enable the views of both the Board of Directors and Council of Governors to be shared and are considered invaluable to all concerned.

Committees of the Trust Board
The Board delegates certain functions to committees that meet regularly. The Board receives any amendments to committee terms of reference. Non-Executive Directors chair the Board committees. Each committee reviews its own effectiveness annually; an up-to-date work programme, action log and terms of reference is maintained for each one. As part of the organisation's implementation of the Patient First improvement methodology the Trust has undertaken a review of its governance and has been aligning the committees' Terms of Reference and work programmes to the new approach.



Audit and Risk Committee
The report of the Audit and Risk Committee is detailed separately as required by section C.3.9 of the NHS Foundation Trust Code of Governance.

Quality Assurance Committee
The Quality Assurance Committee is chaired by a Non-Executive Director and has delegated authority from the Board to be assured that the appropriate structures, systems and processes are in place to manage quality and safety related matters, and that these are monitored appropriately. The Committee ensures an integrated and coordinated approach to the development and monitoring of the quality metrics (patient safety, patient experience and clinical effectiveness) at a corporate level; it leads on the monitoring of quality systems within the Trust to ensure that quality is a key component of all activities within the Trust, and ensures compliance with regulatory requirements and best practice with patient safety, patient experience and clinical effectiveness.

The Committee regularly receives assurance (where necessary seeks further guidance or actions) on serious incidents, safeguarding, infection prevention and control, complaints and other matters relating to the experience of patients. The Committee also receives assurance from the Integrated Quality and Performance Report.

Outcomes from clinical audits are discussed at Committee meetings. The Committee provides an Assurance Report to the Board of directors after every meeting on its activities.

The Committee met 11 times during 2023/24. Attendance record is detailed under Attendance at Board of Directors and Committee meetings in 2023/24.

Finance, Planning and Performance Committee

The Committee is chaired by a Non-Executive Director and provides assurance that the Trust's strategy, financial forecasts, plans and operational performance are being considered in detail, and provides independent and objective assurance to the Board regarding investments and significant contracts before their approval by the Board.

The Committee provides an Assurance Report to the Board of directors after every meeting on its activities.

The Committee met 11 times during the year. Attendance record is detailed under Attendance at Board of Directors and Committee meetings in 2023/24.

People Committee

Chaired by a Non-Executive Director, this Committee has strengthened the Board's focus on key areas such as equalities, Freedom to Speak Up, staff well-being and recruitment.

The Committee provides an Assurance Report to the Board of directors after every meeting on its activities.

The Committee met six times during the year. Attendance record is detailed under Attendance at Board of Directors and Committee meetings in 2023/24.

Nominations and Remuneration Committee

The Nominations and Remuneration Committee is chaired by the Senior Independent Director. Its membership consists of the Trust's Chair and non-executive directors. The Committee is responsible for reviewing and making recommendations to the Board on the composition, balance, skill mix and succession planning of the Board, for determining the appointment of the executive directors, and monitoring the level and structure of other senior managers reporting directly to the Chief Executive.

It is responsible for reviewing the size, structure and composition of the Board on an annual basis and makes recommendations to the Board. Directors have individual appraisals and professional development reviews.

The Committee met three times during the year. Attendance record is detailed under Attendance at Board of Directors and Committee meetings in 2023/24.

Attendance at Board and Committee Meetings - April 2023 to March 2024

Voting Members and Attendees *(see Non-Executive Directors Biography and Committee Structure for Chair of Committees)*	**Job Titles**	**Trust Board Private (Six Meetings)**	**Trust Board Public (Six Meetings)**	**Nomination and Remuneration Committee (Four**	**Audit and Risk Committee (Five Meetings)**	**Finance, Planning and Performance Committee**	**Quality Assurance Committee (11 Meetings)**	**People Committee (Six Meetings)**
Jo Palmer	*Chair (until 31.10.23)*	3 of 3	3 of 3	1 of 1	1 of 3	4 of 6	4 of 6	2 of 3
Mark Spragg	*Senior Independent Director (until 31.10.23)*	3 of 3	3 of 3	1 of 1	4 of 4	5 of 6		
Mark Spragg	**Chair (Acting from 01.11.23)**	3 of 3	3 of 3	2 of 2				
Adrian Ward	*Non-Executive Director (until 31.08.23)*	1 of 2	1of 2	1 of 2	2 of 3		4 of 5	2 of 2
Alan Davies	**Chief Financial Officer**	6 of 6	6 of 6		4 of 5	10 of 11		
Alison Davis	**Chief Medical Officer**	5 of 6	5 of 6				8 of 10	1 of 4
Annyes Laheurte	**Non-Executive Director**	5 of 6	5 of 6	3 of 3	4 of 5	9 of 11		
Evonne Hunt	*Chief Nursing Officer (secondment from 04.12.23)*	4 of 4	4 of 4				6 of 7	
Gary Lupton	**Non-Executive Director (from 01.09.23**	4 of 4	4 of 4	2 of 2	3 of 3	6 of 6		3 of 4
Gavin MacDonald	*Chief Delivery Officer (Interim from 03.04.23 until 31.07.23)*	2 of 2	2 of 2			2 of 2		
Gavin MacDonald	**Chief Delivery Officer (from 01.08.23)**	4 of 4	4 of 4			7 of 9		
Jayne Black	**Chief Executive**	6 of 6	6 of 6	2 of 3		8 of 11	8 of 11	
Leon Hinton	**Chief People Officer**	6 of 6	6 of 6	3 of 3				4 of 6
Mojgan Sani	**Non-Executive Director (from 01.09.23)**	3 of 4	3? of 4	1 of 2	3 of 3		3 of 4	
Nick Sinclair	**Chief Operating Officer**	6 of 6	6 of 6			8 of 11		
Paulette Lewis	**Non-Executive Director**	4 of 6	4 of 6	3 of 3			9 of 10	6 of 6
Sarah Vaux	**Chief Nursing Officer (Interim from 01.01.24)**	2 of 2	2 of 2				2 of 2	1 of 2
Sue Makenzie	**Non-Executive Director**	4 of 6	4 of 6	2 of 3		5 of 11		6 of 6
Non-voting Members								
Adrian Ward	**Non-Executive Director (Non-Voting from 01.09.23)**	4 of 4	4 of 4	1 of 1			4 of 5	4 of 4
Chris Burton	**Associate Non-Executive Director (from 01.02.24)**	1 of 1	1 of 1	0 of 1				
Jenny Chong	**Associate Non-Executive Director**	6 of 6	6 of 6	2 of 3			5 of 10	5 of 6
Rama Thirunamachandran	*Associate Non-Executive Director (until 30.09.23)*	3 of 3	3 of 3	0 of 1				

Audit and Risk Committee Report
The Audit and Risk Committee's responsibilities and key areas discussed during 2023/24, while fulfilling these responsibilities, described below:

PRINCIPLES OF RESPONSIBILITY

Review of the Trusts Risk Management Processes

1) Reviewing the Trust's internal financial controls, its compliance with national guidance for foundation trusts, including the Code of Governance, and the effectiveness of its internal control and risk management systems.

2) Reviewing the principal non-clinical risks and uncertainties of the business and associated annual report risk management disclosures. (Clinical risks are reviewed by the Quality Assurance Committee).

Key areas discussed and reviewed by the Committee during 2023/24:

The outputs of the Trust's risk management processes including reviews of:

a) The Board Assurance Framework – the principal risks and uncertainties identified by the Trust's executive directors and movement in the impact and likelihood of these risks and assurances on controls.
b) Work continuing on the Trust's risk management processes and risk reporting. Annual assessment of the effectiveness of internal control systems taking account of the findings from internal and external audit reports.
c) Internal audit, counter fraud and external audit reports and updates.
d) Interests, gifts, hospitality and sponsorship quarterly declarations.
e) Losses and special payments
f) Waivers of standing financial instructions

Financial Matters

1) Monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance

2) Review the annual report and financial statements before submission to the Board, to determine their objectivity, integrity and accuracy

Key areas discussed and reviewed by the Committee during 2023/24:

a) Annual report and financial statements, including the Head of Internal Audit Opinion, the Annual Governance Statement, the Annual Internal Audit Report, the Annual Counter Fraud Report and the External Audit Opinions on the Financial Accounts and recommended acceptance to the Trust Board.
b) Key accounting policy judgements, including valuations.
c) Impact of changes in financial reporting standards where relevant.
d) Single tender waivers
e) Losses and special payments

External Audit

1) Monitoring and reviewing the external auditor's independence, objectivity and effectiveness.

2) Developing and implementing policy on the engagement of the external auditor to supply non-audit services, considering relevant ethical guidance.

Key areas discussed and reviewed by the Committee during 2023/24:
a) Basis for concluding that the Trust is a going concern.
b) External auditor effectiveness and independence.
c) External auditor reports on planning, a risk assessment, internal control and value for money reviews.
d) External auditor recommendations for improving the financial systems or internal controls.
e) Changes to Accounting Standards.

Internal Audit

1) Monitoring and reviewing the effectiveness of the Trust's internal audit function that meets National Audit Office 2015 Code of Audit Practice and provides appropriate independent assurance to the Committee.

2) Satisfying itself that the Trust has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority's standards and reviewing the outcomes of work in these areas.

Key areas discussed and reviewed by the Committee during 2023/24:

a) High priority internal audit recommendations with progress report covering 18 months.
b) The internal audit reports discussed by the Committee included:
    - Board Assurance Framework – Significant assurance with minor improvement opportunities.
    - 2022-23 Data Security and Protection Toolkit Audit – Partial assurance with improvements required.
    - HFMA Action Plan – Significant assurance with minor improvement opportunities.
    - Resuscitation Training Data - Partial assurance with improvements required.
c) The reports identified recommendations for improvement that have been accepted by the executive directors.
d) There have been regular reports and updates from the Local Counter Fraud Specialist throughout the year. Following the Lucy Letby incident, there was a deep dive into the Fit and Proper Persons Test (FPPT), this included a recommended FPPT check on all Board members.

Composition and Meetings

The Committee is a non-executive committee of the Board, established in accordance with the Trust's Constitution and has delegated authority to review the adequacy and effectiveness of the Trusts systems of internal control and the arrangements for risk management, control and governance processes to support Trust objectives.

Executive directors attend by invitation, and the Chief Executive and Chief Financial Officer are generally in attendance. Other executive directors and staff with specialist expertise attend by invitation. The Committee met five times during the financial year.

Code of Governance

Medway NHS Foundation Trust has applied the principles of the Code of Governance for NHS Provider Trusts (the Code) on a comply or explain basis. This includes the revised Code implemented from 01 April 2023 – it replaces the previous NHS Foundation Trust Code of Governance issued by Monitor. The Code brings together best practice from both the public and private sector in order to help NHS Foundation Trust Boards maintain good quality corporate governance. In so far as the Board are aware, all possible steps have been taken to ensure that all relevant audit information has been disclosed in full to the auditors.

Effectiveness of the Committee

The Committee reviews its effectiveness and impact annually using best practice guidance, and ensures that any matters arising from this review are addressed.

The Non-Executive Directors were satisfied that in 2023/24 the Committee had complied with its obligations and expectations as noted in its terms of reference, with steady progress being made on improving processes, with further improvement required.

The Committee reviewed its terms of reference in March 2024. The terms of reference were revised with changes to adhere to best practice and amendments to the Trust's approach to risk management. The Committee also reviewed and approved its Annual Work Plan for 2024/25.

The Committee also reviewed the performance of its internal and external auditors' service against best practice criteria as detailed in the NHS Audit Committee Handbook.

External Audit

The Council of Governors approved the appointment of Grant Thornton for a three-year term from 2019/20, with an option to extend for a further two years. This reporting period saw the last year of this appointment and the Trust is exploring the market to ascertain future options. This year's fee was £123,000 before VAT.

Their audit and non-audit fees are set, monitored and reviewed throughout the year and are included in the notes to the accounts.

Independence of External Auditor

The Audit and Risk Committee considered the independence of the external auditor undertaking non-audit work. No risks were identified in this respect, particularly in relation to self-review and familiarity. The Trust auditors will not be relying on any additional work undertaken when forming their opinion and the Trust does not believe there to be a threat of familiarity.

Internal Controls, Internal Audit and Counter-Fraud Services

Counter Fraud Services, provided by RSM, carry out reviews of areas at risk of fraud and investigate any reported frauds.

Internal Audit Services are provided by KPMG. Internal audit cover financial and non-financial audits according to a risk-based plan agreed with the Audit and Risk Committee.

The audit plan of the internal auditors is risk-based, and the Executive Team work with the auditors to identify key risks to inform the audit plan. The Committee considers the links between the audit plan and the Board Assurance Framework. The Committee approves the internal audit plan and monitors the resources required for delivery.

During the year, the Committee considers any proposed changes to the audit plan and monitors delivery against the plan approved at the start of the financial year.

The Head of Internal Audit Opinion 2023/24 was presented to the Audit and Risk Committee on 20 June for the period 01 April 2023 to 31 March 2024. An overall rating of ‘‘partial assurance with improvements required (Amber/Red)” can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

The Committee has reviewed the content of the annual report and accounts and taken as a whole:

a) It is fair, balanced and understandable and provides the necessary information for stakeholders to assess the Trust's performance
b) It is consistent with the annual governance statement, head of internal audit opinion and feedback received from the external auditors, and there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.
c) It is appropriate to prepare the accounts on a going concern basis.

The Committee has approved the annual report and accounts under delegated authority from the Board of Directors.

Medway NHS Foundation Trust Volunteer Services

Over 300 volunteers provide invaluable support to the Trust, amounting to over 2,500 hours a month across the following voluntary services: Voluntary Services Department and the Medway League of Friends, Hospital Radio that operate independently alongside them. Volunteers give their time to help support patients and visitors and assist the Trust in providing high-quality, compassionate care to the people of Medway and Swale.

The Trust volunteers offer their time in a variety of roles including:

- On wards
- Reception areas and guiding
- Administration and clerical roles
- Chaplaincy
- Gardening
- Therapy dogs
- Café and Shop

The Trust's longest serving volunteers are Dot Rust and Pat Windsor who have both been volunteering here for nearly 30 years. Zoe Goodman, the Trust's Voluntary Services Manager said: "Volunteering at a hospital can be a highly rewarding experience, and a great way to connect with the local Medway community. Our volunteers do a fantastic job helping patients and visitors, always with a smile on their faces."

The Trust recognised the National Volunteers Week in June 2023, marked with a celebratory afternoon tea for all volunteers. Jayne Black, Chief Executive said: "Our volunteers work tirelessly in contributing to the smooth running of our hospital, including wards, reception areas and as guides. On behalf of everyone here at the Trust, we would like to thank our volunteers for the time they give to support the delivery of the best of care to our patients."

Anyone with an interest in health and wellbeing who is over the age of 18 years old or over, is welcome to apply to become a Trust volunteer at: https://www.medway.nhs.uk/work-with-us/volunteering/

The Medway League of Friends

2023/24 was another memorable year for The Medway League of Friends (the League) and work started on the new shop in 2023. During the construction phase, the League served customers using a small kiosk in the hospital main entrance and this was much appreciated by patients, visitors and staff.

The League moved into the new shop on 14 June 2023. The facility is open 24/7 and has enabled them to close the small outlet in the Emergency Department and return the space to the Trust. The League have received many compliments on the new shop; the variety of items on offer has increased considerably and there are two serving counters available to reduce queues. The new shop was officially opened on 01 November 2023 by the Mayor of Medway, Cllr Nina Gurung.

During the period April 2023 to March 2024 the League was able to support bids totalling £320,500 of which £215,787 comprised capital equipment. The bids included items such as syringe drivers, sara stedys, dementia clocks, patient monitors, an operating table, recliner chairs and a contribution towards the vehicle used by Serv(Kent). However, none of this would have been possible without the support of the Trust and the wonderful volunteers and staff.

Anyone with an interest in health and wellbeing who is over the age of 16 years old or over, is welcome to apply to become a League of Friends volunteer at: https://www.medway.nhs.uk/work-with-us/volunteering/

Governors' Report

Council of Governors

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

The Trust's Constitution sets out the key responsibilities of the Council. Its general functions are to:

- Hold the non-executive directors individually and collectively to account for the performance of the Board of Directors.
- Represent the interests of the members of the Trust as a whole and the interests of the public.
- Appoint and, if appropriate, remove the Chair and non-executive directors.
- Approve (or not) the appointment of any new Chief Executive.
- Decide on remuneration and allowances and other terms and conditions of office of the Chair and non-executive directors.
- Receive the annual accounts, any report of the auditor, and the annual report at a general meeting of the Council of Governors.
- Appoint and, if appropriate, remove the Trust's auditors.
- Approve 'significant transactions'.
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution.
- Decide whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions.
- Approve amendments to the Trust's Constitution.

Membership of the Council of Governors

Members of the Trust, whether they are public or staff, are all able to stand for election to the Council provided they are 16 years of age or over, and are resident in the public constituency for which they are standing. Elected members of the Council are chosen by their constituency. The Council also includes appointed representatives from partner organisations and stakeholders from the local area to ensure a representation of views from the communities we serve.

The Chair of the Council is also the Chair of the Board, which promotes transparency and encourages the flow of information between the Board and the Council.

The Council of Governors consists of 26 Governors and is composed of the following seats:

Appointed Governors	**Number**
Local Authority (represented by a member of the Kent Health and Wellbeing Board)	1
Local Authority (represented by a member of the Medway Health and Wellbeing Board)	1
Local Authority – Swale Borough Council	1
University of Kent	1
Canterbury Christ Church University	1
University of Greenwich	1 (currently vacant)
Charity Representative (League of Friends)	1
Elected Governors (staff members)	**Number**
Staff members	5
Elected Governors	**Number**
Medway	9
Swale	4
Rest of England and Wales	1

Public and staff governors are elected for a maximum term of three years and are able to seek re-election for a further term.

Partner governors are nominated by their organisation and serve a term of office of three years. These governors can be replaced by their organisation during this time. An appointed governor is eligible for re-appointment at the end of their term.

Meetings of the Council of Governors

The Council held four ordinary meetings during 2023/24. Extraordinary meetings are also held from time to time when a decision is required outside of the normal schedule of meetings. For this reporting period there were three extraordinary meetings held; April 2023 – Constitution Update, October 2023 – Chair Resignation (Jo Palmer) and January 2024 – Hospital Bed Capacity.

Council of Governors members also attended the Trust annual general meeting in September 2023.

Individual attendance at Council meetings by governors and directors is detailed under Attendance at Council of Governors' meetings.

Governors canvass the opinion of the Trust's members and the public, including the Trust's forward plan; its objectives, priorities and strategies. Their views are communicated to the Board through a Council of Governors Work Plan that links to the Board work plan. The Lead Governor provides the Board with an Assurance Report. The Board sub-committees have Governor representation.

Lead Governor

The Council elects one of its members to be the Lead Governor who acts as the main point of contact for the Chair and Company Secretary, and between NHS England and the other governors, when communication is necessary.

The Lead Governor is responsible for communicating to the Chair any comments, observations or concerns expressed by governors regarding the performance of the Trust or any other serious or material matter relating to the Trust or its business.

Cllr David Brake continued in the role as lead governor for the entire 2023/24 reporting period.

Committee of the Council of Governors

The Council has one committee, which is the Council of Governors Nomination and Remuneration Committee. The Committee has a number of responsibilities, including to review the remuneration of the non-executive directors each year; to be involved in the nomination process for all non-executive directors including the Chair; and to receive confirmation that appraisals have been carried out for the Chair and non-executive directors.

Attendance at Public Council of Governor Meetings

The information below outlines governors on the Council during 2023/24, with record of attendance.

Date of Meeting	24.05.23	16.08.23	22.11.23	22.02.24	Total (2023-24)
Medway Governors					
Anan Shetty	Yes		Yes		**2 out of 4**
Diana Hill					**No Attendance**
Hari Aggarwal	Not In Post	Yes	Yes	Yes	**3 out of 3**
Ian Chappell			Not In Post	Not In Post	**No Attendance**
Jacqui Hackwell					**No Attendance**
Martina Rowe			Yes	Yes	**2 out of 4**
Olaide Kazeem			Yes		**1 out of 4**
Penny Reid		Yes	Not In Post	Not In Post	**1 out of 2**
Timothy Newman	Yes	Yes	Yes		**3 out of 4**
Swale Governors					
Adrian Parsons	Yes		Not In Post	Not In Post	**1 out of 2**
Bill Sakaria			Not In Post	Not In Post	**No Attendance**
David Nehra	Yes		Yes	Yes	**3 out of 4**
Jay Patel	Yes	Yes	Yes	Yes	**4 out of 4**
Jennifer Oliphant	Yes	Yes		Yes	**3 out of 4**
Rest of England/Wales					
Rebecca Bellars	Yes	Yes			**2 out of 4**
Staff Governors					
Adebayo Da'Costa	Yes	Yes			**2 out of 4**
Karen Fegan	Yes	Yes	Yes	Yes	**4 out of 4**
Lisa Marsh			Not In Post	Not In Post	**No Attendance**
Mohamed Saleh	Yes	Yes	Yes		**3 out of 4**
Vanessa Page	Yes			Yes	**2 out of 4**
Partner Governors					
Angela Harrison	Yes	Yes	Yes	Yes	**4 out of 4**
Claire Peppiatt-Wildman					**No Attendance**
David Brake	Yes	Yes	Yes	Yes	**4 out of 4**
Helen Belcher	Yes		Yes		**2 out of 4**
John Wright	Yes	Yes			**2 out of 4**
Susan Plummer	Yes	Yes	Yes	Yes	**4 out of 4**
Non-Executive Directors					
Adrian Ward					**No Attendance**
Annyes Laheurte			Yes		**1 out of 4**
Gary Lupton	Not In Post	Not In Post	Yes		**1 out of 2**
Jenny Chong	Yes		Yes	Yes	**3 out of 4**
Jo Palmer	Yes	Yes	Not In Post	Not In Post	**2 out of 2**
Mark Spragg	Yes	Yes	Yes	Yes	**4 out of 4**
Mojgan Sani	Not In Post	Not In Post	Yes		**1 out of 2**
Paulette Lewis	Yes	Yes		Yes	**3 out of 4**
Sue Mackenzie	Yes		Yes		**2 out of 4**
Executives					
Alan Davies	Yes		Yes	Yes	**3 out of 4**
Alison Davis	Yes				**1 out of 4**
Evonne Hunt			Not In Post	Not In Post	**No Attendance**
Gavin MacDonald		Yes		Yes	**2 out of 4**
Glynis Alexander	Yes	Yes	Yes	Yes	**4 out of 4**
Jayne Black	Yes	Yes	Yes	Yes	**4 out of 4**
Leon Hinton		Yes	Yes	Yes	**3 out of 4**
Matt Capper	Yes	Yes	Yes	Yes	**4 out of 4**
Nick Sinclair					**No Attendance**
Sarah Vaux	Not In Post	Not In Post		Yes	**1 out of 2**

Director Attendance at Public Council of Governors meetings 01 April 2023 to 31 March 2024

The Directors attend the meetings of the Council by invitation and to present routine assurance reports to the Council of Governors, in line with their duty to take steps to understand the views of governors and for the Non-Executive Directors be held to account.

Dispute Resolution Process

In the event of disputes between the Council of Governors and the Board of Directors, the following Dispute Resolution Procedure shall apply:

1. In the first instance the Chair on the advice of the Company Secretary and such other advice as the Chair may see fit to obtain, shall seek to resolve the dispute.

2. If the Chair is unable to resolve the dispute the individual shall refer the dispute to the Company Secretary who shall appoint a joint special committee constituted as a committee of the Board of Directors and a committee of the Council of Governors, both comprising equal numbers, to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute.

3. If the recommendations (if any) of the joint special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Board of Directors who shall make the final decision.

4. This dispute resolution procedure is set out in the Trust's Constitution which is available on the Trust's website.

Members may contact governors or Board members through the membership office:

By telephone: 01634 825292
By email: met-tr.members-medway@nhs.net
In writing to: Membership Office, Medway Maritime Hospital, Medway NHS Foundation Trust, Windmill Road, Gillingham, Kent, ME7 5NY
Via website at: www.medway.nhs.uk

Membership

Public membership is available for any individual member of the public aged 16 and over who lives in Medway, Swale or the rest of England and Wales. The Trust invites members to apply by completing a written or electronic application form.

Staff membership is available for staff members employed by the Trust if they have a permanent contract, a 12 month or longer fixed term contract (or less than 12 months, but have been in post for at least 12 months), have an honorary contract or are registered volunteers of the Trust and have been volunteering for at least 12 months. Staff members will automatically become members of the Trust in the 'Staff' constituency unless they opt out. If a staff member has public membership, the public membership will end. In February 2024, the Trust had approximately 6,500 public members and 5,100 eligible staff members (total - 11,600) members. The breakdown of the public membership by constituency is:

Constituency	Total
Medway	4,272
Swale	1,059
Rest of England and Wales	1,208
Public Membership total	**6,539**

As part of the "living with Covid" approach, the Trust moved to a hybrid approach of physical and online events and meetings since the pandemic, which have continued since. The Trust held a series of events including a public event considering the barriers and stigma relating to perinatal mental health and the Annual Members' Meeting in September 2023.

Members received regular e-bulletins and information about upcoming events. They receive the Trust's quarterly News@Medway magazine and Community Newsletter by email, both available on the Trust website.

The Council of Governors reviewed the Trust's Membership Strategy in May 2023 and sets out how the Trust attracts, retains and engages with its members. The Engagement Team and Governors held a variety of sessions in order to continue engagement activity within the local community. This included stands at the hospital and in the community, in addition to attending a number of public events such as Medway Pride and Swale Pride for the first time. The events allowed the Trust to share updates, support and encourage people to get involved, and to form positive working relationships and a shared understanding of the community.

Through engagement, the Trust continues to establish its presence, strengthen networks and trust within the local community.

Disclosures

In setting its governance arrangements, the Trust has regard for the provisions of the NHS Foundation Trust Code of Governance 2014 (and the revised version implemented in April 2023) and other relevant guidance where provisions apply to the responsibilities of the Trust. The following section, together with the annual governance statement and corporate governance statement, explain how the Trust has applied the main and supporting principles of the Code.

Principal Activities of the Trust

Information on the Trusts principal activities, including performance management, financial management and risk, efficiency, employee information is outlined in the performance report.

Going Concern

The accounts have been produced on a "going concern" basis. The Trusts going concern disclosure is detailed in the notes to the financial statements.

Directors' Responsibilities

The Directors acknowledge their responsibilities for the preparation of the financial statements.

Safeguarding External Auditor Independence

This is detailed under the Audit and Risk Committee section.

Off Payroll Engagements

Information about off-payroll engagements can be found below.

Transactions with Related Parties

Transactions with third parties are presented in the accounts. None of the other Board members, the Foundation Trust's governors, or parties related to them have undertaken material transactions with the Trust.

Political Donations

There are no political donations to disclose during the 2023/24 financial year (2022/23: none).

Statement on Better Payment Practice Code

The Better Payment Practice Code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The Trust's performance is set out in the table below:

	2023/24 Number	2023/24 £000	2022/23 Number	2022/23 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	66,316	148,397	58,897	129,566
Total non-NHS trade invoices paid within target	63,656	144,198	56,239	124,632
Percentage of non-NHS trade invoices paid within target	96.0%	97.2%	95.5%	96.2%
NHS Payables				
Total NHS trade invoices paid in the year	1,092	33,651	914	32,988
Total NHS trade invoices paid within target	1,034	33,155	801	31,696
Percentage of NHS trade invoices paid within target	94.7%	98.5%	87.6%	96.1%

Fees and Charges (Income Generation)

Please refer to the Annual Accounts.

Income Disclosures Required by Section 43 of the NHS Act 2006

The Trust met the requirement in section 43(2A) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), which requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The bulk of the income is clinical income and it is unlikely that 'other income' will exceed clinical income for any reporting period.

NHS England Well-Led Framework

The CQC Well Led inspections involve an assessment of:

- The leadership and governance at Trust board and Executive Team level.
- The overall organisational vision and strategy.
- Organisation-wide governance, management, improvement; and
- Organisational culture and levels of engagement.

This draws on the CQC's wider knowledge of quality in the Trust at all levels. Along with the implementation of Patient First, this methodology has formed the basis of the Board Development Annual Work Plan in 2023/24 and the development programme for executive directors.

As part of their routine scheduled inspection programme, the CQC conducted an Emergency Department inspection in the 2023/24 period, results were expected to be released in 2024/25.

The Trust has arrangements in place to ensure that services are well-led; the information is discussed in more detail in the Annual Governance Statement section within this annual report. The section summarises:

- Regard to the well-led framework and the overall evaluation of the organisation's performance, internal control and board assurance framework and summary of action plans that give assurance of improvements to the governance of quality.
- Assurance there are inconsistences recorded between the Annual Governance Statement, the Annual Report and reports arising from the Care Quality Commission reviews of the organisation and plans developed thereafter.

Patient Care

Information relating to Patient Care can be found in the Quality Account; published separately. The information includes:

- Development of services and improvements to patient care
- Performance against key healthcare targets
- Monitoring of improvements in the quality of healthcare and the meeting of national and local targets, incorporating the Care Quality Commission assessments and reviews of the organisation and its responses to recommendations.

- Agreed targets with local commissioners, and details of key quality improvements.
- New and revised services
- Improvements in service following staff and patient surveys
- Improvements in patient/carer information
- Complaints handling

Stakeholder Relations
Involving stakeholders is important to the Trust, and it engages with a wide range of people who have an interest in the Trust. This includes patients and carers, staff and volunteers, governors and members of the Trust, partner organisations, councillors and MPs.

The Trust plans its engagement with stakeholders so it is in regular contact throughout the year and communicates through appropriate and relevant channels. This ranges from newsletters and digital bulletins, to face-to-face meetings.

Over the past year, stakeholders were involved in the development of the Trust's Clinical Strategy and Digital and Data Strategy, and recruited patients to focus/working groups to input into discussions about hospital services.

The Trust's Chair and Chief Executive hold regular meetings with key local stakeholders, including MPs for constituencies covering Medway and Swale, and members of Medway Council and Swale Borough Council. Members of the Executive Team report to local authority scrutiny committees and attend the Medway Health and Wellbeing Board. The Trust plays an active role as a partner in the Medway and Swale Health and Care Partnership and the Trust Chair is the Chair of the Health and Care Partnership Board.

Statement as to Disclosure to Auditors

Each individual who is a Director at the date of approval of this report confirms that:

a) They consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy.
b) So far as the Director is aware, there is no relevant audit information of which the NHS Foundation Trust's Auditors are unaware.
c) They have taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Medway NHS Foundation Trust's Auditors are aware of that information.

The Directors have taken all the steps that they ought to have taken as directors in order to do the things mentioned above, and:

a) Made such enquiries of their fellow directors and of the company's auditors for that purpose;
b) Taken such other steps (if any) for that purpose, as are required by their duty as a Director of the company to exercise reasonable care, skill and diligence.
c) All Board members have been assessed against the requirements of the fit and proper person test.

Signed

……..
Jayne Black
Chief Executive
Thursday, 20 June 2024

Remuneration Report

Annual Statement on Remuneration

The Nominations and Remuneration Committee is a sub-committee of the Board, responsible for reviewing and advising the Board of Directors on the composition of the Board of Directors and appointing and setting the remuneration of the executive directors and all very senior manager appointments. Further details of the committee can be found within the Directors' Report section of this document. The Trust have recruited on a substantive basis to senior leadership roles. Newly appointed executive directors have a notice period of six months.

Senior Managers Remuneration Policy

The Trust has a Senior Remuneration policy agreed by the Nominations and Remuneration Committee. The Trust recognises that in order to ensure optimum performance it is necessary to have a competitive pay and benefits structure. The objective of the Committee's strategy for the remuneration of executive directors and very senior managers is to attract and retain suitably skilled and qualified individuals of high calibre, providing sufficient resources and strength and maintaining stability throughout the senior management team. Remuneration is therefore set and maintained to be competitive. The Nominations and Remuneration Committee reviews salaries each year. In 2023/24 the Nominations and Remuneration Committee considered and approved a recommendation for a consolidated cost of living award, for executives in their position on 01 April 2023.

Director salaries were within benchmarked salary ranges. When new appointments are made the salary is determined by reference to the NHS England and NHS Providers benchmarking of executive director salaries, current market rates and internal relativities with executive directors/very senior managers. The only non-cash elements of executive 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 under the scheme.

The figures in the table below relate to the amounts received during the financial year. For 2023/24 there were no annual or long-term performance bonuses. These figures have been audited.

Salaries and Pension Entitlements of Senior Managers										
Salaries and Allowances										
Name	Job Title	Effective Date	Current Year				Prior Year			
			(a)	(b) [1]	(e)	(f)	(a)	(b) [2]	(e)	(f)
			Salary and Fees	Taxable Benefits	All pension related benefits	Total (Columns a to e)	Salary and Fees	Taxable Benefits	All pension related benefits	Total (Columns a to e)
			(Bands of £5,000)	(£ to the nearest £100)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(£ to the nearest £100)	(Bands of £2,500)	(Bands of £5,000)
			£000	£	£000	£000	£000	£	£000	£000
M Spragg	Chair (Acting)	From 01/11/2023	20-25	1,300	-	20-25	10-15	-	-	-
J Palmer	Chair	01/04/2023 – 31/10/2023	25-30	1,400	-	30-35	50-55	1,900	-	50-55
A Laheurte	Non-Executive Director		10-15	100	-	10-15	10-15	-	-	10-15
P Lewis	Non-Executive Director		10-15	-	-	10-15	5-10	-	-	5-10
G Lupton	Non-Executive Director	From 01/09/2023	5-10	600	-	5-10	-	-	-	-
S Mackenzie	Non-Executive Director	Until 31/03/2024	10-15	-	-	10-15	10-15	-	-	10-15
M Sani	Non-Executive Director	From 17/07/2023	5-10	300	-	5-10	-	-	-	-
M Spragg	Non-Executive Director	01/04/2023 – 31/10/2023	5-10	-	-	5-10	10-15	300	-	10-15
A Ward	Non-Executive Director		10-15	200	-	10-15	10-15	-	-	10-15

[1] REMOVED COLUMN – zero value; Current Year - (c) Annual Performance Related Bonuses, (d) Long-term performance related bonuses, Note: Payments or Compensation for loss of office (included in salary and fees)
[2] REMOVED COLUMN – zero value; Prior Year - (c) Annual Performance Related Bonuses, (d) Long-term performance related bonuses, Note: Payments or Compensation for loss of office (included in salary and fees)

J Chong	Non-Executive Director		5-10	-	-	5-10	5-10	-	-	5-10
J Black	Chief Executive		195-200	-	-	195-200	180-185	-	-	180-185
A Davies	Chief Financial Officer		145-150	-	-	145-150	135-140	-	30-32.5	165-170
A Davis	Chief Medical Officer		225-230	-	-	225-230	220-225	-	50-52.5	270-275
L Hinton	Chief People Officer		130-135	-	45-47.5	175-180	120-125	-	40-42.5	160-165
E Hunt	Chief Nursing Officer	01/04/2023 – 03/12/2023	135-140	-	-	135-140	125-130	-	50-55	180-185
G MacDonald	Chief Operating/Delivery Officer		195-200	-	-	195-200	-	-	-	-
N Sinclair	Chief Operating Officer	From 03/04/2023	130-135	-	175-180	310-315	-	-	-	-
S Vaux	Chief Nursing Officer (Interim)		125-130	-	-	125-130	-	-	-	-

For 2023/24, there were no annual or long-term performance-related bonuses. Taxable benefit amounts are all in relation to reimbursement of travel and expenses whilst undertaking Trust duties
Taxable benefit amounts are all in relation to reimbursement of travel and expenses whilst undertaking Trust duties.

Total Pension Entitlement

The table below excludes director who are paid via off-payroll arrangements, on another organisation's payroll and those who have drawn their pension. These figures have been audited.

Salaries and Pension Entitlements of Senior Managers								
Salaries and Allowances								
Pension Benefits								
		Current Year						
		(a)	**(b)**	**(c)**	**(d)**	**(e)**	**(f)**	**(g)**
Name	**Job Title**	**Real Increase in pensions at pension age**	**Real increase in pension lump sum at pension age**	**Total accrued pension at pension age at 31st March 2023**	**Lump sum at pension age related to accrued pension at 31st March 2023**	**Cash Equivalent Transfer Value at 1st April 2022**	**Cash Equivalent Transfer Value at 31st March 2023**	**Real increase in Cash equivalent Transfer value**
		(Bands of £2,500)	**(Bands of £2,500)**	**(Bands of £5,000)**	**(Bands of £5,000)**			
		£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
A Davies	Chief Financial Officer	0	0	55-60	160-165	41	93	29
A Davis	Chief Medical Officer	0	32.5-35	75-80	205-210	1,592	1,896	116
L Hinton	Chief People Officer	2.5-5	0	40-45	25-30	413	629	157
E Hunt	Chief Nursing Officer	0	10-12.5	20-25	50-55	438	435	92
G Macdonald	Chief Operating/Delivery Officer	0	0	30-35	85-90	655	687	0
N Sinclair	Chief Operating Officer	7.5-10	17.5-20	45-50	125-130	741	998	168

Notes

As Non-executive Directors do not receive pensionable remuneration there are no entries in respect of pensions for Non-Executive Directors.

(e - g) A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits values are the members' accrued benefits and any allowable beneficiaries pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

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

NHS Pensions are using pension and lump sum data from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement. The benefits and related CETVs detailed in the table do not allow for a potential future adjustment arising from the McCloud judgement. The Trust considers this appropriate as there is still considerable uncertainty on how the affected benefits within the new NHS 2015 Scheme would be adjusted in future once legal proceedings are completed

Staff Costs

			2023/24	2022/23
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	241,346	0	**241,346**	216,548
Social security costs	27,443	0	**27,443**	24,252
Apprenticeship levy	1,246	0	**1,246**	1,067
Employer's contributions to NHS pension scheme	35,904	0	**35,904**	32,944
Pension cost – other	27	0	**27**	22
Other post-employment benefits	0	0	**0**	0
Other employment benefits	0	0	**0**	0
Termination benefits	0	0	**0**	0
Temporary staff	0	8,160	**8,160**	8,404
Total gross staff costs	**305,966**	**8,160**	**314,126**	**283,237**
Recoveries in respect of seconded staff	0	0	**0**	0
Total staff costs	**305,966**	**8,160**	**314,126**	**283,237**
Of which:				
Costs capitalised as part of assets	0	0	**0**	0

These figures have been audited.

Expenses of Governors and Directors

The directors and governors receive reimbursement of travel and incidental expenses incurred as a result of their duties to the Trust, this is presented in the table below.

	Number in receipt of expenses	Aggregate sum of expenses (£) 2023/24	Aggregate sum of expenses (£) 2022/23
Number of Directors	**12**	**7,130**	**4,955**

Fair Pay Multiple
Fair pay disclosures Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce. The banded remuneration of the highest-paid director in 2023/24 was £225,000 - £230,000 (£220,000-£225,000 in 2022/23). This represents an increase of 2.17%. It is noted that approximately 16% (£36,000) of the remuneration paid to our highest paid director is funded directly by NHS England.

The relationship to the remuneration of the organisation's workforce (calculated as whole-time equivalent salary and exclusive of payments to agency workers) is disclosed in the tables below:

	2023/24		
	25th Percentile	**Median**	**75th Percentile**
Salary Component of remuneration (£)	22,816	30,639	43,742
Total Contractual Remuneration (£)	22,816	30,639	42,618
Ratio (mid pint of highest paid director / total remuneration values	**9.97:1**	**7.43:1**	**5.33:1**
	2022/23		
	25th Percentile	**Median**	**75th Percentile**
Salary Component of remuneration (£)	21,730	29,180	41659
Total Contractual Remuneration (£)	21,730	29,180	40,588
Ratio (mid pint of highest paid director / total remuneration values	**10.24:1**	**7.63:1**	**5.48:1**

During 2023/24 the median salary for all staff increased from £29,180 per annum to £30,639 per annum. This represents an increase of 5.00%

The average total contractual remuneration across the organisation as a whole (excluding the highest paid director) for 2023/24 was £39,022. This is an increase of 3.10% on the same figure for 2022/23 (£37,810)

The salary range of lowest to highest paid individuals for 2023/24 was from £22,383 to £230,000 (this compares to £18,576 to £225,000 for 2022/23)

During 2023/24 there were no individuals paid more than the highest paid director (based on contractual salary remuneration) but factoring in additional non-contractual payments (such as additional bank duties or additional waiting list payments) this number increases to 8 individuals.

These figures have been audited.

Expenditure on Consultancy
The Trust spent £864,000 on consultancy during 2023/24 (2022/23: £1,738,000). The decrease is due to the support and roll out of the Trust's Patient First improvement methodology, which principally took place in 2022/23.

Signed

……..
Jayne Black
Chief Executive
Thursday, 20 June 2024

Staff Report

The table below profiles the average worked full-time equivalent workforce across the organisation (including temporary staff) throughout 2023/24.
Average number of employees (WTE basis); these numbers are calculated based on monthly actual FTE across the period:

			2023/24	2022/23
	Permanent	Other	Total	Total
	Average FTE	Average FTE	Average FTE	Average FTE
Medical and dental	806	12	818	771
Ambulance staff	-	-	-	-
Administration and estates	943	-	943	872
Healthcare assistants and other support staff	1,518	-	1,518	1,373
Nursing, midwifery and health visiting staff	1,518	29	1,547	1,441
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	484	25	509	455
Healthcare science staff	-	-	-	-
Social care staff	-	-	-	-
Other	-	-	-	-
Total average numbers	**5,269**	**66**	**5,335**	**4,912**
Of which:				
Number of employees (WTE) engaged on capital projects	-	-	-	-

These figures have been audited.

Employees by Gender and Sex – Male and Female Employees

The NHS staff record system (ESR) does not record gender, only sex. This means that it is only possible to provide a statistical report on the number of men and women in the workforce. Transgender, non-binary and other minority gender staff members' sex will be recorded according to their officially recognised sex, not gender identity. The workforce profile by sex is currently:

Female	Male	Total
4,149	1,221	5,370

The table below profiles the voting Board Directors (Executive and non-executive) and other senior managers (by contractual full-time equivalent) on 31 March 2024.

	Voting Board Director	Other Senior Managers	All Staff
	Number	Number	Number
Female	**8**	**27**	**4,233**
Male	**6**	**16**	**1,272**
Total	**14**	**43**	**5,505**

Sickness Absence Data
The table below sets out the Trust's sickness absence for 2023/24 compared with 2022/23. The overall sickness rate has decreased over the last 12 months and equates to 17.23 average days sick per full-time employee. This has reduced from an average of 18.00 days in 2023/23.

Staff Group	2023/24 % of available FTE lost	2022/23 % of available FTE lost
Additional professional, scientific and technical	**3.77%**	**4.81%**
Additional clinical services	**6.77%**	**7.13%**
Administrative and clerical	**4.22%**	**4.03%**
Allied health professionals	**3.85%**	**3.46%**
Estates and ancillary	**7.78%**	**7.41%**
Healthcare scientists	**0.27%**	**2.12%**
Medical and dental	**1.85%**	**2.15%**
Nursing and midwifery registered	**4.64%**	**5.29%**
Students	**0.00%**	**0.00%**

The Trust is proactively managing sickness with improved reporting for managers, a policy to support and manage individuals with high sickness levels.

As part of keeping staff healthy and patient's safe, the Trust achieved a staff flu vaccination rate of over 75% in 2023/24.

National NHS Staff Survey 2023

The NHS staff survey is an annual, validated survey that provides a robust measure of employee experience. It enables reliable benchmark group comparisons and provides a trend view of longer-term cultural change requirements for organisations' strategic priorities.

The survey forms part of the national employee listening offering alongside the National Quarterly Pulse Survey and the monthly People Pulse together with local listening activities which together forms a rounded view of employee experience throughout the year.

The survey is aligned with the seven People Promise element and in itself is critical to the promise that we each have a voice that counts. Employee voice is a fundamental enabler for employee engagement. Alignment of the survey with the People Promise elements began in 2021 therefore the 2023 results offers a three-year trend. The Trust was benchmarked nationally against 122 acute and acute and community trusts.

This year eligibility was extended to active, in-house, bank only workers last year (staff who do not have a substantive or fixed term contract with the organisation). This is the second national data collection for bank only staff.

The 2023 survey achieved a 38% response rate (1,944 completed questionnaires) which is a fall of 2% from 2022 and 7% lower than the national average response rate of 45%. Bank only staff completed the survey which attracted an 17% response rate (164 completed questionnaires). In total, 2,108 individual surveys were completed: 1,894 online and 214 paper. The survey ran between 14 September and 24 November 2023. Table 1 below shows the response trend over the past 6 years.

Overall, the Trust has made improvements across 6 of the 7 People Promise elements and has achieved improved scores for both staff morale and staff engagement.

The seven People Promises:

Response Rate

The Staff Engagement score was 6.65 for 2023 and has increased by 0.02 since 2022. The Trust's target (a True North objective) is to move the staff engagement score to the upper quartile of national results by 2025, which is a score of 6.9.

The Staff Morale score was 5.6 for 2023 and has improved by 0.1 since 2022.

The theme indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those. Scores for each indicator together with that of the survey benchmarking group (acute) are presented below.

People Promise	2022 score	2022 respondents	2023 score	2023 respondents
We are compassionate and inclusive	7.0	1,826	7.0	1,934
We are recognised and rewarded	5.6	1,817	5.7	1,939
We each have a voice that counts	6.5	1,803	6.5	1,910
We are safe and healthy	5.7	1,812	5.84	1,909
We are always learning	5.5	1,747	5.6	1,858
We work flexibly	5.9	1,804	6.1	1,922
We are a team	6.5	1,816	6.6	1,930
Themes				
Staff Engagement	6.6	1,826	6.6	1,933
Morale	5.6	1,826	5.6	1,938

Application of Modern Slavery Act

The Trust is fully aware of its responsibilities towards patients, service users, employees and the local community and expects all suppliers to the Trust to adhere to the same ethical principles. The Trust is committed and will not tolerate modern slavery in any of its forms of slavery and servitude, forced or compulsory labour and human trafficking within its activities or supply chains.

The Trust continues to fully support the government's objective to eradicate modern slavery and human trafficking and it acknowledges its role in both combating it and supporting victims. The Trust is committed to ensuring its supply chains and business activities are free from ethical and labour standards abuse.

Currently, all awarded suppliers sign up to the terms and conditions of contract which contain a provision around Good Industry Practice to ensure each supplier's commitment to anti-slavery and human trafficking in their supply chains; and that they conduct their businesses in a manner that is consistent with the Trust's stance on anti-slavery. In addition, an increasing number of suppliers are implementing the Labour Standards Assurance System (LSAS) as a condition of contract for tenders within high risk sectors and product categories and indeed this has been referenced in the Government's Modern Slavery Strategy. Many aspects of the LSAS align to the seven reporting areas that the Government has outlined and should appear within any slavery and human trafficking statement.

People - Human resources policies provide processes and procedures to ensure that the Trust employees and those employed in supply chains are treated fairly at all times; these include:

- Confirming the identities of all new employees and their right to work legally in the UK.
- To have assurance from approved agencies that pre – employment clearance has been obtained for agency staff and to safeguard against human trafficking.
- All staff appointed are subject to references, immigration and identity checks, this is to ensure staff have the legal right to work in the UK.
- The Trust has a set of values and behaviours that staff are expected to comply with, and all candidates are expected to demonstrate these attributes as part of the recruitment selection process.
- Adopting the national pay, terms and conditions of service, the Trust has the assurance that all staff will be treated, fairly and that pay, terms and conditions will comply with the latest legislation.

- The Trust has various employment policies and procedures in place designed to provide guidance and advice to staff and managers and also to comply with the relevant legislation. These are accessible on the intranet.
- The Trust is committed to creating and ensuring a non – discriminatory and respectful working environment for all staff, this is in line with its corporate social responsibilities.
- The Trust's Equality, Diversity and Inclusion, Grievance, Respect and Dignity at Work and Whistleblowing policies and procedures additionally give a platform for all employees the Freedom to Speak Up and to raise concerns about poor working practices.
- Ensuring appropriate mechanisms to regularly review and monitor progress on promoting and supporting diversity and inclusion within the Trust.
- All staff are required to undertake mandatory training in relation to diversity and inclusion and safeguarding.

Whistleblowing (Freedom to Speak Up) – The Trust's Whistleblowing policy gives a platform for employees to raise concerns for further investigation and offers support to individuals that have suffered fiscal or professional detriment as a result of whistleblowing.

- The Trust operates a Freedom to Speak Up, Raising Concerns at Work, so employees feel empowered to raise concerns around poor practices, health and safety or illegal activities which may bring harm to the Trust.

Safeguarding – The Trust is committed to the principles setup in the safeguarding adults and children policies.

- The Trust is compliant with Medway multiagency agreements.
- Ensure clear safeguarding guidance so that employees, contractors, patients and the public are able to raise safeguarding concerns about how they are being treated or/ and about working practices at the Trust.

The Trusts approach to procurement and its supply chain includes:

- Ensuring that suppliers are carefully selected through robust supplier selection criteria/processes;
- Requiring that the main contractor provides details of its sub-contractor(s) to enable the Trust to check their credentials;
- Random requests that the main contractor provides details of its supply chain;
- Ensuring invitation to tender documents contain a clause on human rights issues;
- Ensuring invitation to tender documents also contain clauses giving the Trust the right to terminate a contract for failure to comply with labour laws;
- Using the standard Supplier Selection Questionnaire (SQ) that has been introduced (which includes a section on Modern Day Slavery).
- Trust staff must contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken.
- Supplier adherence to Trust values: the Trust has zero tolerance to slavery and human trafficking and thereby expect all direct and indirect suppliers/contractors to follow suit.
- Where it is verified that a subcontractor has breached the child labour laws or human trafficking, then this subcontractor will be excluded in accordance with Regulation 57 of the Public Contracts Regulations 2015. The Trust will require that the main contractor substitute a new subcontractor.

Trade Union Facility Time

Trade Union Facility Time Disclosures

The Trust and recognised Trade Unions work through a partnership agreement to describe the partnership, processes and structures which are linked to shared goals and objectives. The agreement outlines how it will work together to promote effective partnership regarding the workforce implications of delivering and developing the services provided to patients. In line with the Trade Union (Facility Time Publication Requirements) Regulations 2017, the Trust is required to produce an annual report detailing the facility time (the provision of time off from an employee's normal role to undertake Trade Union duties and activities when they are elected as a Trade Union representative); this information is provided below. The first publication year was 01 April 2017 to 31 March 2018 and the data must be published on or by 31 July every year thereafter.

Table 1 – Relevant Union Officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
16	14.09

Table 2 - Percentage of time spent on facility time

How many of your employees who were relevant union officials during the relevant period spent: a) 0%, b) 1% - 50%, c) 51% - 99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	12
1% - 50%	4
51% - 99%	0
100%	0

Table 3 - Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period?

	Figures
Provide the total cost of facility time	£899
Provide the total pay bill	£283,237,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.317%

Table 4 – Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant trade union officials during the relevant period on paid trade union activities?

Time spent on trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	**47%**

Staff Exit Packages

Reporting of compensation schemes – exit packages 2023/24	No. of compulsory redundancies	No. of other agreed departures	Total No. of exit packages
Exit package cost band (including any special payment element)	**Number**	**Number**	**Number**
< £10,000		9	9
£10,000 - £25,000		3	3
£25,001 - £50,000			
£50,001 - £100,000			
£100,001 - £150,000			
£150,001 - £200,000			
> £200,000			
Total number of exit packages by type	**0**	**12**	**12**
Total cost (£)	0	86,000	86,000

Reporting of compensation schemes – exit packages 2022/23	Number of compulsory redundancies	Number of other agreed departures	Total number of exit packages
Exit package cost band (including any special payment element)	**Number**	**Number**	**Number**
< £10,000		7	7
£10,000 - £25,000		1	1
£25,001 - £50,000			
£50,001 - £100,000		1	1
£100,001 - £150,000	1		1
£150,001 - £200,000			
> £200,000			
Total number of exit packages by type	**1**	**9**	**10**
Total cost (£)	106,000	125,000	231,000

Exit packages: other (non-compulsory) departure payments	2023/24		2022/23	
	Payments agreed	Value of payments agreed	Payments agreed	Value of payments agreed
	Number	**£000**	**Number**	**£000**
Voluntary redundancy including early retirement contractual costs				
Mutually agreed resignation (MARS) contractual costs				
Early retirement in the efficiency of service contractual costs				
Contractual payments in lieu of notice	12	86	9	125
Non-contractual payments requiring HMT approval				
Total	**12**	**86**	**9**	**125**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary				

These figures have been audited 2023/24

Staff Policies
The following are staff policies and actions applied during the financial year. The Trust maintains policies and takes actions to enable the wellbeing, progression and development of staff. The relevant policies and operating procedures are set out in the table below. In addition, the Trust consults regularly with the NHS Trade Unions on the review and application of policies; staff health and wellbeing; and organisational change.

Policies and Standard Operating Procedures (SOP):

Policy/SOP	How it Supports the Workforce	Renewal Date
Reasonable Adjustment and Modified Duties Policy and Standing Operating Procedure	Sets out the requirements for the Trust, managers and staff in meeting the legal duties and best practice for Reasonable Adjustments for disabled persons (as defined in the Equality Act 2010), and/or any Modified Duties that may be required to enable a member person to access work and fulfil their duties. This applies to recruitment, employment and absence management of people who are disabled, living with a long-term limiting illness or impairment, or are neurodiverse; also, to shorter term modifications that may enable a member of staff to continue in or return to work. The Standard Operation Procedure sets out how the Policy should be implemented.	June 2024
Attendance Management Policy and Standing Operating Procedure	This policy is designed to support employees' attendance, and enable employees to remain in work/return to work after absence. The SOP includes the Trust's procedure for Assessment of Adjustment.	September 2026
Flexible Working Policy	This policy provides the framework for flexible working to be considered and applied fairly.	June 2026
Maternity Leave and Fertility Treatment Policy	This is the framework to ensure correct and fair application of maternity-related entitlements, including maternity leave, keeping in touch and return to work.	November 2024
Shared Parental Leave Policy and Standing Operating Procedure	This is the framework to ensure correct and fair application of Shared Parental Leave entitlements, including leave, keeping in touch and return to work.	December 2025
Adoption Leave Policy and Standing Operating Procedure	This is the framework to ensure correct and fair application of Adoption Leave entitlements, including leave, keeping in touch and return to work.	November 2024
Bullying, Harassment, Discrimination and Conflict Resolution Policy	This policy seeks to raise awareness of the expected standards of behaviour in the workplace and the principles through which bullying and harassment will be eliminated and prevented. To set out the framework within which any concerns, problems or complaints raised by employees will be addressed and resolved in a fair, consistent and timely manner as near as possible to the point of origin, and in accordance with the principles of the ACAS Code of Practice and Guidance.	January 2027
Disciplinary Policy	The purpose of this policy and procedure is to encourage employees to achieve and maintain high standards of conduct and behaviour in accordance with the requirements of the Trust and relevant professional codes of conduct.	September 2026
Performance Management Policy and Standing Operating Procedure	To provide a standard framework to address issues of staff performance in a fair and consistent manner, so staff are aware of the level of performance expected from them.	November 2024

Employing Staff in the Reserve Forces (summary of relevant sections of policies)	This is a new Standing Operating Procedure drawing together from other policies the Trust's commitment to staff who are members of the Reserve Forces, enabling them to be released for training and mobilisation.	June 2024
Apprenticeship Policy	This sets out the framework to enable the recruitment of apprentices at all levels (including internal development opportunities) and all ages.	October 2023
Organisational Change Policy	Where organisational changes are required, this policy aims to ensure consistency of practice, consultation where necessary and involvement of staff and Trade Unions in informing the outcome.	December 2025
Health and Safety Handbook	This policy sets out the organisational framework to outline how the Trust achieves compliance with the Health and Safety at Work Act 1974 and associated regulations as required by law. It also ensures all Trust employees are aware of their individual role and responsibilities for health and safety within the organisation. Ensures robust systems are in place to report and investigate health and safety incidents in order to identify lessons learnt to be embedded in policy to support continuous improvement.	November 2026
Inclusion Policy	This policy sets out the Trust's commitment to the Equality Act 2010, and to NHS workforce standards (such as the Workforce Race Equality Standard)	July 2024
Freedom to Speak Up Policy	This enables staff to be able to raise concerns at work safely, and for the Trust to respond to those concerns. Includes Raising Concerns (whistleblowing).	April 2025
Partnership Agreement between Medway NHS Foundation Trust and NHS Trade Unions Policy	This policy provides the framework for the NHS Trade Unions and Trust Managers to meet regularly to review; application of policies, staff wellbeing and organisational change	April 2023
Anti-Fraud, Bribery and Corruption Policy	The aim of the policy and procedure is to set out clearly for staff, the framework and controls in place for dealing with all forms of detected or suspected fraud, bribery and corruption.	June 2025

Code of Governance for NHS Provider Trusts

Medway NHS Foundation Trust has applied the principles of the Code of Governance for NHS Provider Trusts (the Code) on a comply or explain basis. This includes the revised Code implemented from 01 April 2023 – it replaces the previous NHS Foundation Trust Code of Governance issued by Monitor). The Code brings together best practice from both the public and private sector in order to help NHS Foundation Trust Boards maintain good quality corporate governance. Although the Code is best practice advice, certain disclosures are required to be reported in the Trust's Annual Report, along with additional requirements as stated in the Annual Reporting Manual. The Trust's compliance is stated below with these requirements.

Code of Governance for NHS Provider Trusts - Self Assessment

Section	Provision	Comply/ Explain
A2	**Provisions**	
A2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Comply
A2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaborative. This should be a formally agreed statement of the organisation's purpose and intended outcomes, and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners and other decisions.	Comply
A2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce	Comply
A2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners (This may also include working to deliver the financial duties and objectives the trust is collectively responsible for with ICB partners, and improving quality and outcomes and reducing unwarranted variation and inequalities across the system), and that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	Comply
A2.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, e.g. from the internal audit function, to provide an adequate and reliable level of assurance.	Comply
A2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.	Comply
A2.7	The chair and board should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of all stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.	Comply

A2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	Comply
A2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	Comply
A2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement (directors are required to declare any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services. The trust must enter these into a register available to the public in line with Managing conflicts of interest in the NHS: Guidance for staff and organisations. In addition, NHS foundation trust directors have a statutory duty to manage conflicts of interest. In the case of NHS trusts, certain individuals are disqualified from being directors on the basis of conflicting interests).	Comply
A2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.	Comply
B2	**Provisions**	
B2.1	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	Comply
B2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.	Comply
B2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.	Comply
B2.4	A foundation trust chair is responsible for ensuring that the board and council work together effectively.	Comply
B2.5	The chair should be independent on appointment when assessed against the criteria set out in provision 2.6 below. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	Comply
B2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	Comply
B2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	Comply
B2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	Comply

B2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.	Comply
B2.10	Only the committee chair and committee members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	Comply
B2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the Chair appraisal framework.	Comply
B2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.	Comply
B2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	Comply
B2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on material additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.	Comply
B2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	Comply
B2.16	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, request further information if necessary, and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	Comply
B2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.	Comply
C2	**Provisions**	
C2.1	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust, and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the foundation trust should engage with NHS England to agree the approach.	Comply
C2.2	There may be one or two nominations committees. If there are two, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.	Comply

C2.3	The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.	Comply
C2.4	The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.	Comply
C2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	Comply
C2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.	Comply
C2.7	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	Comply
C2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	Comply
C2.9	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.	Comply
C2.10	A requirement of the National Health Service Act 2006 as amended (the 2006 Act) is that the chair, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chair, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.	Comply
C2.11	It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.	Comply
C2.12	The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chair and other non-executive directors.	Comply
C2.13	Non-executive directors, including the chair, should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.	Comply
C2.14	The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to do what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved, and the council of governors should be informed of subsequent changes.	Comply
C3	**For NHS trust board appointments**	
C3.1	NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non-executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.	Comply
C4	**Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts**	
C4.1	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	Comply

C4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	Comply
C4.3	Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.	Comply
C4.4	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.	Comply
C4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.	Comply
C4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.	Comply
C4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	Comply
C4.8	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: Holding the non-executive directors individually and collectively to account for the performance of the board of directors communicating with their member constituencies and the public and transmitting their views to the board of directors contributing to the development of the foundation trust's forward plans. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.	Comply
C4.9	The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest that prevents the proper exercise of their duties. This should be shared with governors.	Comply
C4.10	In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where it has imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.	Comply
C4.11	The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	Comply
C4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	Comply

C4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.	Comply
C5	**Development, information and support**	
C5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors, and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.	Comply
C5.2	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. Directors should also be familiar with the integrated care system(s) that commission material levels of services from the trust. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.	Comply
C5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	Comply
C5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.	Comply
C5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	Comply
C5.6	A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	Comply
C5.7	The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.	Comply
C5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	Comply
C5.9	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required	Comply
C5.10	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	Comply
C5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge	Comply

	and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.	
C5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	Comply
C5.13	Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	Comply
C5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.	Comply
C5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Comply
C5.16	Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included. The board of directors must have regard to the council of governors' views on the NHS foundation trust's forward plan.	Comply
C5.17	NHS Resolution's Liabilities to Third Parties Scheme includes liability cover for trusts' directors and officers. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	Comply
D2	**Provisions**	
D2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.	Comply
D2.2	The main roles and responsibilities of the audit committee should include: monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors reviewing and monitoring the external auditor's independence and objectivity reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements reporting to the board of directors on how it has discharged its responsibilities.	Comply
D2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this. These timeframes are not affected by an NHS trust becoming a foundation trust.	Comply
D2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS	Comply

	trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	
D2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services. The council of governors is responsible for appointing external governors.	Comply
D2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Comply
D2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	Comply
D2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	Comply
D2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare	Comply
E	**Remuneration**	
E2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions. Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients. Pay-outs or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria that reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed, and must be limited to the lower of £17,500 or 10% of basic salary. For NHS foundation trusts, non-executive terms and conditions are set by the trust's council of governors. The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	Comply
E2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	Comply
E2.3	Where a trust releases an executive director, eg; to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Comply
E2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered where a director returns to the NHS within the period of any putative notice.	Comply
E2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity (severance payment includes any payment whether included in a settlement agreement or not, redundancy payment, a secondment arrangement, pay in lieu of notice, garden leave and pension enhancements).	Comply

E2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.	Comply
E2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.	Comply
E2.8	The council of governors is responsible for setting the remuneration of a foundation trust's non-executive directors and the chair.	Comply
AB2.1	The council of governors should meet sufficiently regularly to discharge its duties. Typically the council of governors would be expected to meet as a full council at least four times a year. Governors should make every effort to attend these meetings. The NHS foundation trust should take appropriate steps to facilitate attendance.	Comply
AB2.2	The council of governors should not be so large as to be unwieldy. The council of governors should be of sufficient size for the requirements of its duties. The roles, structure, composition and procedures of the council of governors should be reviewed regularly.	Comply
AB2.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Comply
AB2.4	The roles and responsibilities of the council of governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the council of governors towards members and other stakeholders and how governors will seek their views and keep them informed.	Comply
AB2.5	The chair is responsible for leadership of both the board of directors and the council of governors but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive and other executives and non-executives, as appropriate, to their meetings. In these meetings other members of the council of governors may ask the chair or their deputy, or any other relevant director present at the meeting, questions about the affairs of the NHS foundation trust.	Comply
AB2.6	The council of governors should establish a policy for engagement with the board of directors for those circumstances where they have concerns about the performance of the board of directors, compliance with the provider licence or other matters related to the overall wellbeing of the NHS foundation trust and its collaboration with system partners. The council of governors should input to the board's appointment of a senior independent director.	Comply
AB2.7	The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective, in particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear, unambiguous language.	Comply
AB2.8	The council of governors should only exercise its power to remove the chair or any non-executive directors after exhausting all means of engagement with the board of directors. The council should raise any issues with the chair with the senior independent director in the first instance.	Comply
AB2.9	The council of governors should receive and consider other appropriate information required to enable it to discharge its duties, e.g. clinical statistical data and operational data.	Comply
AB2.10	The chair (and the senior independent director and other directors as appropriate) should maintain regular contact with the governors to understand their issues and concerns.	Comply
AB2.11	Governors should seek the views of members and the public on material issues or changes being discussed by the trust. Governors should provide information and feedback to members and the public at large regarding the trust, its vision, performance and material strategic proposals made by the trust board.	Comply
AB2.12	It is also incumbent on the board of directors to ensure governors have the mechanisms in place to secure and report on feedback that enables them to fulfil their duty to represent the interests of members and the public at large.	Comply
AB2.13	The chair should ensure that the views of governors and members are communicated to the board as a whole. The chair should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors and should expect to attend them if requested to do so by governors. The senior independent director should attend sufficient meetings with governors to hear their views and develop a balanced understanding of their issues and concerns.	Comply
AB2.14	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	Comply

AB2.15	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg; through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Comply
Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Comply

NHS System Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'. A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4).

A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)
b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

For the reporting period the Trust remains within national Recovery Support Programme for financial sustainability.

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). Report published 28 April 2023. Scoring detailed in this document under Quality Governance Arrangements.

Statement of the Chief Executive's responsibilities as the Accounting Officer of Medway NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of an NHS Foundation Trust. The relevant responsibilities of the 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 NHS England.

NHS England has given Accounts Directions which require Medway NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Medway NHS Foundation Trust, of its income and expenditure, and other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- Observe the accounts direction issued by NHS England, 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 (and the Department of Health and Social Care Group Accounting 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
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the Trust's performance, business model and strategy
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable the Trust 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 Trust and for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Signed

……..
Jayne Black
Chief Executive
Thursday, 20 June 2024

Annual Governance Statement 2023-2024

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Medway NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Medway NHS Foundation Trust for the year ended 31 March 2024 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Accounting Officer, I have overall responsibility for risk management within the Trust, for meeting all statutory requirements and for ensuring adherence to the guidance issued by NHS England, Department of Health and Social Care and the Care Quality Commission in respect of governance.

However, the Chief Nursing Officer has had specifically defined responsibilities for leading on the management of risk throughout the Trust. Day to day management of risks is undertaken by operational management, who are charged with ensuring risk assessments are undertaken proactively throughout their area of responsibility and remedial action is carried out where problems are identified. The process of identification, assessment, analysis and management of risks (including incidents) is the responsibility of all staff across the Trust and particularly of all managers.

The Trust has an Integrated Risk Management Strategy and Policy in place which clearly sets out the accountability, reporting arrangements, identification, management for the control of risk, along with the risk management process of escalation and de-escalation to be followed. All relevant policies and procedures relating to risks are available to staff via the Trust's intranet. The Executive Directors also monitor planned actions to mitigate risks and considers risks for inclusion in the corporate risk register or Board Assurance Framework. Risk management is a core component of the job descriptions of senior managers within the Trust.

The Trust's integrated quality and performance report is reviewed by all committees of the Board and the Trust Board at each meeting. Deep dives are usually carried out for indicators where there is sustained adverse performance. There are monthly performance improvement meetings between the group executive and the divisions to discuss areas of adverse performance as well as a dedicated risk review group which has representation from all areas of the Trusts business.

The Trust learns from good practice through a range of mechanisms including clinical supervision and performance management, continuing professional development, clinical and process audit and application of evidence-based practice. At the heart of the Trust Risk Management framework is the desire to learn from events and situations in order to continuously improve management processes. Where necessary, and where appropriate, changes will be made to the Trust's systems to enable this to happen.

The risk and control framework

The process starts with systematic identification of risks which are then evaluated, graded and either managed locally (with risk control measures identified and implemented to mitigate the potential for harm), or escalated for possible inclusion in the clinical or corporate risk registers. There are clear lines of accountability for the management of risks with an integrated and effective approach to managing risk across the Trust with defined structures, clear routes for escalation/de-escalation and challenge.
A risk management matrix with clear risk descriptors and tolerance levels is used to support a consistent

approach to assessing and responding to clinical and non-clinical risks and the Trust's appetite for risk is set within the boundaries of this risk evaluation. The Trust seeks to reduce risks to a level as low as reasonably practicable, however it is recognised that delivering healthcare carries inherent risks that can never be completely eradicated. The Trust recognises that a key factor in driving its priorities is to ensure that effective risk management arrangements are in place and embedded in the organisation's practices and processes. The Board and its committees are aligned to assure that there is independent and strategic focus on risk and assurance.

A Patient Safety Group, chaired by the Director of Integrated Governance, Quality and Patient Safety meets monthly to ensure detailed scrutiny of, and learning from incidents, as well as the early identification of emerging themes and associated organisational risks.

During 2023/24 the Trust embarked on a review of the governance structures following the introduction of the trust wide Patient First continual improvement approach. Arrangements provide the necessary support to deliver operational priorities, improvement plans and strategic ambitions. This included a refreshed Executive structure to ensure optimal assurance and alignment to Board committees. A refreshed constitution and scheme of delegation was drafted and the organisation's clinical division structure was amended. The Trust Executive Team continues to reinforce the importance of clinical leadership and oversees a number of supporting sub-committees.

The Board Assurance Framework (BAF) sets out the principal risks to deliver strategic objectives and the key controls and assurances available to the Board on the management of these significant areas of risk. Principal risks comply with the NHS Provider Licence Section 4. The BAF also includes any Operational Risks, which may affect the achievement of the Trust's Patient First True North Domains escalated to the Board by the Executive. During March 2024 work progressed on a complete refresh of the Trust's BAF and Risk Register.

At the end of the 2023/24 the BAF highlighted six areas where the Board has limited or partial assurance despite significant management attention:

- Not delivering the Efficiencies Programme (red 5x5 = 25).
- The regulatory impact of failing to comply with Article 5 of GDPR (4x5 = 20)
- Non-Compliance of the SAR & FOI timeframes (4x5=20)

Each year the board completes a formal strategic risk review to identify new or continued principal risks which might threaten the achievement of the Trust's strategy and assigns them to a lead Executive Director. These risks are taken forward for the new financial year and overseen through the BAF by the appropriate executive and Board committee.

For 2023/24, the Trust utilised many central control and assurance functions to ensure continued identification and evaluation of risk.

These included:

- Effective mechanisms in place to act upon national safety alerts and recommendations
- The performance management framework, including an Integrated Quality and
- Performance Report across all aspects of the organisation.
- Analysis of patient experience, ward-level performance, incidents and complaints, monthly financial reporting and quality improvement activity
- Assurances provided through the work of the appropriate Risk and Assurance governance routes and reported to the Board and Committees.
- Learning from incidents and near misses and working with system partners to scrutinise response and actions.
- Risk assessments and analysis of risk registers and the Board Assurance Framework.
- Assurance from the Quality and Assurance Committee and the Audit and Risk Committee to the Board.
- Clinical audit, including national audits, audits arising from national guidance (for example from NICE), confidential enquiries and local audits related to patient safety and quality of care.
- Internal assurances through the internal audit activities and independent.
- External regulatory and assessment body inspections and reviews including the Care Quality Commission (CQC), Royal Colleges, Postgraduate Deanery, Information Commissioner's Office and Health and Safety Executive reports.
- Self-assessment against the compliance framework and CQC registration requirements, including well-led reviews.

- Freedom to speak up guardian and guardian of safe working hours (for doctors in training).
- Risk assessments of the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme.

Governance and Well-Led Framework

During the reporting year the Care Quality Commission (CQC) and NHS England collaboratively developed their Single Assessment Framework approach for reviewing how organisations are run.

The Well-led framework emphasise the need for strong integrated governance and leadership across quality, finance, and operations as well as focusing on organisational culture, improvement, and system working.

To ensure its adherence to both the CQC Well-Led framework and the NHS Code of Governance checklist the trust put in place a programme, led by our Chief Nursing Officer and supported by the Trust's Company Secretary, to review its systems, processes and documentation against the available guidance. The programme had representation from every aspect of the Trust and was overseen by a dedicated steering group that reported its progress and escalated any assurance gaps quarterly into the Trust's Quality Assurance Committee (a sub-committee of the Board led by a Non-Executive Chair).

The programme reflected each of the framework domains and our current performance against each domain is:

- Clear Vision and Direction: The Trust has a full suite of interoperable strategies and plans that direct its business including clinical operations, sustainability and people programmes.
- Culture of Continuous Improvement: The Trust has continued to implement its Patient First continual improvement methodology which creates an environment where a positive culture for continuous learning and improvement is centered on meeting the needs of service users and communities. The approach underpins the clinical and quality programmes as well as the sustainability and financial recovery elements.
- Commitment to High-Quality Care: Through its Patient First approach, high quality care in enshrined in each of the five domains. The Patient First governance of continual review is supported by the strategy and transformation teams and delivery is through the Trusts divisions and care groups. Performance is reviewed daily and improvements, issues and successes are escalated as appropriate through the organisation.
- Patient and Service User Needs: The organisation prioritises the needs of patients and service users and this is most notable demonstrated through the Trusts new clinical strategy. Under the Quality domain of the trust Patient First True North objective, patient experience and leaning from feedback is a corporate focused programme and performance is continually reviewed and reported through the Trusts Strategic reviews, Quality and Assurance Committee and the Trust Board.

The gaps identified were highlighted in the Trusts risk register and routinely reviewed by the Trusts Risk and Assurance group, Audit and Risk Committee and, if necessary, the Board.

In the final quarter of the reporting year and in parallel to the internal Well-Led programme the Trust commissioned an independent external audit of its integrated governance and leadership arrangements. The review generated 15 recommendations and these were captured in an action plan adopted by the Trust Executive Team. Recommendations included:

- Board development and succession plans to be updated following changes to Executive and Non-Executive positions.
- The completion of key organisational strategies
- Reviewing the method for reporting performance to the Board (The Trusts IQPR)
- Reviewing the Trusts governance framework to ensure the flow of assurance
- Reviewing the role the Trusts Council of Governors play in scrutinising the performance of the Trusts Non-Executives etc.
- Reviewing the methods used to communicate progress and actions taken following both staff and patient feedback.

Using its Patient First methodology the trust undertook a full review of its integrated governance structures to reduce duplication, improve integration, and improve the flow of assurance and escalation of issues and risks. This work was completed in April 2024 and is being rolled out across the Trust.
As a result of both the internal Well-Led programme and the actions highlighted in the external audit significant progress has been made to ensure the Trusts integrated governance and leadership arrangements are operating effectively and in line with the national framework.

Quality Governance Arrangements

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare a Quality Account for each financial year. The Chief Nursing Officer and the Chief Medical Officer are joint nominated Trust Executive Leads for the Quality Account. The quality priorities have been developed in consultation with a wide range of stakeholders; membership, patients, staff and Board members. Delivery of the quality priorities will be monitored at the Quality Assurance Committee and by the Trust Board. You can read more about the Trusts priorities and developments in the Quality Account (published separately). The quality governance framework is built upon the principles described within the eight domains of NHS England and the CQC's well-led framework. Quality is deeply embedded in the Trust's overall Patient First strategy.

The organisational strategy reinforces the vision, values and Patient First True North Domains. The Board actively engages in quality of care with patients, the public, staff and other relevant stakeholders through a number of different mechanisms and forums.

Quality targets are linked to divisions and quality governance is delegated to each one, with assurance reported to the Quality and Patient Safety sub-committee and ultimately the Quality and Assurance Committee. Each committee receives the monthly Integrated Quality and Performance Report, with up-to-date information on key quality, safety and performance indicators including patient safety, patient experience and clinical effectiveness. The Board receives the information bi-monthly.

The Trust's Scheme of Delegation details decisions reserved for the Board and its committees. The Trust has established four divisions that will provide world-class care to the diverse communities that it serves and will be supported by the corporate services. These divisions are:

- Medicine and Emergency Care
- Surgery and Critical Care
- Women, Children and Young People
- Cancer and Core Clinical Services

Each division is the key building block of successfully delivering the core objectives and to ensure that strong clinical leadership remains at the heart of decision making at all levels of the Trust.
The governance arrangements underpinning the Trust operating model are kept under close review to ensure that issues and risks relating to quality of care are managed and where necessary escalated appropriately, and also to identify areas for improvement in executive or Board oversight of the performance of the divisions.

Assessing the quality of performance information

The data-driven performance framework is used to monitor key performance indicators at corporate trust level, divisional and care group level, with a monthly Integrated Quality and Performance Reports collating trends and analysis for Committee and Board review and public scrutiny. A risk-based assessment of the data associated with key indicators helps determine the programme undertaken by the Trust's internal auditors and the quality of the information is also audited.

Assurance on compliance with the Health and Social Care Act 2008

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). A range of mechanisms are in place to provide assurance of compliance with the Health and Social Care Act 2008 (Regulated Activities) and Regulations 2010, as set out in the CQC's guidance for providers. *[Report published 28 April 2023]*

	Date	Rating
Safe	-	Requires Improvement
Effective	-	Requires Improvement
Caring	-	Good
Responsive	-	Requires Improvement
Well-Led	-	Requires Improvement
Medical Care including older people's care	30 July 2021	Requires Improvement
Services for children and young people	30 July 2021	Requires Improvement
Critical Care	30 April 2020	Outstanding
Diagnostic Imaging	26 July 2018	Requires Improvement
End of Life Care	30 April 2020	Good
Maternity	28 April 2023	Good
Outpatients	26 July 2018	Good
Surgery	30 April 2020	Requires Improvement
Urgent and Emergency Services	24 June 2022	Good

Managing risks to data security

All staff receive data security training as part of their corporate induction upon joining the Trust, with annual information governance and information security training mandated for all staff. Training requirements are supported by comprehensive policies and guidance to ensure access to relevant and up-to-date information.

An information asset owner (IAO), with responsibility for managing information risks, is named for each key information asset and is supported by specialist information security and information governance staff. Registers of information assets, flows and uses are maintained, reviewed and updated in year.

The Trust's annual Data Security and Protection Toolkit (DSPT) submission to NHS Digital is due on 30 June 2024. The Audit and Risk Committee received an update report in March 2024 to give members an overview of progress on the DSPT, both for our upcoming external audit and the full submission in June. The DSPT is an online self-assessment tool that the Trust is required to complete on an annual basis to measure its performance against the 10 National Data Guardian security standards.

The Trust is working towards obtaining 'Standards Met' as this will assist the Trust in providing assurance to both research collaborators and NHS England of our data protection and data security compliance.

Minor issues identified at an early-stage of the Data Protection Officer's (DPO) review of the DSPT are a need for improved standardisation of evidence formatting and alignment with the DSPT Strengthening Assurance Framework. Major issues identified at an early-stage of the DPO's review is that the Trust is behind schedule on completion of auditable evidence items. To mitigate these issues the DPO has:

a) implemented an evidence template to assist leads in completing items
b) updated the evidence action plan to provide guidance to staff on 'top tips', 'approach' and 'assentation documentation' from the Strengthening Assurance Framework, to help improve the quality of evidence submission
c) taken a first view of evidence drafts to compare with the aforementioned guidance to help improve the quality of evidence submission, and therefore meet the level expected by external auditors.
d) started compiling Information Governance related items and has liaised with non-ICT departments for non-IG non-ICT evidence items
e) maintained weekly catch-ups with ICT in relation to ICT evidence items and ad hoc catch-ups with other departments

This work will be tracked by the Trust's internal audit tracker and will be overseen by the Audit and Risk Committee. All information incidents and near misses are investigated and used as opportunities to improve processes and reduce risk. This is reinforced by information governance and information security awareness training that focuses on the need for safe processing and protection of personal and sensitive data.

As with all NHS organisations, the Trust faces continual challenges in balancing the delivery of high-quality care with rising demand, rising acuity, rising rates of inflation and the need to increase both productivity and efficiency to meet challenging activity requirements.

Successful management of the risk management strategy and policy will be critical in enabling the Trust to do this in the future. The Trust recognises that strategic and transformational change internally and across the local and system health economy is required to address identified risks.
The same principal strategic risks for the organisation in 2023/24 will therefore be carried forward into 2024/25, but the effectiveness of their controls and sources assurance will need to continue to be assessed in light of the challenges facing the Trust and ongoing developments. The Director of Strategy and Partnerships is completing a full review of the Risks working in conjunction with the Audit and Risk Committee in 2024.

All staff are encouraged to report incidents and near misses as part of an open and fair culture. Training is given to all staff at induction, including junior doctors, newly-appointed governance leads and newly-qualified nurses/midwives. The electronic incident reporting system gives feedback when an incident is investigated if the member of staff wishes to receive this. Staff are prompted by the incident reporting system to follow the 'duty of candour' process, with duty of candour information and training widely available.

All reported incidents are fully investigated to ensure the lessons are learnt and shared across the Trust. Themes are identified, so that future recurrences can be prevented by coordinated work. The Trust has robust controls in place to manage the risk of nosocomial (hospital-acquired) infections. These controls are reviewed regularly by the Trust's infection, prevention and control assurance group to ensure they remain fit for purpose.

Register of Interest

Medway NHS Foundation Trust has published on its website an up-to-date Declaration of Interests, including gifts and hospitality, for decision-making staff within the past twelve months as required by the Managing Conflicts of Interest in the NHS27 guidance.

The Board regularly reviews the Declarations of Interest Register and requires all executive and non-executive directors to confirm their entries. A standing item is contained on all Board and committee agendas which requires all senior staff, executive and non-executive directors to make known any declarations of interests in relation to the agenda.

The Declarations of Interest Register is available to the public on the Trust's website 'Board Papers' at www.medway.nhs.uk or by contacting:

The Company Secretary
Medway NHS Foundation Trust,
Medway Maritime Hospital, Windmill Road,
Gillingham, Kent
ME7 5NY
medwayft.trustsecretary@nhs.net

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

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

Green Plan

The Trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Emergency Preparedness, Resilience and Response (EPRR)

The Trust is a Category One responder under the Civil Contingencies Act (2004). Within the Act the Trust has specific statutory duties in relation to maintaining a resilient organisation that is able to work in partnership with other responders in response and recovery from major and business continuity incidents. In order to demonstrate compliance, the Trust is aligned to the National Emergency preparedness, Resilience and Response Framework (2015). NHS England nationally issues core standards against which each Trust undertakes a self-assessment and is then audited by its commissioner.

Medway NHS Foundation Trust have been assessed as Fully compliant against the 2023/24 NHS England EPRR core standards. NHS England define Fully Compliant as: The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards.

This has been reported via Kent and Medway ICB, the Local Health Resilience Partnership Executive Group for Kent and Medway and to NHS England region and England.
Brian Williams – Head of EPRR, Medway NHS Foundation Trust

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

The Trust has a range of processes to ensure resources are used economically, efficiently and effectively. This includes clear and effective management and supervision arrangements for staff and the presentation of regular finance and efficiency programme reports to the Executive Team, the Board and associated committees.

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

Information Governance
The table below breaks down the information breaches recorded on the Trusts DATIX reporting system for the 2023/24 reporting period. No incidents met the criteria required to report to the Information Commissioner's Office (ICO).

Identifiable data lost in transit	Data disclosed in error such as emails sent to the wrong place, reports sent to the wrong patient	Non-secure disposal of paperwork	Unauthorised access to staff or patient information including sharing passwords or smartcards	Other Information Governance/data security incident
2	28	7	4	31

Data quality and governance

The quality and assurance teams work closely with colleagues in the business intelligence team to ensure data provided to the Board is validated and accurate. Both teams have a variety of skills and expertise including analytics. This includes oversight by those with expertise in the relevant field; for example, the head of complaints would sign off any complaints data, ensure that correct processes have been applied to reporting the data from the system and that the data set is complete.
The quality and assurance teams collate data monthly from a variety of sources for the executive and trust management meetings and Integrated Quality and Performance Report. Primary sources include the local risk management system, which holds all incident, complaints, legal services, risks and safety alert databases.

A senior clinical analyst validates the data and issues the data packs monthly to the executive, which feeds into the Integrated Quality and Performance Report for data accuracy, validity and alignment. The Trust has a number of policies and protocols which describe the desired outcome or key performance indicator (KPI) which assists the Trust Board in determining if they are assured by the data they are receiving. For example, the Trust's position relating to mortality outcomes is demonstrated by the Summary Hospital-Level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) which are benchmarked nationally to give Board members a clear picture of the Trust's performance in this area.

A range of audits – internal and external – give assurance about the accuracy of data throughout the year. The Trust has a Quality and Patient Safety sub-committee where all data and information relating to quality of care and patient experience is reviewed. The Trust employs rigorous information assurance

processes in the production of the monthly Integrated Quality and Performance Report at both clinical group and Trust level, including local and Trust-wide validation of data and national benchmarking where available. The Integrated Quality and Performance Report is published as part of the Board papers and is available on the Trust's website.

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 who have responsibility for the development and maintenance of the internal control framework. I have drawn on 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 and Risk Committee and its sub-committees and groups and the Quality Assurance Committee and its sub-committees and groups, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work. My review of the effectiveness of the system of internal control is informed by executives and managers within the organisation who have responsibility for the development and maintenance of the system of internal control and the assurance framework. The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its objectives have been reviewed.

The Board Assurance Framework is framed in the context of the Trust's strategic objectives (Patient First) to ensure that focus is maintained on the delivery of agreed outcomes and the effective management of attendant risks. The internal auditors have confirmed that the Trust's Board Assurance Framework does reflect the Trust's key objectives and risks and is regularly reviewed by the board. The Executive reviews the Board Assurance Framework on a monthly basis and the Trust Board reviews it on a bi-monthly basis, and the Audit and Risk Committee provides views on whether the Trust's risk management procedures are operating effectively.

The Head of Internal Audit Opinion 2023/24 was presented to the Audit and Risk Committee on 20 June for the period 01 April 2023 to 31 March 2024. An overall rating of ‘‘partial assurance with improvements required (Amber/Red)" can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

The Board, through the executive directors, reviews risks to the delivery of the Trust's performance objectives through bi-monthly monitoring and discussion of the performance in the key areas of finance, activity, national targets, patient safety, patient experience, quality and workforce. The implementation of Patient First has strengthened this approach and enables the organisation to focus on addressing key issues as they arise in the most appropriate place.

The Audit and Risk Committee oversees the effectiveness of the Trust's overall risk management and internal control arrangement. On behalf of the board, it independently reviews the effectiveness of risk management systems in ensuring all significant risks are identified, assessed, recorded and escalated as appropriate. The Audit and Risk Committee regularly receives reports on internal control and risk management matters from the internal and external auditors. Concerns raised by the internal or external auditors have been considered by the executive team and the Audit and Risk Committee and have been addressed appropriately.

The responsibility for compliance with the CQC essential standards is allocated to lead executive directors who are responsible for maintaining evidence of compliance. The Trust is addressing all areas of underperformance and non-compliance identified either through external inspections and patient and staff surveys, raised by stakeholders, including patients, staff, governors and others or identified by internal peer review.

The Trust has redesigned its governance systems and processes to both support the implementation of Patient First but also to strengthen decision making, accountability and quality.

Conclusion

I can confirm that no significant internal control issues have been identified.

Signed

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Jayne Black
Chief Executive
Thursday, 20 June 2024

Independent auditor's report to the Council of Governors of Medway NHS Foundation Trust

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of Medway NHS Foundation Trust (the 'Trust') for the year ended 31 March 2024, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2023-24.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2024 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2023-24; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2023-24 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to

continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements, or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2023/24 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2023/24; and
- based on the work undertaken in the course of the audit of the financial statements the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of the Chief Executive's responsibilities as the Accounting Officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial

statements in the form and on the basis set out in the Accounts Directions included in the NHS Foundation Trust Annual Reporting Manual 2023/24, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2023-24).
- We enquired of management and the Audit and Risk Committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit and Risk Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.

We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls, the valuation of property, plant and equipment, the risk of improper revenue recognition and the risk of fraud in expenditure recognition. We determined that the principal risks were in relation to:

- Improper revenue recognition;
- Management override of controls;
- Revaluation of land and buildings;
- Expenditure recognition prevalent around year end.

- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - testing of income and year end receivables to invoices and cash payment or other supporting evidence;
  - testing of year end expenditure to invoices, cash payments and other supporting evidences;

- journal entry testing with a focus on high value journals posted after year end, journals posted by specific members of management and journals that have a material impact on financial reporting;
- challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations;

- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communicated with management and the Audit and Risk Committee in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to valuation of land and buildings included within the accounts.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the Trust operates; and
  - understanding of the legal and regulatory requirements specific to the Trust including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2024.

We have nothing to report in respect of the above matter except on 14 June 2024 we identified a significant weakness in how the Trust plans and manages its resources to ensure that it can continue to deliver its services. This was in relation to the Trust's failure during 2023/24 to plan to bridge its funding gaps and identify achievable savings. We recommended that the Trust completes the identification of

the 2024/25 efficiency programme by the end of quarter one to achieve a fully ‘green’ assessed programme. The Trust should aim for an efficiency programme with 90% recurrent savings/efficiency initiatives for this year and future years. The Trust should also initiate the identification of a multi-year efficiency/financial improvement programme, recognising the need for further CIPs in the medium term, and report milestone progress to the Finance and Performance Committee.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor’s responsibilities for the review of the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of ‘proper arrangements. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services.
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor’s Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of Medway NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report
This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors 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 Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Darren Wells

Darren Wells
for and on behalf of Grant Thornton UK LLP, Local Auditor, London

24 June 2024

Annual Accounts

Medway NHS Foundation Trust

Annual Accounts for the year ended 31 March 2024

Foreword to the accounts

Medway NHS Foundation Trust

These accounts, for the year ended 31 March 2024, have been prepared by Medway NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

Signed ……

Name **Jayne Black**
Job title **Chief Executive Officer**
Date **Thursday, 20 June 2024**

Statement of Comprehensive Income

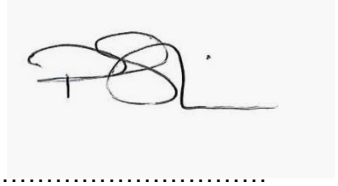
for the year ended 31 March 2024

	Note	2023/24 £000	2022/23 £000
Operating income from patient care activities	3	433,955	397,443
Other operating income	4	36,717	34,801
Operating expenses	5	(487,131)	(431,098)
Operating Surplus/(Deficit) from continuing operations		**(16,459)**	**1,146**
Finance income	8	1,370	844
Finance expenses	9	(72)	(26)
PDC dividends payable	26	(8,835)	(8,168)
Net finance costs		**(7,537)**	**(7,350)**
Other gains/(losses)	4	19	0
Deficit for the year		**(23,977)**	**(6,204)**
Other comprehensive income/(expense)			
Will not be reclassified to income and expenditure:			
Impairments	12	(8,623)	(2,200)
Revaluations	12	5,398	23,081
Total comprehensive income/(expense) for the period		**(27,202)**	**14,677**

Statement of Financial Position
as at 31 March 2024

	Note	31 March 2024 £000	31 March 2023 £000
Non-current assets			
Property, plant and equipment	10	279,165	271,810
Right of use assets	13	1,966	928
Receivables	14	757	780
Total non-current assets		**281,888**	**273,518**
Current assets			
Inventories	15	6,554	6,374
Receivables	14	29,574	29,086
Cash and cash equivalents	16	21,042	34,742
Total current assets		**57,170**	**70,202**
Current liabilities			
Trade and other payables	17	(57,537)	(50,285)
Borrowings	19	(358)	(953)
Provisions	20	(285)	(519)
Other liabilities	18	(881)	(800)
Total current liabilities		**(59,061)**	**(52,557)**
Total assets less current liabilities		**279,997**	**291,163**
Non-current liabilities			
Borrowings	19	(3,072)	(1,950)
Provisions	20	(1,307)	(1,031)
Total non-current liabilities		**(4,379)**	**(2,981)**
Total assets employed		**275,618**	**288,182**
Financed by			
Public dividend capital		489,836	475,198
Revaluation reserve		61,181	64,406
Income and expenditure reserve		(275,399)	(251,422)
Total taxpayers' equity		**275,618**	**288,182**

The notes on pages 7 to 40 form part of these accounts. **Signed:**



…… ……

Jayne Black
Chief Executive
20 June 2024

Paul Kimber
Acting Chief Financial Officer
20 June 2024

Statement of Changes in Equity for the year ended 31 March 2024

	Public Dividend Capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2023 - brought forward	**475,198**	**64,406**	**(251,422)**	**288,182**
Deficit for the year	0	0	(23,977)	**(23,977)**
Net impairments	0	(8,623)	0	**(8,623)**
Revaluations - property, plant and equipment	0	5,398	0	**5,398**
Public dividend capital received	14,716	0	0	**14,716**
Public dividend capital repaid	(78)	0	0	**(78)**
Taxpayers' equity at 31 March 2024	**489,836**	**61,181**	**(275,399)**	**275,618**

Statement of Changes in Equity for the year ended 31 March 2023

	Public Dividend Capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2022 - brought forward	**461,656**	**43,525**	**(245,218)**	**259,963**
Deficit for the year	0	0	(6,204)	**(6,204)**
Net impairments	0	(2,200)	0	**(2,200)**
Revaluations - property, plant and equipment	0	23,081	0	**23,081**
Public dividend capital received	13,542	0	0	**13,542**
Public dividend capital repaid	0	0	0	**0**
Taxpayers' equity at 31 March 2023	**475,198**	**64,406**	**(251,422)**	**288,182**

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 predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

for the year ended 31 March 2024

	Note	2023/24 £000	2022/23 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(16,459)	1,146
Non-cash income and expense:			
Depreciation and amortisation	5	18,560	15,635
Impairments and reversals	12	171	(42)
Income recognised in respect of capital donations (cash and non-cash)	4	(228)	(100)
(Increase)/decrease in receivables		(486)	(15,252)
(Increase)/decrease in inventories		(180)	(378)
Increase/(decrease) in trade and other payables		6,671	17,603
Increase/(decrease) in other liabilities		81	(553)
Increase/(decrease) in provisions		(392)	(445)
Net cash flows from / (used in) operating activities		**7,738**	**17,614**
Cash flows from investing activities			
Interest received		1,407	719
Purchase of property, plant and equipment		(27,288)	(21,366)
Proceeds from sales of property, plant and equipment		19	0
Receipt of cash donations to purchase capital assets		228	100
Net cash used in investing activities		**(25,634)**	**(20,547)**
Cash flows from financing activities			
Public dividend capital received		14,716	13,542
Public dividend capital repaid		(78)	0
Movement in loans from the Department of Health and Social Care		(126)	(126)
Capital element of lease liability repayments		(984)	(956)
Interest on DHSC loans		(26)	(27)
Other interest (e.g. overdrafts)		0	(3)
Interest element of lease liability repayments		(38)	(14)
PDC dividend (paid)/refunded		(9,268)	(8,196)
Net cash generated from financing activities		**4,196**	**4,220**
Increase/(decrease) in cash and cash equivalents		**(13,700)**	**1,287**
Cash and cash equivalents at 1 April - brought forward		**34,742**	**33,455**
Cash and cash equivalents at 31 March	16	**21,042**	**34,742**

Notes to the accounts

For the year ended 31 March 2024

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2023/24 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office for National Statistics (ONS). Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Note 1.3.1 Revenue from NHS Contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1 April 2023. The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. In 2023/24 API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

In 2023/24 fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts. These payments are accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differed from the agreed level set in the fixed payments, the variable element either increased or reduced the income earned by the Trust at a rate of 100% of the tariff price.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead it forms part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed. Payment for CQUIN is included in the fixed element of the API.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.
Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. In 2023/24, trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners. In 2022/23 elective recovery funding for providers was separately identified within the aligned payment and incentive contracts.

Note 1.3.2 Revenue from Research Contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases, it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

Note 1.3.3 NHS Injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.3.4 Other income

Education and Training Income

Funding for the national training programme is recognised in the year of award.

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4 Expenditure on employee benefits
Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The 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.

Note 1.5 Expenditure on other goods and services
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.
Note 1.6 Property, plant and equipment
Note 1.6.1 Recognition
Property, plant and equipment is capitalised where:
- It is held for use in delivering services or for administrative purposes
- It is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- It is expected to be used for more than one financial year
- The cost of the item can be measured reliably
- The item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
- costs form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Staff costs have also been capitalised where they arise directly from the construction or acquisition of specific property, plant or equipment.
The finance costs of bringing fixed assets into use are not capitalised.
Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software is assessed on a case by case basis and is either capitalised as a tangible asset or expensed over the life of the licence.

Subsequent Expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Note 1.6.2 Measurement
Valuation
All property, plant and equipment is 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.
Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.
Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.
Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

All land and buildings are restated to current value using professional valuations in accordance with IAS 16 every five years. A yearly interim valuation is also carried out. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. In accordance with this policy the valuation undertaken for 2023/24 was therefore a desktop revaluation.
The valuation exercise was carried out in March 2024 with a valuation date of 31st March 2024
Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Assets are revalued and depreciation commences when the assets are brought into use.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment will be depreciated from the first quarter after the asset is deemed ready for use at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated economic lives. Freehold land is considered to have an infinite life and is not depreciated.
Property, plant and equipment reclassified as ‘Held for Sale’ cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.
Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other operating expenses'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.
An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.6.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.
Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.6.4 Donated and grant funded assets

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

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.
This includes assets donated to the trust by the Department of Health and Social Care or NHS England as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Note 1.6.5 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min Years	Max Years
Buildings (set-up costs in new buildings)	1	10
Buildings & Dwellings	1	80
Plant & machinery	5	25
Transport (Vehicles)	7	7
Information technology	5	8
Furniture & fittings	7	10

Note 1.7 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.
The Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.8 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.9 Financial assets and financial liabilities

Note 1.9.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.
This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Note 1.9.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.
Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.
Financial assets are classified as subsequently measured at amortised cost.
Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable**.**

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).
The Trust has developed a model for Non DHSC group bodies' contract and other receivables which assesses the liability by category and debtor type factoring in any known specifics to calculate the value of impairment.

The DHSC provides a guarantee of last resort against the debts of DHSC group bodies (excluding NHS charities); in accordance with the GAM these liabilities have been deemed risk free so no credit losses are calculated in relation to these liabilities.
For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.9.3 Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

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

Note 1.10 Leases
A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

Note 1.10.1 The Trust as lessee
Initial recognition and measurement
At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 3.51% applied to new leases commencing in 2022 and 4.72% to new leases commencing in 2024.

The trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement
As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

Initial application of IFRS 16 in 2022/23
IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury was applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaced IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations.

The standard was applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 were only applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments were not revisited.

No adjustments were made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets had a value below £5,000. No adjustments were made in respect of leases previously classified as finance leases.

Note 1.11 Provisions
The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.
Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 2.45% in real terms (prior year: 1.70%).

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 20 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution 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.

Note 1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 21 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 21, unless the probability of a transfer of economic benefits is remote.
Contingent liabilities are defined as:

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

Note 1.13 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 predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from the trust. PDC is recorded at the value received.
A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.14 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.

Note 1.15 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 on an accruals basis.
The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.16 Gifts
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.17 Critical judgements in applying accounting policies
Any judgements, apart from those involving estimations (see below) that management has made in the process of applying The NHS foundation Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements are disclosed in the notes.

Note 1.17.1 Sources of estimation uncertainty
Valuation of specialised assets as per note 1.6.2 is estimated by qualified valuers on a modern equivalent asset (MEA) basis using reduced land area of 4.9 hectares as opposed to the existing site of 14.6 hectares. This reflects a more efficient use of space, delivering the same service capacity but using modern building and design practice.

Note 1.18 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2023/24.

Note 1.19 Charitable Funds
The Trust is the corporate Trustee of Medway NHS Foundation Trust Charitable Fund – Registered Charity number 1051748. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities for itself, its patients or its staff.
The NHS Foundation Trust has not consolidated the charitable funds as it is not deemed material to its accounts.

Note 1.20 Discontinued Operations
Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.
There are no discontinued operations.

Note 1.21 Climate change levy
Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 2 Operating segments

The Trust has only one segment of business which is the provision of healthcare. The segment has been identified with reference to how the Trust is organised and the way in which the chief operating decision maker (determined to be the Board of Directors) runs the Trust.

The geographical and regulatory environment and the nature of services provided are consistent across the organisation and are therefore presented in one segment. The necessary information to develop detailed income and expenditure for each product and service provided by the Trust is currently not discretely available and the cost to develop this information would be excessive.

Significant amounts of income are received from transactions with the Department of Health and other NHS bodies. Disclosure of all material transactions with related parties is included in note 28 to these financial statements. There are no other parties that account for more than 10% of total income.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.

Note 3.1 Income from patient care activities (by nature)	**2023/24**	**2022/23**
	£000	**£000**
Aligned payment & incentive (API) income[1]	386,160	335,440
High cost drugs income from commissioners[5]	27,623	24,680
Other NHS clinical income	7,244	6,689
Private patient income	57	0
Elective recovery fund[2]	0	10,771
Agenda for change pay award central funding[3]	187	8,266
Additional pension contribution central funding[4]	10,930	10,036
Other clinical income	1,754	1,561
Total income from activities	**433,955**	**397,443**

[1]Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. This includes £75,841k (2022/23 £0k) variable income based on activity and £310,319k (2022/23 £335,440k) fixed income.

More information can be found in the 2023/25 NHS Payment Scheme documentation. https://www.england.nhs.uk/pay-syst/nhs-payment-scheme

[2]Elective recovery is part of aligned payment & incentive income in 2023/24

[3]Additional funding was made available by NHS England in 2023/24 and 2022/23 for implementing the backdated element of pay awards where government offers were made at the end of the financial year. 2023/24: In March 2024, the government announced a revised pay offer for consultants, reforming consultant pay scales with an effective date of 1 March 2024. Trade Unions representing consultant doctors accepted the offer in April 2024. 2022/23: In March 2023, the government made a pay offer for staff on agenda for change terms and conditions which was later confirmed in May 2023. The additional pay for 2022/23 was based on individuals in employment at 31 March 2023.

[4]The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2023/24 £000	2022/23 £000
NHS England	61,052	61,486
Clinical Commissioning Groups[1]	0	76,547
Integrated Care Boards[1]	370,877	256,711
Other NHS Providers	215	1,138
Non-NHS: private patients	57	2
Non-NHS: overseas patients (chargeable to patient)	561	372
Injury cost recovery scheme[2]	1,193	1,173
Non NHS: other	0	14
Total income from activities	**433,955**	**397,443**

[1]Clinical Commissioning Groups ceased to exist 1 June 2022, replaced by Integrated Care Boards

[2]Injury cost recovery scheme income is subject to a credit loss allowance of 23.07% (2022/23: 24.86%) to reflect expected rates of collection.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2023/24 £000	2022/23 £000
Income recognised this year	561	372
Cash payments received in-year	123	136
Amounts added to provision for impairment of receivables	547	468
Amounts written off in-year	75	197

Note 4 Other operating income

	2023/24 £000	2022/23 £000
Other operating income from contracts with customers:		
Research and development (contract)	1,657	1,309
Education and training (excluding notional apprenticeship levy income)	16,422	13,544
Non-patient care services to other bodies	6,824	7,866
Income in respect of employee benefits accounted on a gross basis	8	133
Other contract income	10,892	10,474
Other non-contract operating income		
Education and training - notional income from apprenticeship fund	282	148
Receipt of capital grants, donations and assets	228	100
Charitable and other contributions to expenditure	404	1,227
Total other operating income	**36,717**	**34,801**

	2023/24	2022/23

Other Income includes:	**£000**	£000
Car parking income	**1,786**	1,478
Catering	**898**	708
Pharmacy sales	**236**	168
Staff accommodation rental	**606**	579
Non-clinical services recharged to other bodies	**370**	285
Crèche services	**344**	344
Clinical tests	**1,406**	2,221
Clinical excellence awards	**163**	172
Other income not already covered (recognised under IFRS 15)	**5,083**	4,519
	10,892	10,474

Note 4.1 Additional information on revenue from contracts with customers recognised in the period

	2023/24	**2022/23**
	£000	**£000**
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	482	896
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0	0

Note 4.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	**2023/24**	**2022/23**
	£000	**£000**
within one year	881	544
after one year, not later than five years	0	256
after five years	0	0
Total revenue allocated to remaining performance obligations	**881**	**800**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 4.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2023/24	**2022/23**
	£000	**£000**
Income from services designated as commissioner requested services	421,000	385,860
Income from services not designated as commissioner requested services	2,026	10,022
Total	**423,026**	**395,882**

Note 4.4 Profits and losses on disposal of property, plant and equipment

The Trust has disposed of 2 equipment assets for £19k (2022/23 £0k) with a net book value of zero.

Note 5 Operating expenses

	2023/24	2022/23
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	17,025	13,614
Purchase of healthcare from non-NHS and non-DHSC bodies	9,170	1,715
Purchase of social care	1,310	0
Staff and executive directors costs [1]	306,424	276,332
Remuneration of non-executive directors	149	141
Supplies and services - clinical (excluding drugs costs)	31,759	34,158
Supplies and services - general	11,917	9,273
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	39,761	37,327
Inventories written down	9	10
Consultancy costs	864	1,738
Establishment	2,175	2,404
Premises	15,737	11,517
Transport (including patient travel)	1,809	1,285
Depreciation on property, plant and equipment and right of use assets	18,560	15,635
Impairments net of (reversals)	171	(42)
Movement in credit loss allowance: contract receivables / contract assets[2]	842	(375)
Increase/(decrease) in other provisions	(200)	(304)
Change in provisions discount rate(s)	(28)	(149)
Audit fees payable to the external auditor		
audit services - statutory audit[4]	148	131
other auditor remuneration	0	0
Internal audit costs	62	131
Clinical negligence	16,787	16,003
Legal fees	303	99
Insurance	270	239
Research and development	1,403	1,243
Education and training	8,342	7,415
Operating lease expenditure (short term, low value)	111	137
Redundancy	50	0
Car parking & security	281	277
Hospitality	17	19
Losses, ex gratia & special payments[3]	295	412
Other services, e.g. external payroll	414	392
Other	1,194	321
Total	**487,131**	**431,098**

[1] Staff and executive directors costs - excluded from this are Research and development costs, non-executives costs and Education and training costs, as they are reported separately.
This includes £10,930k (2022/23 £10,036k) relating to 6.3% pensions increase paid directly by Department of Health.

[2] Net movement in credit losses. Credit risk is only associated with Non-NHS receivables.

[3] Excludes £8k (2022/23 £10k) inventory write down detailed in separate line -see note 23.

[4] Audit Fees are inclusive of VAT.

Note 5.1 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2,000k (2022/23: £2,000k).

Note 6 Employee benefits

	2023/24	2022/23
	£000	£000
Salaries and wages	241,346	216,548
Social security costs	27,443	24,252
Apprenticeship levy	1,246	1,067
Employer's contributions to NHS pensions	24,974	22,908
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	10,930	10,036
Pension cost - other	27	22
Temporary staff (including agency)	8,160	8,404
Total gross staff costs	**314,126**	**283,237**

Note 6.1 Directors remuneration and other benefits

	2023/24	2022/23
	£000	£000
Directors Remuneration	1,064	1,182
Social Security Costs	139	130
Employer contributions to NHS Pension scheme	120	87
Total remuneration	**1,323**	**1,399**

6 Directors are accruing pension benefits under the NHS Pension defined benefit scheme (2022/23; 5)

Note 6.2 Retirements due to ill-health

During 2023/24 there were 6 early retirements from the Trust agreed on the grounds of ill-health with an estimated total additional pension liability of £577k (3 totalling £276k in 2022/23).

Please Note: In line with the HM Treasury requirements, some previous accounts disclosures relating to staff costs are now required to be included in the staff report section of the annual report instead.

Note 7 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% of pensionable pay from 1 April 2024 (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

c) Alternative pension scheme

For those employees who do not have access to the NHS pensions scheme but who are otherwise classified as employees with an entitlement to automatic enrolment in an appropriate pension the Trust has put in place an alternative workplace pension scheme. This scheme is administered by NEST (National Employment Savings Trust) and is a defined contribution pension scheme. The total contribution costs for this scheme for the financial year 2023/24 amount to £27k (2022/23: £22k).

Note 8 Finance income

Finance income represents interest received on assets and investments in the period.

	2023/24	2022/23
	£000	£000
Interest on bank accounts	1,370	844
Total finance income	**1,370**	**844**

Note 9 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2023/24	2022/23
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	25	26
Lease obligations	38	13
Interest on late payment of commercial debt	0	3
Total interest expense	**63**	**42**
Unwinding of discount on provisions	9	(16)
Total finance costs	**72**	**26**

Note 9.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2023/24	2022/23
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	0	0
Amounts included within interest payable arising from claims under this legislation	0	3
Compensation paid to cover debt recovery costs under this legislation	0	0

Note 10 Property, plant and equipment

Note 10.1 Property, plant and equipment - 2023/24

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2023 - brought forward	**7,997**	**196,668**	**5,833**	**18,869**	**52,594**	**86**	**47,400**	**2,579**	**332,026**
Additions	0	3,785	0	21,107	2,823	0	571	0	**28,286**
Impairments	(399)	(8,169)	(111)	0	0	0	(165)	0	**(8,844)**
Reversals of impairments	5	45	0	0	0	0	0	0	**50**
Revaluations	119	(3,777)	61	0	0	0	0	0	**(3,597)**
Reclassifications	0	5,144	0	(12,488)	4,509	36	2,799	0	**0**
Disposals / derecognition	0	0	0	0	(771)	0	(785)	0	**(1,556)**
Valuation/gross cost at 31 March 2024	**7,722**	**193,696**	**5,783**	**27,488**	**59,155**	**122**	**49,820**	**2,579**	**346,365**
Accumulated depreciation at 1 April 2023 - brought forward	**0**	**0**	**0**	**0**	**36,267**	**86**	**21,537**	**2,326**	**60,216**
Provided during the year	0	8,654	341	0	3,456	0	5,003	81	**17,535**
Revaluations	0	(8,654)	(341)	0	0	0	0	0	**(8,995)**
Disposals / derecognition	0	0	0	0	(771)	0	(785)	0	**(1,556)**
Accumulated depreciation at 31 March 2024	**0**	**0**	**0**	**0**	**38,952**	**86**	**25,755**	**2,407**	**67,200**
Net book value at 31 March 2024	**7,722**	**193,696**	**5,783**	**27,488**	**20,203**	**36**	**24,065**	**172**	**279,165**
Net book value at 31 March 2023	**7,997**	**196,668**	**5,833**	**18,869**	**16,327**	**0**	**25,863**	**253**	**271,810**

Note 10.2 Property, plant and equipment - 2022/23

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022 - brought forward	**7,542**	**175,559**	**4,783**	**16,077**	**51,273**	**86**	**34,829**	**2,579**	**292,728**
Additions	0	2,288	0	18,335	342	0	4,964	0	**25,929**
Impairments	(58)	(2,218)	0	0	0	0	0	0	**(2,276)**
Reversals of impairments	0	118	0	0	0	0	0	0	**118**
Revaluations	513	13,964	1,050	0	0	0	0	0	**15,527**
Reclassifications	0	6,957	0	(15,543)	979	0	7,607	0	**0**
Disposals / derecognition	0	0	0	0	0	0	0	0	**0**
Valuation/gross cost at 31 March 2023	**7,997**	**196,668**	**5,833**	**18,869**	**52,594**	**86**	**47,400**	**2,579**	**332,026**
Accumulated depreciation at 1 April 2022 - brought forward	**0**	**0**	**0**	**0**	**32,700**	**85**	**18,005**	**2,243**	**53,033**
Provided during the year	0	7,294	260	0	3,567	1	3,532	83	**14,737**
Revaluations	0	(7,294)	(260)	0	0	0	0	0	**(7,554)**
Disposals / derecognition	0	0	0	0	0	0	0	0	**0**
Accumulated depreciation at 31 March 2023	**0**	**0**	**0**	**0**	**36,267**	**86**	**21,537**	**2,326**	**60,216**
Net book value at 31 March 2023	**7,997**	**196,668**	**5,833**	**18,869**	**16,327**	**0**	**25,863**	**253**	**271,810**
Net book value at 31 March 2022	**7,542**	**175,559**	**4,783**	**16,077**	**18,573**	**1**	**16,824**	**336**	**239,695**

Note 10.3 Property, plant and equipment financing- 2023/24

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	7,722	193,696	5,783	27,488	19,195	36	24,065	172	278,157
Owned - donated/granted	0	0	0	0	1,008	0	0	0	**1,008**
Total net book value at 31 March 2024	**7,722**	**193,696**	**5,783**	**27,488**	**20,203**	**36**	**24,065**	**172**	**279,165**

Note 10.4 Property, plant and equipment financing- 2022/23

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Restated Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	7,997	196,668	5,833	18,869	15,058	0	25,863	242	270,530
Owned - donated/granted	0	0	0	0	1,269	0	0	11	1,280
Total net book value at 31 March 2023	**7,997**	**196,668**	**5,833**	**18,869**	**16,327**	**0**	**25,863**	**253**	**271,810**

Note 11 Donations of property, plant and equipment

Note 11.1 Donations

Donations	2023/24 £000	2022/23 £000
Additions - donations of physical assets (non-cash)	0	0
Additions - assets purchased from cash donations/grants	228	100
Total Donations	**228**	**100**

Note 12 Revaluations and impairments of property, plant and equipment

The date of the latest valuation of land, buildings and dwellings was 31 March 2024. The valuation was carried out by an externally appointed independent RICS qualified valuer. Land and non-specialised buildings have been valued at market value for existing use and specialised buildings at depreciated replacement cost on a modern equivalent asset basis. See note 1.6.2 for more detail. Information on the economic life of property, plant and equipment is included in the accounting policies.

The overall impact of the valuation exercise was a decrease of £3,231k, £5,398k revaluation net of £8,629k impairments.

Note 12.1 Revaluations

Changes in market price	2023/24 £000	2022/23 £000
Land	119	513
Buildings including dwellings	5,279	22,568
Total Revaluations	**5,398**	**23,081**

Note 12.2 Impairments

In 2023/24 net impairment reversals of £8,629k have occurred as result of the interim revaluation of The Trust estate and £165k in relation to an obsolete IT asset.

	2023/24 £000	2022/23 £000
Impairments charged to revaluation reserve	**8,623**	**2,200**
Unforeseen obsolescence	165	0
Changes in market price	6	(42)
Total net impairments charged to operating expenditure	**171**	**(42)**
Total Net Impairments	**8,794**	**2,158**

Note 13 Right of use assets

Note 13.1 Right of use assets 2023/24

	Property (land and buildings)	Plant & machinery	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**208**	**1,618**	**1,826**
Additions	1,602	36	1,638
Movements in provisions for restoration / removal costs	425	0	425
Valuation/gross cost at 31 March 2024	**2,235**	**1,654**	**3,889**
Accumulated depreciation at 1 April 2023 - brought forward	**119**	**779**	**898**
Provided during the year	217	808	1,025
Accumulated depreciation at 31 March 2024	**336**	**1,587**	**1,923**
Net book value at 31 March 2024	**1,899**	**67**	**1,966**

Note 13.2 Right of use assets 2022/23

Note 13.2 Right of use assets 2022/23

	Property (land and buildings)	Plant & machinery	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2022 - brought forward	**0**	**0**	**0**
IFRS 16 implementation - adjustments for existing operating leases / subleases	208	1,618	1,826
Additions	0	0	0
Movements in provisions for restoration / removal costs	0	0	0
Valuation/gross cost at 31 March 2023	**208**	**1,618**	**1,826**

	Property (land and buildings)	Plant & machinery	Total
Accumulated depreciation at 1 April 2022 - brought forward			
IFRS 16 implementation - adjustments for existing subleases	0	0	0
Provided during the year	119	779	898
Accumulated depreciation at 31 March 2023	**119**	**779**	**898**
Net book value at 31 March 2023	**89**	**839**	**928**

Note 13.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 19.

	2023/24	2022/23
	£000	£000
Carrying value at 1 April - brought forward	**869**	**0**
IFRS 16 implementation - adjustments for existing operating leases	0	1,826
Lease additions	1,638	0
Interest charge arising in year	38	13
Lease payments (cash outflows)	(1,022)	(970)
Carrying value at 31 March	**1,523**	**869**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.
These payments are disclosed in Note 5 Operating expenses.
Cash outflows in respect of leases recognised on statement of financial position are disclosed in the reconciliation above.

Note 13.4 Maturity analysis of future lease payments

	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2024	31 March 2024	31 March 2023	31 March 2023
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	223	84	817	0
- later than one year and not later than five years;	967	465	52	0
- later than five years.	333	333	0	0
Total gross future lease payments	**1,523**	**882**	**869**	**0**
Finance charges allocated to future periods	0	0	0	0
Net lease liabilities at 31 March 2024	**1,523**	**882**	**869**	**0**
Of which:				
Leased from other DHSC group bodies		882		0

Note 14 Trade and other receivables

	2023/24 £000	2022/23 £000
Current		
Contract receivables[1]	28,370	29,131
Allowance for impaired contract receivables / assets	(4,401)	(4,088)
Prepayments (non-PFI)[2]	4,179	2,975
Interest receivable	108	145
PDC dividend receivable	16	0
VAT receivable	793	529
Clinician pension tax provision reimbursement funding from NHSE	6	4
Other receivables	503	390
Total current trade and other receivables	**29,574**	**29,086**
Non-current		
Contract receivables[1]	519	462
Allowance for impaired contract receivables / assets	(120)	(115)
Clinician pension tax provision reimbursement funding from NHSE	358	433
Total non-current trade and other receivables	**757**	**780**
Of which receivables from NHS and DHSC group bodies:		
Current	20,154	21,949
Non-current	358	433

[1]Contract receivables includes invoiced £17,045k (2022/23 £16,272k) and uninvoiced accruals of £11,324k (2022/23 £12,859k)

[2]Prepayments includes £227k for the Trust Lease Car scheme launched in 2023/24, other increases relate to various new/increased cost Trust systems such as EPR, Allocate and Frontier where payment is required annually in advance.

Note 14.1 Allowances for credit losses

	Contract receivables and contract assets	
	2023/24 £000	**2022/23 £000**
Allowances as at 1 April - brought forward	**4,203**	**4,949**
New allowances arising	1,349	1,302
Reversals of allowances	(507)	(1,677)
Utilisation of allowances	(524)	(371)
Allowances as at 31 March	**4,521**	**4,203**
Loss recognised in expenditure	**842**	**(375)**

*The impairment allowance relates to £3,975k non-NHS (2022/23 £3,681k) and £546k Injury Cost Recovery Scheme (2022/23 £522k) receivables only. Intra-Group receivables are deemed to be risk free as they are backed by a guarantee from the Department of Health and Social Care.

Note 15 Inventories

	2023/24 £000	2022/23 £000
Drugs	1,562	1,756
Consumables	4,992	4,619
Total inventories	**6,554**	**6,375**
of which:		
Held at lower of cost and NRV	6,554	6,375

Inventories recognised in expenses for the year were £71,321k (2022/23: £71,485k)

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £197k of items purchased by DHSC (2022/23 £940k)
These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 16 Cash and cash equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2023/24 £000	2022/23 £000
At 1 April	**34,742**	**33,455**
Net change in year	(13,700)	1,287
At 31 March	**21,042**	**34,742**
Broken down into:		
Cash at commercial banks and in hand	57	79
Cash with the Government Banking Service	20,985	34,663
Total cash and cash equivalents as in Statement of Financial Position	**21,042**	**34,742**

Note 17 Trade and other payables

	2023/24 £000	2022/23 £000
Current		
Trade payables	26,098	13,024
Capital payables[1]	10,792	9,794
Accruals	8,888	16,723
Social security costs	3,525	3,271
Other taxes payable	3,860	3,370
PDC dividend payable	0	417
Pensions contributions payable	3,598	3,122
Other payables	776	564
Total current trade and other payables	**57,537**	**50,285**
Of which payables from NHS and DHSC group bodies:		
Current	15,437	7,545
Non-current	0	0

[1]Includes £6,658k of capital accruals (2022/23 £3,955k)

Note 17.1 Better Payment Practice Code

	2023/24 Number	2023/24 £000	2022/23 Number	2022/23 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	66,316	148,397	58,897	129,566
Total non-NHS trade invoices paid within target	63,656	144,198	56,239	124,632
Percentage of non-NHS trade invoices paid within target	96.0%	97.2%	95.5%	96.2%
NHS Payables				
Total NHS trade invoices paid in the year	1,092	33,651	914	32,988
Total NHS trade invoices paid within target	1,034	33,155	801	31,696
Percentage of NHS trade invoices paid within target	94.7%	98.5%	87.6%	96.1%

The Better Payment Practice code requires that 95% of all valid invoices are paid by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 18 Other Liabilities

	2023/24 £000	2022/23 £000
Current		
Deferred income: contract liabilities	881	800
Total other current liabilities	**881**	**800**

Note 19 Borrowings

	2023/24 £000	2022/23 £000
Current		
Capital Loans from the Department of Health and Social Care[1]	135	136
Lease liabilities	223	817
Total current borrowings	**358**	**953**
Non-current		
Capital Loans from the Department of Health and Social Care	1,772	1,898
Lease liabilities	1,300	52
Total non-current borrowings	**3,072**	**1,950**
Total borrowings	**3,430**	**2,903**

[1]Includes £9k (2022/23 £23k) of interest payable in accordance with IFRS9.

Note 19.1 Reconciliation of liabilities arising from financing activities

	TOTAL £000	DHSC Loans £000	Lease Liabilities £000
Carrying value at 1 April 2023	**2,903**	**2,034**	**869**
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,110)	(126)	(984)
Financing cash flows - payments of interest	(64)	(26)	(38)
Non-cash movements:			
Additions	1,638	0	1,638
Application of effective interest rate (interest charge arising in year)	63	25	38
Carrying value at 31 March 2024	**3,430**	**1,907**	**1,523**

	TOTAL £000	DHSC Loans £000	Lease Liabilities £000
Carrying value at 1 April 2022	**2,161**	**2,161**	**0**
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,082)	(126)	(956)
Financing cash flows - payments of interest	(41)	(27)	(14)
Non-cash movements:			
Impact of implementing IFRS16	1,826	0	1,826
Application of effective interest rate (interest charge arising in year)	39	26	13
Carrying value at 31 March 2023	**2,903**	**2,034**	**869**

Note 20 Provisions for liabilities and charges

	Pensions relating to staff	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2023	**673**	**176**	**701**	**1,550**
Transfers by absorption	0	0	0	**0**
Change in the discount rate	(28)	0	(79)	**(107)**
Arising during the year	73	112	425	**610**
Utilised during the year	(81)	(10)	(4)	**(95)**
Reversed unused	(53)	(68)	(278)	**(399)**
Unwinding of discount	9	0	24	**33**
At 31 March 2024	**593**	**210**	**789**	**1,592**
Expected timing of cash flows:				
- not later than one year;	69	210	6	**285**
- later than one year and not later than five years	524	0	358	**882**
- later than five years.	0	0	425	**425**
Total	**593**	**210**	**789**	**1,592**

The provision for pensions relating to staff reflects the liabilities due to early retirements prior to 6 March 1995.
The legal claims provision reflects liabilities arising from Public and Employee Liability claims.
Other provisions are for dilapidations and onerous contracts.

	Restated Pensions relating to staff	Legal claims	Restated Other	Total
	£000	£000	£000	£000
At 1 April 2022	**1,022**	**66**	**923**	**2,011**
Change in the discount rate	(149)	0	(397)	**(546)**
Arising during the year	29	156	492	**677**
Utilised during the year	(84)	(3)	0	**(87)**
Reversed unused	(129)	(43)	(317)	**(489)**
Unwinding of discount	(16)	0	0	**(16)**
At 31 March 2023	**673**	**176**	**701**	**1,550**
Expected timing of cash flows:				
- not later than one year	75	176	268	**519**
- later than one year and not later than five years	459	0	22	**481**
- later than five years.	139	0	411	**550**
Total	**673**	**176**	**701**	**1,550**

Restated; Provisions relating to 2019/20 clinicians' pension reimbursement, managed centrally by NHSE have been reclassified under 'Other'.

Note 20.1 Clinical negligence liabilities

At 31 March 2024, £160,205k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Medway NHS Foundation Trust (31 March 2023: £213,444k).

Note 21 Contingent assets and liabilities

	2023/24 £000	2022/23 £000
Value of contingent liabilities		
NHS Resolution legal claims	(52)	(31)
Gross value of contingent liabilities	**(52)**	**(31)**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**(52)**	**(31)**
Net value of contingent assets	0	**0**

Note 22 Financial instruments

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The Trust actively seeks to minimise its financial risks. In line with this policy, the Trust neither buys nor sells financial instruments. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Interest-rate risk
All of the Trust's financial liabilities carry nil or fixed rates of interest. The only element of the Trust's assets that are subject to a variable rate are short term cash investments. The Trust is not, therefore, exposed to significant interest-rate risk.

Foreign currency risk
The Trust has negligible foreign currency income or expenditure.

Credit risk
The Trust operates primarily within the NHS market and receives the majority of its income from other NHS organisations. There is therefore little risk that one party will fail to discharge its obligations with the other. Disputes can arise, however, around how the amounts owed are calculated, particularly due to the complex nature of the Payments by Results regime. For this reason the Trust makes a provision for irrecoverable amounts based on historic patterns and the best information available at the time the accounts are prepared. The Trust does not hold any collateral as security. The Trust's maximum exposures to credit risk at 31 March 2023 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's net operating costs are incurred under contracts with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust received such contract income in accordance with Block contracts agreed with Commissioners and receives cash each month based on that contract.
Financial shortfalls incurred in day to day activities are financed by revenue support loans received from the Department of Health.

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

Note 22.1 Carrying values of financial assets

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial assets as at 31 March 2024		
Trade and other receivables excluding non financial assets	25,341	**25,341**
Cash and cash equivalents at bank and in hand	21,042	**21,042**
Total at 31 March 2024	**46,383**	**46,383**

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial assets as at 31 March 2023		
Trade and other receivables excluding non financial assets	26,358	26,358
Cash and cash equivalents at bank and in hand	34,742	34,742
Total at 31 March 2023	61,100	61,100

Note 22.2 Carrying value of financial liabilities

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2024		
Loans from the Department of Health and Social Care	1,907	1,907
Obligations under finance leases	1,523	1,523
Trade and other payables excluding non financial liabilities	49,586	49,586
Provisions under contract	998	998
Total at 31 March 2024	54,014	54,014

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2023		
Loans from the Department of Health and Social Care	2,034	2,034
Obligations under finance leases	869	869
Trade and other payables excluding non financial liabilities	43,226	43,226
Provisions under contract	877	877
Total at 31 March 2023	**47,006**	47,006

Note 22.3 Maturity of financial liabilities

	2023/24	2022/23
	£000	£000
In one year or less	50,174	45,070
In more than one year but not more than five years	2,004	802
In more than five years	2,109	1,527
Total	**54,287**	**47,399**

Note 22.4 Fair values of financial assets and liabilities

All financial assets and liabilities are held at book value which is deemed to be a reasonable approximation of fair value

Note 23 Losses and special payments

	2023/24		2022/23	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Fruitless payments	1	9	1	10
Bad debts and claims abandoned	115	85	31	211
Stores losses and damage to property	14	161	12	171
Total losses	**130**	**255**	**44**	**392**
Special payments				
Ex-gratia payments	17	48	19	30
Special severance payments	0	0	0	0
Extra-statutory and extra-regulatory payments	0	0	1	0
Total special payments	**17**	**48**	**20**	**30**
Total losses and special payments	**147**	**303**	**64**	**422**

Note 24 Gifts
No gifts of more than £300,000 have been declared in 2023/24 (£0k 2022/23).

Note 25 Third party assets
The Trust held £0k cash at bank and in hand at 31 March 2024 (£0k at 31 March 2023) which relates to monies held on behalf of patients.

Note 26 Public Dividend Capital payable
The Trust is required to demonstrate that the PDC dividend payable is in line with the actual rate of 3.5% of average relevant net assets. £8,835K is payable this year (£8,168k 2022/23).

Note 27 Capital commitments
There are capital commitments in 2023/24 totalling £3,233k to report (£6,208k in 2022/23).

Note 28 Related parties
The Medway NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health and Social Care.
The Department of Health and Social Care is the parent department of the Medway NHS Foundation Trust.
The Department of Health and Social Care is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

- Department of Health and Social Care ministers
- Board members of the Trust
- The Department of Health and Social Care
- Other NHS providers
- ICBs and NHS England
- Other health bodies
- Other Government departments
- Local authorities
- Medway Hospital Charity

Paragraph 25 of IAS 24 allows entities which are related parties because they are under the same government control to reduce the volume of the detailed disclosures so no further detail of transactions will be disclosed.
There are no prior year balances 2022/23 to disclose.

Note 29 Events after the reporting date
There are currently no events after the reporting date.

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