NHS
Medway
NHS Foundation Trust

ANNUAL REPORT

AND ACCOUNTS

2022/23

Best of care
Best of people

Medway NHS Foundation Trust Annual Report and Accounts 2022/2023

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

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Foreword from the Chief Executive and Chair

Chief Executive Overview

We are proud to be at the centre of our community and throughout 2022/23 our hard-working colleagues continued to serve the residents of Medway and Swale with great professionalism and compassion. I would like to thank them all for their outstanding commitment to providing care of the highest quality to our patients.

I would also like to take this opportunity to thank local our patients for their ongoing support. Thank you for your understanding when we had to make the very difficult decision to cancel appointments because of industrial action and for being patient when the waits for care were longer than we would have liked. Our staff continue to work very hard to reduce backlogs and ensure that you receive your appointment in a timely manner, and although we have had some success in doing so, we know there is still much more to do.

We know that receiving prompt emergency care is of vital importance to our community, which is why colleagues have been working hard to improve the responsiveness of our care. We have seen some good progress with our four-hour waiting times, but we want to ensure that we are able to deliver timely care every time, and that remains our focus.

We were delighted to improve the experience and outcome for some of our most vulnerable patients who arrive at our Emergency Department (ED), through our relaunched Accelerated Hip Fracture Pathway. The pathway was originally launched by our ED Team in 2016 with great success and received national praise due to its innovative approach and significant improvements. We were pleased to reintroduce this pathway and start offering the best possible care to our patients once again.
We also launched our new acute medical model at the Trust. The initiative is supported by NHS England and brings a new model to the Trust for patients with an acute medical need. As a result, we saw an immediate improvement in ambulance handover times.

We were delighted to see the hard work of our urgent and emergency care colleagues. Inspectors noted significant improvements since their previous inspection in December 2020 and rated the service as ‘Good’ overall. It had previously been rated as ‘Inadequate’.

In the report, inspectors commended staff for managing infection control risks, assessing risks to patients, and acting upon them. They praised the way care was planned to meet the needs of local people and individual patients. They also reported that staff felt respected, valued, and supported and that they were focused on the needs of patients receiving care.

Providing high-quality care for our cancer patients remains an important priority for the Trust and the fantastic work of our Cancer Services Team was recognised when they were named south east regional winner at the NHS Parliamentary Awards 2022 in the ‘Excellence in Healthcare’ category. The team scooped the award after being nominated by local MP Rehman Chishti, following significant improvements which saw the Trust achieve the national standard in four key areas of cancer care. Having timely access to imaging services is an important part of a patient’s healthcare journey and we were pleased to welcome a new MRI scanner to our site. The new mobile scanner helped patients get their diagnostic appointments quicker and reduced the number of people waiting for scans, which had increased since the COVID-19 pandemic.

We want to ensure that our care continues to be easily accessible for our communities and this year we were proud to open the Sheppey Frailty Unit. The unit, based in Sheppey Community Hospital, provides care to frail elderly patients closer to their homes in Swale. It also has the added advantage of freeing capacity within Medway Maritime Hospital enabling us to allocate further beds for planned operations and treatment.

This year we were proud to launch Patient First, our new, dynamic approach to providing excellent

care, every time. Patient First helps us to improve the care and services we provide to the people of Medway and Swale by allowing us to target priorities that can have a big impact quickly. With this approach, we can deliver real and lasting change over time.

We are also continuing to work on the development of a Community Diagnostic Centre (CDC) with a hub at Sheppey Community Hospital, and a spoke site at Rochester Healthy Living Centre. Both sites will provide a range of new diagnostic services, including CT scans, MRIs, ECGs and x-rays, and will significantly improve the accessibility of these services to patients. Work is due begin in 2023 with new services being introduced over a two-year period, working towards achieving a seven-day, 12-hour-a-day service by 2025.

At Medway, we remain committed to embracing technology to improve care for our patients and the Trust took another step forward on its digital transformation journey when we went live with Electronic Prescribing and Medicines Administration (EPMA), and Electronic Discharge Notification (EDN) as part of our Sunrise Electronic Patient Records project.

The Emergency Department also went live with Sunrise. Once EPR is fully in place across the hospital, all information about a patient's medical history and treatment will be available electronically, on screen, at any location, at any time.

We also launched our new Single Sign-On (SSO) system. Previously some clinical staff had to use as many as 15 computer programmes when tending to a patient, with each requiring its own login details. As well as being time consuming, this required busy staff to remember multiple passwords or use the same one on multiple systems, potentially creating a cyber-security risk. As a result of the new system, the time spent logging into multiple computer systems has reduced significantly, meaning our clinicians are able to spend more time providing patient care.

Our colleagues continue to work hard to ensure that our hospital is financially sustainable; this means living within our means and providing high quality services by optimising the use of our resources. We take seriously our responsibility to get the very best value for the taxpayers of Medway and Swale. Most importantly, we know that by working more efficiently we can provide better and safer care for our patients.
Thank you for your ongoing support as we do our best to deliver the very best of care for local people.

Jayne Black
Chief Executive
28 June 2023

Foreword from the Chair

This year has been a year like no other for our country and we were deeply saddened to hear of the death of Her Majesty Queen Elizabeth II. She served her country for 70 years and was an inspiration to so many people; her dedication to her role was second to none. Patients, colleagues, and visitors across the hospital joined more than seven billion people worldwide to watch her funeral.

It has also been a year of significant challenge for the NHS, and my thanks go to all our staff for their skill and compassion in caring for our population. It is important to me they are well supported in every aspect of their working lives.

Providing compassionate and dignified care is a cornerstone for us at Medway and I was proud that in the past year the Trust opened a new Changing Places toilet for people with significant learning and physical disabilities, making us the first acute Trust in Kent and Medway to offer such a facility. Changing Places toilets, which are larger than a standard wheelchair accessible toilet, are specially equipped to ensure those who are unable to use a toilet independently, can use the bathroom with dignity and hygienically.

We also introduced the Dandelion Scheme in our theatre department and recovery areas. The dandelion compassion sign is displayed when a person is expected to die in the next few hours or days, or when a person has just died. The aim is to promote dignity, respect and compassion at the end of life by encouraging a quiet atmosphere for the patient and their relatives at a very difficult time.

As an organisation we remain committed to delivering the highest quality of care to our patients and we have made a great deal of progress in achieving this. Of course, we will not rest on our laurels, and our Patient First programme, and the hard work of our staff, help us to drive improvement through every aspect of our care. There is more to do, and I am excited to see what the year ahead will bring.

I would like to extend my heartfelt gratitude to the League of Friends for their invaluable assistance over the past year. Our longstanding partnership with the Friends is of great importance to our Trust and their unwavering support, in conjunction with the contributions from the Oliver Fisher Trust and our own Trust Charity, has facilitated the purchase of essential items that have significantly benefited both our patients and staff.

I would also like to express my gratitude to our Trust governors for generously contributing their time to serve as a vital liaison between our organisation and the community we serve. Additionally, my sincere appreciation goes to our volunteers, whose kindness and dedication to our patients are indispensable when it comes to providing exceptional care. Without their selfless commitment, we would not be able to deliver the standard of care that we do.

I was very pleased to welcome Jayne Black who took on the role of Chief Executive in the past year. A nurse by background, Jayne has extensive leadership experience in acute, community and the wider healthcare system throughout her career, in a variety of roles, including Director of Operations, Deputy Chief Executive and Chief Operating Officer.

Finally, I would like to express my gratitude to our patients and their families for putting their confidence in us. We consider it a great privilege to serve our community, and we are keenly aware of the responsibility that comes with it.

Jo Palmer
Chair

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PERFORMANCE
REPORT

Best of care
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Overview

Purpose and Activities

Medway NHS Foundation Trust is a public benefit corporation authorised under the National Health Service Act 2006. It is a single-site hospital based in Gillingham and serves a population of more than 427,000 across Medway and Swale.

We provide clinical services to more than half a million patients a year, including more than 180,000 ED attendances, more than 55,000 admissions, more than 360,000 outpatients' appointments and more than 4,500 babies born last year.

As an NHS Foundation Trust, we have 26 seats on the Council of Governors and more than 10,000 public members. We employ more than 4000 staff, making us one of Medway's largest employers. In addition, over 300 volunteers provide invaluable support across the League of Friends, Hospital Radio and the Voluntary Services Department.

The hospital is made up of two clinical divisions – Unplanned and Integrated Care and Planned Care – supported by corporate functions.

The Board of directors, led by Chairman Jo Palmer comprises five executive directors including Jayne Black, Chief Executive, and seven non-executive directors including the Chairman.

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 modernised 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 tradition.

Key Issues and Risks

The principal risks 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 and by the Executive Group.

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

Going Concern

Our going concern disclosure is detailed in the performance report.

After making enquiries, the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

The accounts have been prepared on a going concern basis as we do 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.

Summary of Performance

The Trust did not achieve the national standard for the four hour performance target in 2022/23, finishing the year on 72.7% (all types). This was a 9% increase in performance from 2021/22 and only 3% below the national target. The Trust has achieved the national target several times in April 2023.

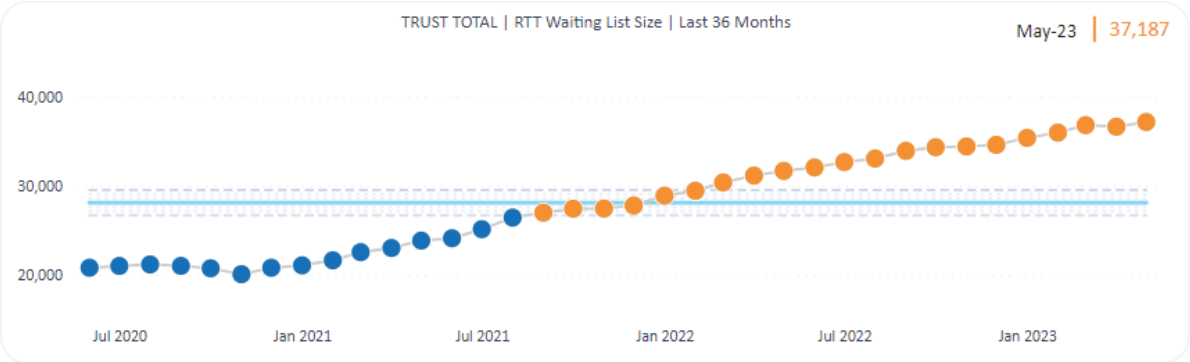
Key Performance Measures

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%. We reported a year end position of 60.3%. The total waiting list size has steadily increased over the reporting period ending on 36,835 patients compared to 31,154 at the start of the year. The number of patients waiting more than 52 weeks for treatment is currently 475.



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, and
- 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 72.7%. Although factors such as capacity vs 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 to support the improvement plans for DM01.

Cancer

2022/23 Cancer Waiting Times Performance

The Trust reported an end of year compliance position of 80.9% against the national target of 93% for two-week waits (2WW) – all cancers, with the trust performing above the standard in seven of the twelve months of the reporting period. The Trust achieved this by continuing to work to the internal seven-day stretch target while also implementing new ways of working such as telephone and virtual clinics.

The Trust was compliant in two of the twelve months with the 93% operational standard for 2WW – breast symptomatic. The operational standard was not achieved for ten out of the twelve months as a result of patient choice and the breast service at the Trust unable to provide the required capacity to deal with the peaks and high level of demand for the service. The 2WW booking team now has access to real- time performance reports which allows issues to be escalated to service managers allowing 2WW breaches to be prevented before they occur.

The Trust has consistently met the 96% operational standard for 31-day for the full twelve 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 eight 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 our 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 twelve months. This represents a huge improvement in performance from the previous

The Trusts achievement of compliance with the operational standard of 85 per cent for 62 day waits from urgent GP referral continues to be maintained, and the role of cancer navigators, multidisciplinary team coordinators and other leadership and support staff in Cancer Services has again supported delivery of this

Emergency Care Standard

The year 2022/23 saw levels of attendance settling back to those experienced pre-pandemic. The Trust has continued to drive forward with improvements on a range of actions that ensure all parts of the hospital, and wider health and social care system, are able to respond to meet the emergency demand. In summary, these include:

- Closure of escalation areas to be used only during periods of extreme pressure.
- Safe access and initial assessment for patients conveyed by ambulance.
- Increase direct ambulance conveyance to Same Day Emergency Care (SDEC), Surgical Assessment Unit (SAU) and Frailty.
- Ensure that ED Internal Professional Standards are monitored and we are responsive to exceptional variation in activity.
- Validate Trust Internal Professional Standards in response to emergency referral and flow.
- Increase the number of patients who access zero Length of Stay clinical pathways across surgery, medicine and frailty.
- Minimise delays at every step of the ED journey.

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

Sustainability Report

Our carbon footprint

At Medway NHS Foundation Trust we continue to recognise that we are not only part of the NHS but that we play an integral role in the local community.

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

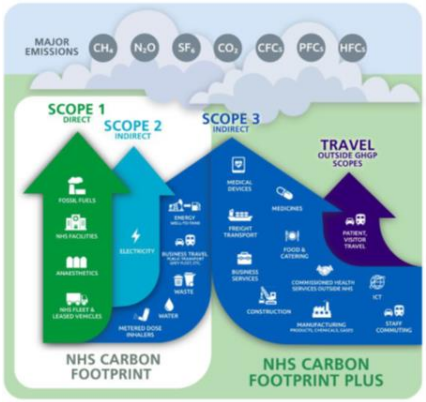
The Trust's formal Green Plan, first issued during 2020-21and updated annually, provides an organisation-wide strategy that outlines the Trust's plan of action that are necessary to achieve the targets within the Greener NHS Net Zero Programme.

Carbon Emissions

Carbon emissions are categorised into three scopes; scope 1 emissions (direct from owned resources), scope 2 emissions (indirect, through the generation of purchased energy) and scope 3 emissions (indirect, within the value chain). As the largest public sector emitter of carbon emissions, the NHS has a duty to respond to the targets for decarbonisation that are now embedded within law.

The Greener NHS National Programme published its strategy, 'Delivering a Net Zero NHS' in October 2020. The report set out trajectories and actions for the NHS to reach net zero carbon emissions by 2040 in relation to the emissions it controls directly, (**NHS Carbon Footprint targets**) and by 2045 for those emissions, it can only influence (**NHS Carbon Footprint Plus targets**).

In addition to this target, the NHS is committed to reaching an interim target of an 80% reduction by 2028 to 2032 for the NHS Carbon Footprint and an 80% reduction by 2036 to 2039 for the NHS Carbon Footprint Plus. Both reductions are measured against a 1990 baseline. The following diagram illustrates the constituent elements of each group.



In October 2022 the NHS became the first in the world to commit to delivering a net zero national health system. We continue to work hard to minimise our carbon footprint in line with the NHS commitments. These targets are:

The way this organisation can embed sustainability into its operation is to implement its Green Plan. Our Green Plan is endorsed by the Trust Board and supported by a dedicated Board sub-committee, as an organisation we acknowledge our responsibilities towards creating a sustainable future and have aligned our strategies with those priorities and ambitions of the United Nations Sustainable Development Goals (SDGs). Our organisation is starting to contribute to these SDGs at a local level.

Energy

During the most recent year, 22/23, the Trust spent a total of around £5.6m on Electricity and Gas which, in terms of cost alone, represents an increase of just over 101%. This movement in total costs is however made up of both an increase in the total volume of energy used, which accounts for 21% of the increased total costs, and increases in the unit price of energy which accounts for around 80% of the total increase in costs.

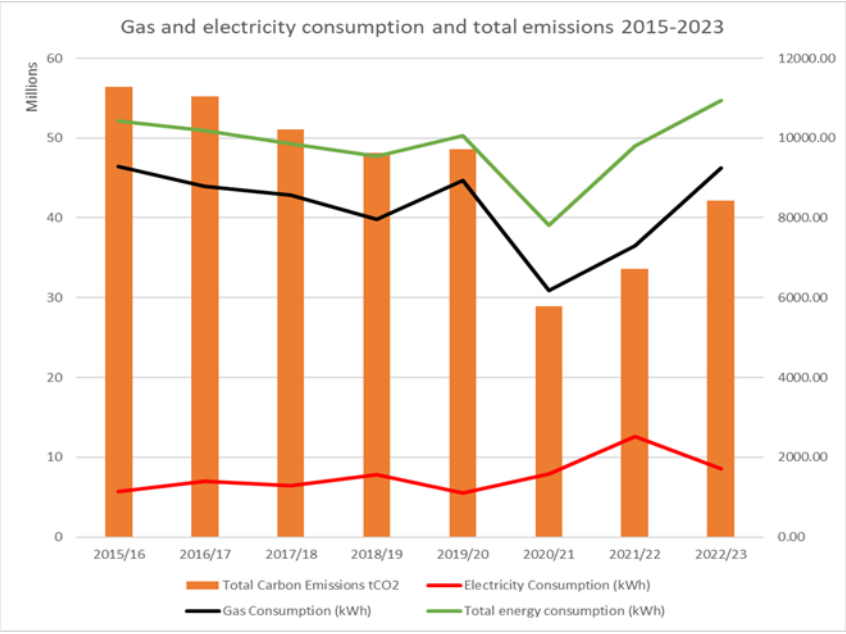
Energy Usage and Costs 21-22 to 22-23				
	Consumption		Costs	
	21-22	22-23	21-22	22-23
	KWH	KWH	£	£
Gas	36,491,997	46,214,831	874,698	3,300,348
Electricity	12,558,811	8,565,071	1,924,119	2,344,706
Total	**49,050,809**	**54,779,902**	**2,798,817**	**5,645,054**

The two principal factors causing these increases are as follows:

- Recovery from the COVID 19 Pandemic has seen significant increases in the level of operational activity on site and the return to site based work for many employees. These specific issues have had a direct impact upon the overall volume increases in energy consumption.
- International supply pressures upon gas and generated electricity have led directly to very significant increases in unit costs charged by suppliers.

Within our Green Plan we have also produced a Heat Decarbonisation Plan (HDP) that will enable the Trust to work towards a number of other NHS decarbonisation requirements. The HDP is a starting point for the Trust to plan how we intend to replace fossil fuel reliant heating systems with low carbon alternatives.

The Trust is committed to finding new and innovative ways to reduce both the cost and the volume of energy used and despite the turbulence of the past two years the emissions trend over the past eight years continues to show a medium to long term reduction as shown in the following graph.



As trust we are committed to reducing our environmental impact, and every action counts. Below are a few examples of the actions the Trust has undertaken in 2022/23:

- Anesthetic gases and measured dose inhalers.

According to recent research, operating theatres are often three to six times more energy-intensive than the rest of a hospital and are major contributors of waste. Anesthetic gases alone account for 2% of NHS emissions and 5% of a typical hospital's emissions. The NHS has committed to reducing greenhouse gas emissions from anesthetic gases and inhalers by both switching to alternative inhalers, and reducing the proportion of desflurane used in surgery to 2% or less by volume, across 2023/24, as a whole. The longer-term objective is the total elimination of desflurane and within this Trust Greener Edge recently undertook a nitrous oxide waste review. The Trust is currently awaiting the results of this review, which are expected to provide recommendations for rapid implementation via the action plans of a dedicated working group.

- Procurement processes
  This Trust has included a 10% social value weighting within the tender assessment process in order to reflect the potential supplier's impact upon local employment, the community, well-being and decarbonisation.
  Looking forward, from 1 April 2023, the NHS requires all suppliers of goods, services and works bidding new contracts above £5 million per annum to have a published Carbon Reduction Plan (CRP) in place, in line with the guidance published by the NHS.

- Waste
  Domestic waste recycling increased by 41% between 20/21 and 21/22 yielding a reduction in carbon emissions of 1.5 tonnes. We are still awaiting the figures for 22/23, however they are expected to show increased levels of recycling and reduction in emissions. This is a result of recent focus upon segregation of waste.
  Recycling posters have been reviewed and up-dated and the Trusts waste contractor held a waste roadshow in October 2022. This was a sustainability themed lunchtime event raising awareness with staff on environmental issues such as recycling.

- Catering
  Our Catering Team continues to recycle oil and food waste and introduced new recycling bins towards the end of the 2022/23 reporting year. The bins, funded by the League of Friends, have an additional aperture to allow food waste segregation and were rolled out as part of Global Recycling Day.
  From November 2022 to March 2023, the Catering Team actively reduced 88,125 items of plastic from the catering department. The Trust will be participating in the NHS England Pilot on measuring food waste. Collating spoilage and plate wastage to identify food waste reduction and avoidance opportunities.

- Walking Aids
  The nationally set target is that within the coming 5-year period 40% of all walking aids used will be refurbished. This Trust procures walking aids through an equipment loans scheme which promotes a circular economy approach through the return of equipment for refurbishment and reuse, helping the Trust to reduce our carbon emissions and meet the 40% national target. Further work to reduce emissions will include the inclusion of orthopaedic crutches. From November 2021 to March 2023, 467 items were returned to the Trust with 301 of those being recycled.

- Travel and Transport
  New Lease Car scheme
  The Trust launched a new car lease scheme in collaboration with Fleet Solutions in April 2023 limited to providing fully electric cars.
  Staff Transport
  We have created a Staff Transport Group. The work streams for this group include developing and promoting the Cycle to Work Scheme, the Season Ticket Loan Scheme and the Car Share Scheme.

- Air quality
  The Trust is in partnership with Medway Council regarding outdoor air quality monitoring. Medway Council will supply diffusion tubes to measure pollutant concentrations in the atmosphere.

Community Engagement, Human Rights and Anti bribery

Community Engagement

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

We will continue to share updates and opportunities to get involved by attending virtual and face-to-face meetings, community events, sharing information, and invitations to events with members and the community, providing updates on our website and through our bi-monthly Community Engagement newsletter.

In the last year, we have hosted and attended a variety of public events, including events focusing on Patient Experience, Improvement and Innovation, Improvements to our Emergency Department and frailty services.

One particular example of this is the work the Trust has undertaken with the Integrated Care Board and Medway and Swale Health and Care Partnership to identify ways of providing care closer to home for frail patients, and to create increased capacity in Medway Maritime Hospital to treat more elective patients.

Through this work a proposal to utilise vacant space in the Sheppey Community Hospital and creating a 22-bed frailty ward primarily for patients living in Swale, providing care closer to home for these patients.

Following a successful period of engagement with both our community and our staff the Sheppey facility was approved and was opened on 20 January 2023.

People, and Quality Priorities.

We also held our Annual Members' Meeting in October 2022.

The Trust actively participated in a plethora of engagement opportunities and our public governors have attended shopping and community centres, colleges, universities and events on our own premises. This included specifically engaging with residents from the Swale area about the opening of the Trusts new frailty ward within the Sheppey Community Hospital.

We plan to continue to build on our community engagement and provide opportunities to engage with the wider community groups in areas that are harder to reach. This will ensure that we continue to learn and discover the amazing work that is taking place in our local community, and ensure their voices are heard within the Trust.

Anti-bribery

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 also 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 action tracker. The local counter fraud services team works closely with the internal audit team 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 counter fraud 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 a tailored combination of refreshing of induction materials for the Trust, Fraud Alerts to Trust staff and communications through events like Fraud Awareness Week. .

The counter fraud team brought two investigations forward from 2021/22 and eight new referrals of fraud were received during 2022/23, which were investigated and outcomes reported to the Audit and Risk Committee. Eight 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 (EDS2). This is reviewed periodically, and the Equality Strategy will be refreshed in 2023. Additionally, the Trust publishes the results and action plans on mandatory equality metrics, such as the Gender Pay Gap and Workforce Race Equality Standard. 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.

Gender Pay Gap

In May 2022, the Trust published its gender pay gap and supporting statement for 2021/22, as required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. The Trust's mean gender pay gap is 30 per cent and the median gender pay gap is 21.4 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.

The refreshed data for the 2022/23 reporting period is due in May 2023 and will be published on the Trusts website.

Overview of financial performance

Although on occasion the quality of the service we offer has not achieved the levels we have strived for, this has not been as a result of the removal of resource nor through 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 we will maintain our close relationships with local commissioners and the Integrated Care System/Board to ensure our patients receive the best care for the best value.

The accounts presented in this 2022/23 annual report show a deficit of £6.0 million; the performance against the Trust's control total is as per the table below.

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The accounts presented in this 2022/23 annual report show a deficit of £6.0 million; the performance against the Trust's control total is as per the table below:

	Plan £m	Actual £m	Variance £'000
Clinical income	357.8	397.4	39.6
Other income	34.8	34.8	5.3
Pay	(277.5)	(283.2)	(38.7)
Non-pay	(135.7)	(147.9)	(12.2)
Operating surplus	**7.1**	**1.1**	**6.0**
Non-operating expenses	(7.3)	(7.3)	0.0
Reported surplus/(deficit)	**(0.2)**	**(6.2)**	**(6.0)**
Net impairments	0.0	(0.1)	(0.1)
Donated Asset cost/income net	0.2	0.2	0.0
Impact of consumables from DHSC	0.0	0.1	0.1
Other adjustments	0.0	0.0	0.0
Control total	**0.0**	**6.0**	**6.0**

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

- Opening additional bed capacity that had not been budgeted due to demand and patient safety.
- Additional medical costs associated with that capacity, high levels of staff turnover coupled with vacancies, and a continued and unrelenting increase in activity.
- High drugs costs, linked both to the activity noted above and the sharp rise in inflation during the year.

In November 2022 NHSE released their "Protocol for changes to in-year revenue financial forecast". This set out the process to follow in the event of a deterioration in the forecast compared to the annual plan. Due to the performance and continuing risks, the Trust worked with its system partners and NHSE to follow this process and declare the £6m deficit that was subsequently achieved.

Income

The majority of the Trust's income is directly related to patient care from commissioning organisations such as Integrated Care Boards, CCGs and NHS England. Since 2020/21, this has been based on fixed income sums to cover historic contract levels, recognising that "ordinary" activity would be much reduced as a result of the Covid measures in place. The Integrated Care System did not 'clawback' or revert to an activity based income model for elective work.

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 constructions to expenditure.

An additional £8.2m income and expenditure was accounted for as non-recurrent clinical income in relation to the non-consolidated national pay award being considered at 31st March.

Expenditure

In 2022/23 the Trust is reporting increased costs of £27.1 million on pay: these arose from: £13.6 million on pay awards, £5.0m in respect of increases in social security (inclusive of the rate changes during the year) and directly paid pension contributions and £8.5 million to the additional staff in post to meet safer staffing and activity needs. Non-pay has increased by £10.5 million when compared to 2021/22; £3.7 million relates to higher depreciation charges (from investments made in the current and preceding financial year), £4.5 million on drugs costs (activity and inflation) and £2.1m on premises (maintenance, repairs and cleaning).

Capital expenditure plan

During the year, the Trust has invested £25.9 million in capital schemes in the areas shown below:

	£m
Estates and Site infrastructure	2.3
Fire Safety	2.5
Service Development	8.2
IT	6.5
Equipment	6.4
Total	**25.9**

The total investment is 15% 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 2023/24.
- Redevelopment of Endoscopy services
- Continuing implementation of an electronic patient records system
- Fire safety works

Cash flow and balance sheet

The balance sheet shows £288.2m of net assets at the end of the year, up from £260.0m of net assets at previous year end.

The Trust ended the year with £34.7 million cash in the bank; higher than originally planned due to late allocations of Public Dividend Capital and £0.8m unplanned bank income relating to interest rates rises.

Financial outlook

2023/24 will be another challenging year for the Trust. We have submitted a deficit plan for the year of £15.0 million, arising as a consequence of the continuation of those 2022/23 cost pressures.

From nationally collected data we know 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 £3,377 in 2020/21 (the last available period).

It shows the Trust 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 our performance to comfortably within the top left hand quartile (better than average efficiency; surplus) while ensuring patients receive the care they deserve.

In conjunction with this improvement, the Trust has also experienced an improvement in its reference cost index. This again is a national measure to look at relative efficiency of organisations, with the baseline score of 100. With a score of 93 for 2021/22, the Trust is therefore operating at a lower comparative cost base.

To address this financial sustainability challenge, the Trust worked with system partners to produce a Financial Recovery Plan ("FRP"). The FRP set out the historic performance of the Trust, identified those key factors that had and continue to give rise to the Trust being in a loss-making position, the proposed mitigations to address these and long term financial modelling to assess the impacts. This did demonstrate that there was a route to financial sustainability for the Trust over the medium-term. However, performance and events during 2022/23 – including the rapid and significant inflationary rates – have meant that the Trust will revisit the work, the gaps that have developed and will reset those mitigations and strategic initiatives that will deliver this programme of work.

There remain a number of key risks to the overall 2023/24 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 hyper-inflationary costs;
- Controlling expenditure in line with budgets;
- Delivery of a £27.0 million / 6.6% efficiency programme, ensuring no compromise on quality;
- Recruitment and retention of workforce to reduce reliance on premium cost temporary staff;
- Managing investments to a tight capital programme.

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 2022/23.

Signed

Jayne Black
Chief Executive
28 June 2023

NHS
Medway
NHS Foundation Trust

ACCOUNTABILITY REPORT

Best of care
Best of people

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 2022/23.

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 comprised a non-executive Chair, seven other non-executive directors, five voting executive directors, including the chief executive chief finance officer, chief nursing officer and chief medical officer. 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 chairperson.

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.

All voting board directors (executive and non- executive) have joint responsibility for board decisions, 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 development 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 Nominations and Remuneration Committee.

Board Appointments and Leavers

Non-executive directors are appointed via a formal and transparent procedure, managed through the governors' nominations 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 Nominations Committee, appointed Paulette Lewis as a non-executive director for three years from 1st October 2022. The role was advertised.

Executive directors
The post of Chief Operating Officer was recruited to during the year. The role was publicly advertised and interviews were held by the Board's Nominations Committee.
At the time this report was produced, the Trust was recruiting two new non-executive directors to fill planned vacancies.

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 Nominations 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 2022/23

Joanne Palmer
Chair – appointed 22 October 2020

Appointed as non-executive director 1 September 2015
Appointed as Senior Independent Director 22 December 2016
Appointed as Deputy Chair 1 April 2017 Acting Chair from 1 April to 21 October 2020
Term: first as Chair, ending 30 September 2023

Experience and Qualifications
Current role: Chief Operating Officer at BC&E
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
- Trust Nominations and Remuneration Committee
- Finance Planning and Performance Committee
- Quality Assurance Committee

Mark Spragg
Non-Executive Director
Deputy Chairman and Senior Independent Director.

Appointed 1 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 the area of Financial Services.
Involved in a number of notable cases Involved in charity work.

Membership of committees
- Audit & Risk Committee (Chair)
- Finance, Planning and Performance Committee
- Trust Nominations and Remuneration Committee (Chair)
- Charitable Trustee

Adrian Ward
Non-Executive Director

Non-Executive Director for Freedom to Speak Up
Appointed 1 August 2017
Term: second, ending 31 July 2023

Experience and Qualifications
Practicing 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 Practice Panel for the Nursing and Midwifery Council from 2017
Member of the Institute of Chartered Accountants in England and Wales investigating Committee from 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 Charitable Trustee

Annyes Laheurte
Non-executive Director

Appointed 1 April 2021
Term: first, ending Mach 2024

Experience and Qualifications
Annyes has over 25 years' experience in financial reporting together with financial planning and analysis for international organisations.

Whilst working at Lloyd's of London, she focused on financial controls, process enhancements and safeguarding the Society's assets by mitigating operational risks.

Annyes is a Chartered Global Management Accountant (1991) and member of the Institute of Risk

Management (2007) and was awarded Specialist status (2009).

Membership of committees
Chair of Finance Planning and Performance Committee
Member of Audit & Risk Committee
Member of Nominations and Remuneration Committee
Charitable Trustee

Sue Mackenzie
Non-Executive Director
Appointed 1 April 2020
Term: second, 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 (CiS),

Membership of committees
- Chair of People Committee
- Member of Nominations and Remuneration Committee
- Charitable Trustee

Paulette Lewis MBE
Non-Executive Director

Appointed November 2022.
Term: First, ending October 2025

Experience and Qualifications
Paulette has worked over 35 years in a variety of healthcare settings, gaining wide experience across acute and community services. She has held several senior/executive posts, including Director of Midwifery and Children Services, Executive Director Nursing and Director of the Pan London Maternity Service Review.

Paulette is a leadership and management consultant and has spent a great deal of her time mentoring and coaching individuals to help them reach their full potential.
In the year 2000, Paulette 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, Paulette received the Zenith Global Healthcare Award as special recognition for her global healthcare work. She was also a nominee for Nurse of The Year by The Jamaican Times UK Community Award in 2014.

Paulette was awarded an MBE in the Queen's Birthday Honours List in June 2014 for her work and contribution to nursing and charity work.

Non-voting Associate Non-Executives:

- Rama Thirunamachandran
- Jenny Chong

Jayne Black, Chief Executive

Experience and Qualifications
Jayne Black 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,

including Director of Operations, Deputy Chief Executive and Chief Operating Officer.

(01 April to 01 June 2022) Dr George Findley, Chief Executive

Experience and Qualifications
George was previously Deputy Chief Executive and Chief Medical Officer at University Hospitals Sussex NHS Foundation Trust, the trust formed following the merger of Western Sussex Hospitals with Brighton and Sussex University Hospitals.

During his seven years at Western Sussex George contributed to the Trust becoming the first non-specialist acute trust in the country to be rated 'Outstanding' in all the key inspection areas assessed by the Care Quality Commission. He was also part of the leadership team at Brighton during the period when the Trust exited special measures and climbed three inspection ratings to Outstanding for Caring and Good overall.

A specialist intensive care consultant, George is an experienced clinical leader at national and regional level, and a Fellow of the Health Foundation's GenerationQ leadership develop and quality improvement programme.

Alan Davies
Chief Finance Officer

Experience and Qualifications
Alan joined the Trust in November 2020 and brings with him extensive Finance experience within the NHS, in Acute, CCG and Strategic settings. His last NHS role was as CFO for Luton CCG and prior to that was 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 17 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 also holds financial accreditation and has studied with the Healthcare Finance Management Association.
Leon was an integral part of the leadership team at Great Ormond Street Hospital who won the national HPMA award in 2015 for improved HR capability. He is currently leading the work on the Trust's refreshed People Strategy following the achievement of the regional CIPD award for HR team of the year in 2017.

Evonne Hunt
Chief Nursing Officer

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 and 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 wanted to be a nurse since she was seven years old, heavily influenced by her mum who is a

nurse. She is extremely passionate about patient safety and experience, organisational culture and staff development and wellbeing.

Dr Alison Davis,
Chief Medical Officer (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.

Trust Board meetings

The Trust board held a total of 7 public meetings between 1 April 2022 and 31 March 2023, and two development sessions. Trust board meetings normally 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.

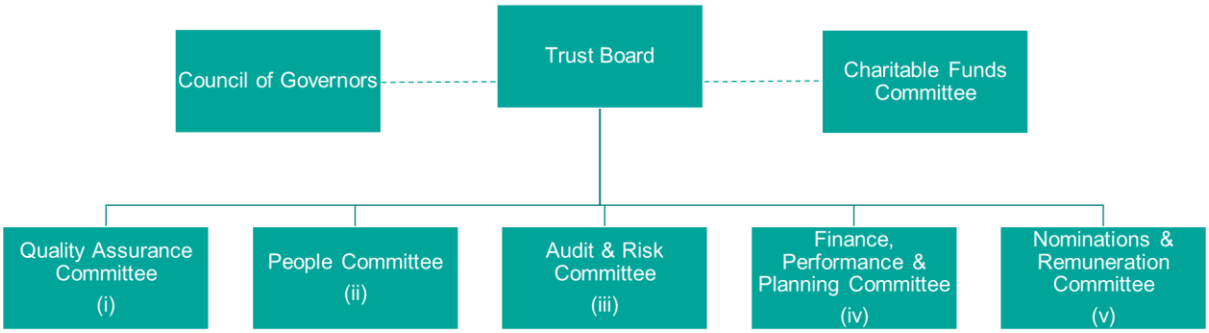
Director attendance at formal committee and public board meetings is detailed under: Attendance at Board of Directors and Committee meetings in 2022/23.

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 organisations 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.



Committee structure

Audit & Risk Committee
The report of the Audit & 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 our 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 a key issues report to the Board of Directors after every meeting on its activities.

The Committee met 12 times during 2022/23. Attendance record is detailed under Attendance at Board of Directors and Committee meetings in 2022/23.

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 Trust Board regarding investments and significant contracts before their approval by the Trust Board.

The Committee provides a key issues report on its activities to the Board of Directors after every meeting. The Committee met 13 times during the year. Attendance is detailed under Attendance at Board of Directors and Committee meetings in 2022/23.

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. It has met 6 times in 2022/23.

Nominations and Remuneration Committee
The Nominations and Remuneration Committee (the Committee) is chaired by the Senior Independent Director and Deputy Chair. Its membership consists of the Trust's chair and non-executives. The committee is responsible for reviewing and making recommendations to the Trust board on the composition, balance, skill mix and succession planning of the Trust 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 four times during the year. Attendance record is detailed under Attendance at Board of Directors and Committee meetings in 2022/23.

Attendance at Board of Directors and Committee meetings in 2022/23

		Trust Board and Committees						
Voting Members *(See Non-Executive Directors Biography and Committee structure for Chair of Committees)*	**Job Titles**	**Trust Board Private (7 formal meetings)**	**Trust Board (7 formal meetings)**	**Noms and Rems (4 meetings)**	**Audit and Risk (4 meetings)**	**Finance and Performance (11 meetings)**	**Quality Assurance (12 meetings)**	**People (6 meetings)**
Jo Palmer	**Chair**	7 of 7	7 of 7	4 of 4				4 of 6
Mark Spragg	**Senior Independent Director**	6 of 7	6 of 7	4 of 4	4 of 4	9 of 11		1 of 2
Sue Mackenzie	**Non-Executive Director**	4 of 7	4 of 7	4 of 4				6 of 6
Paulette Lewis	**Non-Executive Director**	2 of 2	2 of 2	1 of 1			4 of 4	
Adrian Ward	**Non-Executive Director**	6 of 7	6 of 7	4 of 4	3 of 4		9 of 12	
Annyes Laheurte	**Non-Executive Director**	7 of 7	7 of 7	4 of 4	4 of 4	11 of 11	5 of 8	3 of 6
Jenny Chong	**Associate Non-Executive Director**			4 of 4				
RamaThirunamachandran	**Academic Non-Executive Director**			2 of 4				
Tony Ullman	*Non-Executive Director*	2 of 3	2 of 3	2 of 2		0 of 11	4 of 4	1 of 2
Ewan Carmichael	*Non-Executive Director*	2 of 4	2 of 4	1 of 2			3 of 4	0 of 2
Jayne Black	**Chief Executive (from June 22)**	7 of 7	7 of 7			8 of 9		
Jayne Black	*Chief Operating Officer (until May 22)*					1 of 2		
Alan Davies	**Chief Finance Officer**	5 of 7	5 of 7		4 of 4	11 of 11		
Evonne Hunt	**Chief Nursing Officer**	6 of 7	6 of 7				9 of 12	
Alison Davis	**Chief Medical Officer**	6 of 7	6 of 7				9 of 12	
Leon Hinton	**Chief People Officer**	7 of 7	7 of 7	3 of 4				5 of 6
Sunny Chada	*Chief Operating Officer (from June 22 to Sept 22)*					3 of 3		
Mandy Woodley	*Chief Operating Officer (from Oct 22 to Dec 22)*	3 of 4	3 of 4			1 of 3		
Gavin Macdonald	*Chief Operating Officer (from Jan 23 to Apr 23)*	1 of 1	1 of 1			3 of 3		
Gary Lupton	*Director of Estates and Facilities (until May 22)*					2 of 2		
Richard Daniel	*Director of Estates and Facilities (from May 22 to Jan 23)*					4 of 7		
George Findlay	*Chief Executive (until May 22)*	1 of 2	1 of 2	1 of 1		0 of 2		
Paula Tinniswood	*Chief Strategy and Transformation Officer (until Sept 22)*					5 of 5		

Audit & Risk Committee Report

The Audit & Risk Committee's (the Committee) responsibilities and key areas discussed during 2022/23, whilst fulfilling these responsibilities, described in the table below:

	Principles of responsibility	Key areas discussed and reviewed by the committee during 2022/23
Review of the Trusts Risk Management Processes	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. 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).	The outputs of the Trust's risk management processes including reviews of: • 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. • 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. • Internal audit, counter fraud and external audit reports and updates. • Interests, gifts, hospitality and sponsorship quarterly declarations. • Losses and special payments • Waivers of standing financial instructions
Financial Matters	Monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance Review the annual report and financial statements before submission to the Board, to determine their objectivity, integrity and accuracy	• 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. • Key accounting policy judgements, including valuations. • Impact of changes in financial reporting standards where relevant. • Single tender waivers • Losses and special payments
External Audit	Monitoring and reviewing the external auditor's independence, objectivity and effectiveness. Developing and implementing policy on the engagement of the external auditor to supply non audit services, taking into account relevant ethical guidance.	• Basis for concluding that the Trust is a going concern. • External auditor effectiveness and independence. • External auditor reports on planning, a risk assessment, internal control and value for money reviews. • External auditor recommendations for improving the financial systems or internal controls. • Changes to Accounting Standards.

Internal Audit	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.	• High priority internal audit recommendations with progress report covering 18 months. • The internal audit reports discussed by the Committee included: • Payroll record management – Partial assurance with improvements • Risk Management – significant assurance with minor improvement opportunities • Business Continuity - significant assurance with minor improvement opportunities • Risk Maturity – assurance with improvements required • (mandatory audit of core financial systems) - Partial assurance with improvements required • Data Security Toolkit – Partial assurance with improvement required
	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.	The reports identified recommendations for improvement that have been accepted by the executive directors. There have been regular reports and updates from the Local Counter Fraud Specialist throughout the year. This has included a review of the application of the Trust's Conflicts of Interest Policy.

Composition and meetings

The Committee is a non-executive committee of the Trust board, established in accordance with the Trust's constitution and has delegated authority to review the adequacy and effectiveness of our systems of internal control and our arrangements for risk management, control and governance processes to support our objectives.
Executive directors attend by invitation, and the Chief Executive and Chief Finance 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.

Attendance at meetings

Non-executive directors (members)	Attendance at meetings
Mark Spragg (Chairman)	4/4
Annyes Laheurte	4/4
Adrian Ward	3/4

Code of Governance

Medway NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance (including the revised Code implemented in April 2023) on a comply or explain basis. In so far as the Board is 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 the Committee in 2022/23 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 and approved its terms of reference in December 2022. The terms of reference were revised with changes to adhere to best practice and amendments to the Trusts approach to risk management. The Committee has also reviewed and approved its work plan for 2023/24.

The Committee also reviews 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 £100,000. A separate fee is paid for work in connection with the hospital charity.

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 Committee considered the independence of our external auditor undertaking non-audit work. No risks were identified in this respect, particularly in relation to self-review and familiarity. Our auditors will not be relying on any additional work undertaken when forming their opinion and we do 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 & Risk Committee.

The audit plan of the internal auditors is risk- based, and the executive team works 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 2022/23 was presented to the Audit & Risk Committee on 22 June for the period 1 April 2022 to 31 March 2023 an overall rating of ‘‘Significant assurance with minor improvements" 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.

Governors' report

Council of Governors

The Council of Governors (the Council) is made up of elected and appointed governors who provide an important link between the Trust, local people and key stakeholder organisations. They share information and views that can influence and shape the way 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 Chairman 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 Chairman 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 foundation trust's auditor.
- 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, be they public or staff are all able to stand for election to the Council provided they are 16 years of age 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 Trust 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 people:

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

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 five ordinary meetings during 2022/23. 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 two extraordinary meetings were held to review and approve the Trusts constitution.

Council of Governor members also attended the Trust annual general meeting in October 2022.

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

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 2022/23 reporting period.

Committee of the Council of Governors

The Council has one committee, which is the Governors' Nominations 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.

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. Members are invited to apply by completing a written or electronic application form.

Staff membership is available for staff members if they have a permanent contract, a 12-month or longer fixed term contract, have an honorary contract or are employed by the Trust although they may be working with other NHS organisations locally. Staff will automatically become Staff members unless they opt out.

In March 2023, the Trust had approximately 10,300 public members and 4,500 staff members giving a total of 14,800 members. The breakdown of our public membership by constituency is:

Constituency	Total
Medway	6,353
Swale	1,700
Rest of England and Wales	2,262
Membership total	10,315

As part of the Trusts "living with Covid" approach we moved to a hybrid approach of physical and online events and meetings. We held a series of events on including a members' event considering the Trust's Patient First programme and the Annual Members' Meeting in October 2023 to name but a few.

Members received regular e-bulletins and received the Trust's Special Edition News@Medway magazine by email which was also available on the Trust website.

The Trust's membership strategy was reviewed by the Council of Governors in May 2022 and sets out how we attract, retain and engage with members. Our Community Engagement Officer and Governors held 'Meet the Governor' sessions in order to continue our engagement activity with our local community. This allowed us to share updates, support and encourage people to get involved and to form positive working relationship and a shared understanding of our community.

Through our engagement, we continued our efforts to establish our presence and strengthen networks and trust within the community.

Attendance at Public Council of Governors' meetings

The information below outlines governors on the Council during 2022/23, together with their record of attendance.

	12/05/2022	11/08/2022	01/12/2022	09/02/2023	Total	Total (financial year 22-23)
George Findlay	Yes					
Jayne Black	Yes		Yes	Yes		3 out of 4
Partner Governors						
Cllr David Brake		Yes	Yes			**2 out of 4**
Susan Plummer	Yes	Yes	Yes			**3 out of 4**
Helen Belcher						**No attendance**
Claire Peppiatt-Wildman	Yes		Yes	Yes		**3 out of 4**
Cllr Angela Harrison		Yes		Yes		**2 out of 4**
Cllr John Wright	Yes	Yes	Yes			**3 out of 4**
Staff Governors						

Mohamed Mohamed	Yes		Yes	Yes		**3 out of 4**
Nithesh Mathai	Yes	Yes	Yes			**3 out of 4**
Lisa Marsh						**No attendance**
Vanessa Page		Yes	Yes	Yes		**3 out of 4**
Adebayo Da'Costa	Yes					**1 out of 4**
Medway Governors						
Penny Reid	Yes	Yes		Yes		**3 out of 4**
Diana Hill						**No attendance**
James Chespy	Yes					**1 out of 4**
Adrian Parsons		Yes	Yes	Yes		**3 out of 4**
Jacqui Hackwell	Yes	Yes		Yes		**3 out of 4**
Ian Chappell						**No attendance**
Timothy Newman		Yes	Yes			**2 out of 4**
Olaide Kazeem		Yes				**1 out of 4**
Martina Rowe						**No attendance**
Prof Anan Shetty		Yes	Yes			**2 out of 4**
Zoe Van Dyke	Yes	Yes	Yes			**3 out of 4**
Swale Governors						
Bill Sakaria						**No attendance**
Jennifer Oliphant		Yes				**1 out of 4**
Jay Patel		Yes	Yes	Yes		**3 out of 4**
David Nehra		Yes	Yes	Yes		3 out of 4
Rest of England & Wales Governor						
Rebecca Bellars		Yes	Yes			2 out of 4
Amran Hussain						**No attendance**
Non-Executive Directors						
Rama Thirunamachandran			Yes			**1 out of 4**
Ewan Carmichael	Yes					**1 out of 4**
Tony Ullman	Yes	Yes				**2 out of 4**
Joanne Palmer	Yes		Yes	Yes		**3 out of 4**
Mark Spragg	Yes	Yes	Yes	Yes		**4 out of 4**
Jenny Chong	Yes	Yes	Yes	Yes		**4 out of 4**
Sue Mackenzie						**No attendance**
Annyes Laheurte	Yes			Yes		**2 out of 4**
Paulette Lewis	Not in Post	Not in Post	Yes	Yes		**2 out of 4**
Adrian Ward						**No attendance**

Directors						
Glynis Alexander	Yes	Yes	Yes	Yes		**4 out of 4**
Paula Tinniswood	Yes					**1 out of 4**
Alison Davis	Yes			Yes		**2 out of 4**
David Sulch						**No attendance**
Leon Hinton	Yes	Yes	Yes	Yes		**4 out of 4**
Paul Kimber						**No attendance**
Gary Lupton	Yes	N/A	N/A	N/A		**1 out of 4**
Gurjhit Mahil						**No attendance**
David Seabrooke	Yes	N/A	N/A	N/A		**1 out of 4**
Alan Davies	Yes	Yes	Yes	Yes		**4 out of 4**
Liam Edwards						**No attendance**
Matt Capper	Not in post	Not in Post	Yes	Yes		**2 out of 4**
Evonne Hunt	Yes	Yes	Yes	Yes		**4 out of 4**

Director attendance at Public Council of Governors meetings 1 April 2022 to 31 March 2023

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 on 01634 825292, by email to met-tr.members-medway@nhs.net, in writing to Membership Office, Gundulph, Medway Maritime Hospital, Medway NHS Foundation Trust, Windmill Road, Gillingham, Kent, ME7 5NY, or through our website www.medway.nhs.uk

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 our 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. Our 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.

Statement on Better Payment Practice Code (BPPC)
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 below.

	2022/23 Number	**2022/23 £000**	***2021/22 Number***	***2021/22 £000***
Total trade invoices paid in the year	59,811	162,554	*62,364*	*188,856*
Total trade invoices paid within target	57,040	156,328	*57,595*	*171,534*
Percentage of trade invoices paid within target	**95.4%**	**96.2%**	***92.4%***	***90.8%***

Also see Note 17.1 of the accounts

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 development programme for executive directors and informed the board development programme in 2022/23.

As part of their routine scheduled inspection programme, the CQC conducted a follow-up Well-led inspection of the Trust. The findings of this inspection were published in the summer 2022; the Trust received an improved rating of 'Good'.
The Trust has reviewed its position in relation to the enforcement undertakings agreed with NHS England – of 19 criteria, 17 have been discharged and work continues to close the remaining action points which all relate to the financial position of the Trust.

Stakeholder Relations

Over the past year we have been proactive in seeking the involvement of patients and public in the progress of the Trust and development of services, through workshops and focus groups and at events within the Trust.

The Trust's Chair and Chief Executive regularly meet key stakeholders to ensure they are kept informed about Trust progress and are able to support the involvement of the local community. Trust Executives also report to local authority scrutiny committees on a regular basis. Following the introduction of the Health and Care Act 22 the Trust is also a key partner in the Medway and Swale Health and Care Partnership and the Medway Health and wellbeing Board.

Patient Care

Please refer to the Quality Account published separately.

Fees and charges (income generation)

Please refer to the Annual Accounts.

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

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 our income is clinical income and it is unlikely that 'other income' will exceed clinical income for any reporting period.

Jayne Black
Chief Executive
28 June 2023

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. We 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 2022/23 the Nominations and Remuneration Committee considered and approved a recommendation for a consolidated cost of living award, for executives in their position on 1 April 2022.

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 2022/23 there were no annual or long-term performance bonuses.

			Current Year							Prior Year						
			(a)	(b)	(c)	(d)	(e)	(f)	Note:	(a)	(b)	(c)	(d)	(e)	(f)	Note:
Name	Title	Dates where not full year	Salary and Fees	Taxable Benefits	Annual Performance Related bonuses	Long-term performance-related bonuses	All pension-related benefits	Total (Columns a to e)	Payments or Compensation for loss of office (included in salary & Fees)	Salary and Fees	Taxable Benefits	Annual Performance Related bonuses	Long-term performance-related bonuses	All pension-related benefits	Total (Columns a to e)	Payments or Compensation for loss of office (included in Salary & Fees)
			(Bands of £5,000)	(£ to the nearest £100)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £5,000)	(£ to the nearest £100)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)
			£000	£	£000	£000	£000	£000	£000	£000	£	£000	£000	£000	£000	£000
Ms J Palmer	Chair		50-55	1900	0	0	0	50-55	0	50-55	2700	0	0	0	50-55	0
Mr E Carmichael	Non Executive Director	(01/04/2022-31/08/2022)	5-10	0	0	0	0	5-10	0	10-15	0	0	0	0	10-15	0
Mr M Spragg	Non Executive Director		10-15	300	0	0	0	10-15	0	10-15	300	0	0	0	10-15	0
Mr A Ward	Non Executive Director		10-15	0	0	0	0	10-15	0	10-15	200	0	0	0	10-15	0
Ms J Chong	Associate Non Executive Director		5-10	0	0	0	0	5-10	0	5-10	0	0	0	0	5-10	0
Mr A Ullman	Non Executive Director	(01/06/2022-11/08/2022)	5-10	0	0	0	0	5-10	0	10-15	500	0	0	0	10-15	0
Ms S Mackenzie	Non Executive Director		10-15	0	0	0	0	10-15	0	10-15	0	0	0	0	10-15	0
Ms A Laheurte	Non Executive Director		10-15	0	0	0	0	10-15	0	10-15	0	0	0	0	10-15	0
Mr G Findlay	Chief Executive - Interim	(01/04/2022-31/05/2022)	40-45	0	0	0	0	40-45	0	220-225	0	0	0	25-27.5	245-250	0
Mrs J Black	Acting Chief Executive	(01/06/2022-14/08/2022)	35-40	0	0	0	0	35-40	0	0	0	0	0	0	0	0
Mrs J Black	Chief Executive	(From 15/08/2022)	115-120	0	0	0	0	115-120	0	0	0	0	0	0	0	0
Mrs J Black	Chief Operating Officer	(01/04/2022-31/05/2022)	20-25	0	0	0	0	20-25	0	60-65	0	0	0	70-75	135-140	0
Mr L Hinton	Chief People Officer		120-125	0	0	0	40-42.5	160-165	0	115-120	0	0	0	15-17.5	130-135	0
Ms E Hunt	Chief Nursing and Quality Officer - Honorary	(01/04/2022-18/04/2022)	5-10	0	0	0	0	5-10	0	0	0	0	0	0	0	0
Ms E Hunt	Chief Nursing and Quality Officer	(From 19/04/2022)	120-125	0	0	0	50-55	175-180	0	50-55	0	0	0	95-97.5	145-150	0
Mr A Davies	Chief Financial Officer		135-140	0	0	0	30-32.5	165-170	0	135-135	0	0	0	5-7.5	140-145	0
Ms M Woodley	Interim Chief Operating Officer - Honorary	(From 16/06/2022-06/01/2023)	130-135	0	0	0	0	130-135	0	0	0	0	0	0	0	0
Ms P Tinniswood	Chief Strategy and Transformation Officer	(01/04/2022-30/11/2022)	115-120	0	0	0	10-12.5	125-130	0	130-135	0	0	0	25-30	160-165	0
Miss A Davis	Chief Medical Officer		220-225	0	0	0	50-52.5	270-275	0	40-45	0	0	0	75-77.5	115-120	0
Miss P Lewis	Non Executive Director	(From 01/11/2022)	5-10	0	0	0	0	5-10	0	0	0	0	0	0	0	0

For 2022/23, 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 These figures have been audited.

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.

		Current Year						
		(a)	(b)	(c)	(d)	(e)	(f)	(g)
Name	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
Mr L Hinton	Chief People Officer	0-2.5	0-2.5	35-40	25-30	368	413	25
Ms P Tinniswood	Chief Strategy and Transformation Officer	0-2.5	0	5-10	0	133	112	8
Mr A Davies	Chief Financial Officer	2.5-5	0	55-60	160-165	-	41	21
Miss A Davis	Chief Medical Officer	2.5-5	0-2.5	75-80	155-160	323	390	67
Ms E Hunt	Chief Nursing and Quality Officer	2.5-5	2.5-5	25-30	45-50	161	197	36

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

			2022/23	2021/22
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	215,439	1,109	**216,548**	**196,071**
Social security costs	24,252	-	**24,252**	**21,075**
Apprenticeship levy	1,067	-	**1,067**	**976**
Employer's contributions to NHS pension scheme	32,944	-	**32,944**	**30,289**
Pension cost - other	22	-	**22**	**14**
Other post employment benefits	-	-	**-**	**-**
Other employment benefits	-	-	**-**	**-**
Termination benefits	-	-	**-**	**-**
Temporary staff	-	8,404	**8,404**	**7,688**
Total gross staff costs	**273,724**	**9,513**	**283,237**	**248,425**
Recoveries in respect of seconded staff	-	-	**-**	**-**
Total staff costs	**273,724**	**9,513**	**283,237**	**256,113**
Of which				
Costs capitalised as part of assets	-	-	**-**	-

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 £	Aggregate sum of expenses paid 2021/22 £
Directors	9	4,955	6,503

Fair Pay Multiple

The table below provides the ratio between the highest paid Director in the trust and the median total remuneration of the whole workforce.

		Pay Multiplier	
		2021/22	2022/23
Band of Highest Paid Director	(£'000)	235-240	230-235*
Median Total Remuneration	(£'000)	25.7	27.0
	Ratio	9.2	8.5

* Amount adjusted from senior manager disclosure to reflect c.16% of cost is covered by NHS England

These figures have been audited.

Expenditure on consultancy

The Trust spent £1,738,000 on consultancy during 2022/23; this was a change of £1,198,000 compared to the previous year (2021/22) of £540,000. The increase is due to the support and roll out of the Trusts Patient First improvement methodology.

Jayne Black
Chief Executive
28 June 2023

Staff report

The table below profiles the average worked full-time equivalent workforce across the organisation (including temporary staff) throughout 2022/23.

	Permanent	Other	2022/23 Total	2021/22 Total
	Number	Number	Number	Number
Medical and dental	762	9	**771**	704
Ambulance staff	-	-	**-**	-
Administration and estates	868	4	**872**	855
Healthcare assistants and other support staff	1,373	-	**1,373**	1,360
Nursing, midwifery and health visiting staff	1,410	31	**1,441**	1,378
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	438	17	**455**	458
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	**4,851**	**61**	**4,912**	**4,755**
Of which:				
Number of employees (WTE) engaged on capital projects	-	-	-	-

These figures have been audited.

Male and Female Employees

The table below profiles the voting Board Directors (Executive and non-executive) and other senior managers (by contractual full-time equivalent) on 31 March 2023.

	Voting Board Director	Other Senior Managers	All Staff
Female	3.0	28.0	3,934.0
Male	4.0	17.0	1,133.0
Total	**7.0**	**45.0**	**5,067.0**

Sickness Absence Data

The table below sets out the Trust's sickness absence for 2022/23 compared with 2021/22. The overall sickness rate has increased over the last 12 months and equates to 18.00 average days sick per full-time employee. This has reduced from an average of 18.95 days in 2021/22.

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 per cent in 2022/23

Staff Group	2022/23	2021/22
Additional Professional, Scientific and Technical	4.81%	3.73%
Additional Clinical Services	7.13%	8.77%
Administrative and Clerical	4.03%	4.47%
Allied Health Professionals	3.46%	3.65%
Estates and Ancillary	7.41%	6.23%
Healthcare Scientists	2.12%	0.87%
Medical and Dental	2.15%	2.17%
Nursing and Midwifery Registered	5.29%	5.22%
Students	0.00%	0.00%

Staff policies

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:

Policy/SoP	How it supports the workforce	Renewal Date
Disability in Employment Policy	Enables the employment of disabled persons by ensuring due regard to their skills and abilities; this policy applies at recruitment and throughout employment, including, where appropriate, reasonable adjustments and adaptations. (see also the Attendance Management Policy)	October 2023
Attendance Management Policy and SOP	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.	April 2025
Flexible Working Policy	This policy provides the framework for flexible working to be considered and applied fairly.	May 2025
Maternity Leave & 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 & 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.	November 2025
Parent Leave Policy	This is the framework to ensure correct and fair application of entitlements for partners not already eligible for maternity leave.	November 2024
Adoption Leave Policy & 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
Dignity at Work Policy	This policy seeks to raise awareness of the expected standards of behavior in the workplace and the principles through which bullying and harassment will be eliminated and prevented.	Under review at time of publishing
Grievance Policy & Procedure	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.	Under review at time of publishing
Disciplinary Policy	The purpose of this policy and procedure is to encourage employees to achieve and maintain high standards of conduct and behavior in accordance with the requirements of the Trust and relevant professional codes of conduct.	Under review at time of publishing
Performance Management Policy & 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	This is a new policy drawing together from other policies the Trust's commitment to staff	December 2025

	who are members of the Reserve Forces, enabling them to be released for training and mobilisation.	
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.	November 2024
Health and Safety Policy	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.	April 2025
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)	June 2023
Freedom to Speak Up/Raising Concerns at Work/Whistleblowing Policy	This enables staff to be able to raise concerns at work safely, and for the Trust to respond to those concerns.	May 2025
Relationship 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.	March 2025

National NHS Staff Survey 2022

The NHS staff survey is a vital measure of the Trust's level of staff engagement, how staff are feeling, their morale and their experiences of working here. This is used by the Trust to listen and adapt to make improvements. The survey is conducted annually and compared against other NHS acute organisations and also against the Trust's own results from the previous year. This provides not only an opportunity to learn from our staff, but also how we compare to the national picture.
Since 2021, the Trust has improved in five of the seven themes; we are compassionate and inclusive; we each have a voice that counts; we are safe and healthy; we are always learning and we are a team. The score for we work flexibly remained static and the score for we are recognised and rewarded dropped by 0.1 points, mirroring the national picture. The Trust's People Strategy retains culture as a key delivery programme for the future. By continuing the embedding of our culture improvement programme in tandem with our staff survey action planning and implementation, values-based recruitment and continuous improvement methodologies – the Trust is committed to improving our staff experience which, in turn, will improve patient experience.

This year's Staff Survey response rate was 40 per cent, which is unchanged from 2021.

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 2022 results offers a two-year trend. This year eligibility was extended to active, in-house, bank only workers (staff who do not have a substantive or fixed term contract with the organisation). This is the first national data collection for bank only staff.

The seven People Promises:

The two themes, Staff Engagement and Staff Morale, are scored out of 10. The below table shows the People Promise themes for the Staff Survey.

The Staff Engagement score was 6.6 for 2022 and has increased by 0.1 since 2021. Our target as a Trust (our True North objective) is to move our 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 2022 and has similarly improved by 0.1 since 2021.

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	2021 score	2021 respondents	2022 score	2022 respondents
We are compassionate and inclusive	6.9	1839	7.0	1826
We are recognised and rewarded	5.7	1832	5.6	1817
We each have a voice that counts	6.4	1816	6.5	1803
We are safe and healthy	5.6	1818	5.7	1812
We are always learning	5.4	1736	5.5	1747
We work flexibly	5.9	1813	5.9	1804
We are a team	6.4	1829	6.6	1816
Themes				
Staff Engagement	6.5	1843	6.6	1826
Morale	5.5	1842	5.6	1826

Application of Modern Slavery Act

Modern slavery encompasses slavery, servitude, human trafficking and forced labour. The Trust has a zero-tolerance approach to any form of modern slavery. The Trust continues to fully support the government's objective to eradicate modern slavery and human trafficking and we acknowledge our role in both combating it and supporting victims. The Trust is committed to ensuring our supply chains and our business activities are free from ethical and labour standards abuse.

- People - Human resources policies provide processes and procedures to ensure that our

employees and those employed in our 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 our 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.

- Our approach to procurement and our supply chain includes:
  - Ensuring that our suppliers are carefully selected through our 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 our values: the Trust has zero tolerance to slavery and human trafficking and thereby expect all our 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.

Advice and training about modern slavery and human trafficking is available to staff through our mandatory safeguarding children and adults training programmes, our safeguarding policies and procedures, and our safeguarding leads. It is also discussed at our compulsory staff induction training.

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 our shared goals and objectives. The agreement outlines how we will work together to promote effective partnership regarding the workforce implications of delivering and developing the services we provide to our patients. In line with the Trade Union (Facility Time Publication Requirements) Regulations 2017, we are 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 1 April 2017 to 31 March 2018 and the data must be published on or by 31 July every year thereafter.

Table1

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**
19	16.84

Table2

Percentage of time spent on facility time **How many of your employees who were relevant union officials employed 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%	17
1-50%	2
51-99%	0
100%	0

Table3

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	£430.00
Provide the total pay bill	£242,425,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.00018%

Table4

Paid trade union activities **As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?**	
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	**51.81%**

Exit packages

Staff exit packages

Reporting of compensation schemes - exit packages 2022/23

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£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**

Reporting of compensation schemes - exit packages 2021/22

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	3	**3**
£10,000 - £25,000	3	2	**5**
£25,001 - 50,000	1	2	**3**
£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	**5**	8	**13**
Total resource cost (£)	£188,000	£220,000	**£408,000**

includes increase to amounts declared in 21/22 annual report following additional information provided by NHSEngland

Exit packages: other (non-compulsory) departure payments

	2022/23		2021/22	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	9	125	6	120
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	2	100
Total	**9**	**125**	**8**	**220**
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.
2022/23

NHS Foundation Trust Code of Governance

Code of Governance

The NHS Foundation Trust Code of Governance was consulted on and updated for implementation in April 2023 (the Code) and 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 Foundation 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	In line with principle 1.3 above, 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.	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 that 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, material 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 (but note 4.3 in Section C below, where chairs and NEDs can serve beyond six years subject to rigorous review and NHS England approval). 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 responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available. 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	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions. 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 that 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	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team is available for use by nominations committees to support the council of governors in the appointment of the chair and non-executive directors. 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. Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	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 or governors.	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, governors 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 strategy, 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.	
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.	
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 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.	Comply
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 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 an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	Comply
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 a 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, e.g. 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. A record should be kept of the number of meetings of the council and the attendance of individual governors and it should be made available to members on request.	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, e.g. through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Comply

NHS Oversight Framework

Oversight Framework

The NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at four themes: Quality, access and outcomes, Finance and use of resources, Preventing ill health and reducing inequalities People, Leadership and capability

Based on information from these themes, providers are catagorised from one to four, where ‘four’ reflects providers receiving the most support, and ‘one’ reflects providers with maximum autonomy.

A Foundation Trust will only be in segments three or four where it has been found to be in breach or suspected breach of its licence.

The Trust was entered into enforcement undertakings in 2017 with the then NHS improvement. This position has been under review and a full progress review was undertaken in 2021. Although the category 4 status was not lifted from the trust, it was recognised that much progress had been made. Progress is reported through the year through regionally led oversight meetings. To date only the financial sustainability of the trust is listed on its ‘undertakings’ for breach of its license.

Statement of the chief executive's responsibilities as the accounting officer of Medway NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of 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 and of its income and expenditure, 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 NHS foundation trust's performance, business model and strategy and
- 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 NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation 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.

Jayne Black
Chief Executive

28 June 2023

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Medway NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Medway NHS Foundation Trust for the year ended 31 March 2023 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 CQC 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 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 & 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 2022/23 we embarked on a review of our corporate governance structures following the introduction of the trust wide Patient First continual improvement approach. Our arrangements provide the necessary support to deliver our 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 sets out the principal risks to delivery strategic objectives and the key controls and assurances available to the Board on management of these significant areas of risk. The Board Assurance Framework 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.

At the end of the 2021/22 the Board Assurance Framework highlighted six areas where the Board has limited or partial assurance despite significant management attention:

- Lack of mitigating options against medical staffing (agency/locum/additional sessions) overspend (red 5x5 = 25), and
- There is a risk that the Trust may be unable to staff clinical and corporate areas to acceptable levels (red 4x4 = 16).
- Delivery of the control total and Financial Recovery Plan (red 5x5 = 25).
- Not delivering the Efficiencies Programme (red 4x5 = 20).
- The financial impact of non-closure of escalation areas (red 4x4 = 16).
- Internal financial governance controls, linked to efficiencies programme (red 4x4 =16)

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 Board Assurance Framework by the appropriate executive and Board committee.

For 2022/23, 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
- Our 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 our 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).

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, 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 our priorities and developments in the Quality Account (published separately).

Our 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. Our refreshed organisational strategy was developed in liaison with staff, governors and wider partners and approved by the Board in July 2022. The 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. This is being reviewed as part of the overall governance review. We are establishing four divisions that will provide world-class care to the diverse communities that we serve, and will be supported by our corporate services. These divisions are (from June 2023):

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

Each division is the key building block of successfully delivering our 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

Our 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 our 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 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. The Trust underwent a full assurance review with the CQC, providing assurance on our maternity services. The CQC carried out an unannounced inspection of our maternity services and awarded the trust a 'Good' rating. The Trust is currently rated:

Medical care (including older people's care)	30 July 2021	Requires improvement
Services for children & 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 submission to NHS Digital on 30 June achieved an assessment of 'Partial Assurance with improvements required' rating.

The Trust is assessed for a level of confidence in the veracity of the DSP Toolkit self-assessment as per the NHS Strengthening Assurance Assessment Guide and our internal auditors felt our self-assessment provided a medium confidence level. The overall standard classification risk rating was described as moderate as no standards were rated as 'Unsatisfactory' and one or less are rated as 'Limited'. However, not all standards were rated as 'Substantial'.

An example of the areas where the Trust requires improvement are:

- Data security and protection training has not been completed in a timely manner for a proportion of new joiners
- A proportion of sampled user accounts of those no longer at the Trust had not been promptly disabled.
- Backups are not kept securely and separate from the Trust's network (offline), or in a cloud service designed for this purpose.

The Trust has compiled a recovery plan and these actions and their achievement will be tracked by the trusts internal audit tracker and will be overseen by the Audit and Risk Committee.

The Trust introduced a new electronic health record system during the reporting year and the programme continues to mature.

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, we face 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 our risk management strategy and policy will be critical in enabling the Trust to do this in the future. We recognise that strategic and transformational change internally and across our local and system health economy will also be required to address any risks that we identify.

As we begin an era of 'living with COVID' we are acutely aware of the unique operational and strategic challenges to the Trust, most notably around workforce resilience, elective recovery and economic sustainability and uncertainty. These challenges are the same across the NHS and the country as a whole. This legacy has been, and will continue to be, felt across all our services and threaten the achievement of the Trust's objectives.

The same principal strategic risks for the organisation in 2022/23 will therefore be carried forward into 2023/24, 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. A full review of these risks will be undertaken by the Board in 2023/24.

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. Any 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.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

Register of Interest

NHS Medway Foundation Trust has published on its website an up-to-date register 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 Trust Board reviews the register of interests at each meeting and requires all executive and non-executive directors to confirm their entries. A standing item is contained on all Board and Committee agenda's which requires all senior staff, executive and non-executive directors to make known any interests in relation to the agenda.

A register of the directors' interests is available to the public on the Trust's website www.medway.nhs.uk or by contacting:

The Company Secretary,
Medway NHS Foundation Trust,
Medway Maritime Hospital, Windmill Road,
Gillingham, Kent
ME7 5NY.

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 foundation 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.

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. The Trust was awarded 'Substantial Compliance' by the Kent and Medway Integrated Care Board. This has been reported via the Local Health Resilience Partnership Executive Group for Kent and Medway to NHS England.

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 group, the trust board and associated sub-committees.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity

and human rights legislation are complied with.

The foundation 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.

Information governance

The table below breaks down the information breaches recorded on the Trusts DATIX reporting system for the 2022/23 reporting period. No incidents met the criteria required to report to the Information commissioners Officer (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 IG/data security incident
7	33	6	1	12

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 our 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 quarterly 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 for this year is 'significant assurance with minor improvements required' 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 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 Integrated Audit 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. For this reporting period, the Audit and Risk Committee 'in-housed' the role of tracking the implementation of auditor recommendations enabling a more streamlined and timely role out of improvements and a greater level of accountability for improvement.

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.

Chief Executive
Date: 28 June 2023

NHS
Medway
NHS Foundation Trust

ANNUAL ACCOUNTS

Best of care
Best of people

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Foreword to the accounts

Medway NHS Foundation Trust

These accounts, for the year ended 31 March 2023, have been prepared by Medway NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name	**Jayne Black**
Job title	**Chief Executive Officer**
Date	**28 June 2023**

Report on the Audit of the Financial Statements

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

Opinion on financial statements

We have audited the financial statements of Medway NHS Foundation Trust (the 'Trust') for the year ended 31 March 2023, 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 2022-23.

In our opinion, the financial statements:

- Give a true and fair view of the financial position of the Trust as at 31 March 2023 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 2022-23; 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 2022-23 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 2022/23 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 2022/23; 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 2022/23, 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 2022-23).
- 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:
    - Journal entries that altered the Trust's financial performance for the year;
    - The reasonableness of year-end revenue and expenditure accruals; and
    - The reasonableness of estimates in respect of property, plant and equipment valuation.

- Our audit procedures involved:
    - Evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
    - 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 property, plant and equipment valuations and revenue and expenditure accruals; and
    - Assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

- 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 2023.

We have nothing to report in respect of the above matter except on 22 June 2023 we identified significant weaknesses in the Trust's arrangements for financial sustainability. The Trust delivered a deficit in 2022-23 and a deficit is planned for 2023-24 which assumes the delivery of £27 million sustainable efficiency savings which have not yet been identified. We recommended that the Trust further develop its cost improvement plans and works with local healthcare system partners to identify wider opportunities for efficiency savings over the medium and longer term.

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

29 June 2023

Statement of Comprehensive Income

for the year ended 31 March 2023

	Note	2022/23 £000	2021/22 £000
Operating income from patient care activities	3	397,443	370,315
Other operating income	4	34,801	30,160
Operating expenses	5	(431,098)	(393,469)
Operating surplus from continuing operations		**1,146**	**7,006**
Finance income	8	844	44
Finance expenses	9	(26)	(21)
PDC dividends payable	26	(8,168)	(6,976)
Net finance costs		**(7,350)**	**(6,953)**
Surplus/(Deficit) for the year		**(6,204)**	**53**
Other comprehensive Income/(Expense)			
Will not be reclassified to income and expenditure:			
Impairments	12	(2,200)	0
Revaluations	12	23,081	7,463
Total comprehensive Income/(expense) for the period		**14,678**	**7,516**

Statement of Financial Position

as at 31 March 2023

	Note	31 March 2023 £000	31 March 2022 £000
Non-current assets			
Property, plant and equipment	10	271,810	239,695
Right of use assets	13	928	0
Receivables	14	780	600
Total non-current assets		**273,518**	**240,295**
Current assets			
Inventories	15	6,374	5,996
Receivables	14	29,086	13,889
Cash and cash equivalents	16	34,742	33,455
Total current assets		**70,202**	**53,340**
Current liabilities			
Trade and other payables	17	(50,285)	(28,147)
Borrowings	19	(953)	(136)
Provisions	20	(519)	(763)
Other liabilities	18	(800)	(1,353)
Total current liabilities		**(52,557)**	**(30,399)**
Total assets less current liabilities		**291,163**	**263,236**
Non-current liabilities			
Borrowings	19	(1,950)	(2,025)
Provisions	20	(1,031)	(1,248)
Total non-current liabilities		**(2,981)**	**(3,273)**
Total assets employed		**288,182**	**259,963**
Financed by			
Public dividend capital		475,198	461,656
Revaluation reserve		64,406	43,525
Income and expenditure reserve		(251,422)	(245,218)
Total taxpayers' equity		**288,182**	**259,963**

The notes on pages 88 to 123 form part of these accounts.

Signed

Name	**Jayne Black**	**Alan Davies**
Position	**Chief Executive Officer**	**Chief Finance Officer**
Date	**28 June 2023**	**28 June 2023**

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**
Surplus/(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**
Taxpayers' equity at 31 March 2023	**475,198**	**64,406**	**(251,422)**	**288,182**

Statement of Changes in Equity for the year ended 31 March 2022

	Public Dividend Capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2021 - brought forward	**453,870**	**36,062**	**(245,271)**	**244,661**
Surplus/(deficit) for the year	0	0	53	**53**
Revaluations - property, plant and equipment	0	7,463	0	**7,463**
Public dividend capital received	7,786	0	0	**7,786**
Taxpayers' equity at 31 March 2022	**461,656**	**43,525**	**(245,218)**	**259,963**

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 2023

	Note	2022/23 £000	2021/22 £000
Cash flows from operating activities			
Operating surplus / (deficit)		1,146	7,006
Non-cash income and expense:			
Depreciation and amortisation	5	15,635	11,914
Impairments and reversals	12	(42)	(78)
Income recognised in respect of capital donations (cash and non-cash)	4	(100)	(631)
(Increase)/decrease in receivables		(15,252)	2,083
(Increase)/decrease in inventories		(378)	966
Increase/(decrease) in trade and other payables		17,603	(762)
Increase/(decrease) in other liabilities		(553)	(6,231)
Increase/(decrease) in provisions		(445)	(657)
Net cash flows from / (used in) operating activities		**17,614**	**13,610**
Cash flows from investing activities			
Interest received		719	24
Purchase of property, plant and equipment and investment property		(21,366)	(30,858)
Receipt of cash donations to purchase capital assets		100	75
Net cash used in investing activities		**(20,547)**	**(30,759)**
Cash flows from financing activities			
Public dividend capital received		13,542	7,786
Movement in loans from the Department of Health and Social Care		(126)	(126)
Capital element of lease liability repayments		(956)	0
Interest on DHSC loans		(27)	(28)
Other interest (e.g. overdrafts)		(3)	(5)
Interest element of lease liability repayments		(14)	0
PDC dividend (paid)/refunded		(8,196)	(6,207)
Net cash generated from financing activities		**4,220**	**1,420**
Increase/(decrease) in cash and cash equivalents		**1,287**	**(15,729)**
Cash and cash equivalents at 1 April - brought forward		**33,455**	**49,184**
Cash and cash equivalents at 31 March	16	**34,742**	**33,455**

Notes to the accounts
For the year ended 31 March 2023

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 2022/23 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 income is earned from NHS commissioners in the form of fixed payments to fund an agreed level of activity. In 2022/23 fixed payments are set at a level assuming the achievement of elective activity targets. These are termed '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 differs from the agreed level set in the fixed payments, the variable element either increases or reduces the income earned by the Trust at a rate of 75% of the tariff price. Elective recovery funding provides

additional funding for the delivery of elective services. In 2022/23 elective recovery funding was included within the aligned payment and incentive contracts. In 2021/22 income earned by the system based on achievement of elective recovery targets was distributed between individual entities by local agreement and income earned from the fund was accounted for as variable consideration. 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 CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner. In 2022/23 payment under these schemes is included in fixed payments from commissioners based on assumed achievement of criteria.

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 on 2022/23 was therefore a desktop revaluation.

The valuation exercise was carried out in March 2023 with a valuation date of 31st March 2023

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.

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 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)	3	10
Buildings & Dwellings	3	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.

This 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.

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 0.95% applied to new leases commencing in 2022 and 3.51% to new leases commencing in 2023.

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.

Operating Leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Initial application of IFRS 16

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

The standard has been 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 have only been 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 have not been revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the statement of financial position immediately prior to initial application. Hindsight has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

No adjustments have been 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 has a value below £5,000. No adjustments have been made in respect of leases previously classified as finance leases.

2021/22 comparatives

Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line or other systematic basis.

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 1.70% in real terms (prior year: minus 1.30%).

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:

- Asset revaluation - See note 1.6.2
- Credit Loss Provision - See note 1.9.2 Financial Asset Impairments

Note 1.17.1 Sources of estimation uncertainty

There are no estimation uncertainties that could have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Note 1.18 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2022/23.

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)	2022/23	2021/22
	£000	£000
Aligned payment & incentive (API) contract income / system block income	335,440	325,238
High cost drugs income from commissioners	24,680	22,360
Other NHS clinical income	6,689	7,217
Private patient income	0	93
Elective recovery fund	10,771	4,555
Agenda for change pay award central funding[1]	8,266	0
Additional pension contribution central funding[2]	10,036	9,205
Other clinical income	1,561	1,647
Total income from activities	**397,443**	**370,315**

[1]Proposed settlement for national pay dispute as advised and funded by NHS England.

[2]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:	2022/23	2021/22
	£000	£000
NHS England	61,486	48,473
Clinical commissioning groups *(demised 01/07/2022)*	76,547	319,399
Integrated care boards *(commenced 01/07/2022)*	256,711	0
Other NHS Providers	1,138	700
Non NHS: private patients	2	93
Non NHS: overseas patients (non-reciprocal, chargeable to patient)	372	594
Injury cost recovery scheme	1,173	829
Non NHS: other	14	227
Total income from activities	**397,443**	**370,315**

Injury Cost Recovery income is subject to a credit loss allowance of 24.86% (2021/22: 23.76%) to reflect expected rates of collection.

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

	2022/23	2021/22
	£000	£000
Income recognised this year	372	594
Cash payments received in-year	136	110
Amounts added to provision for impairment of receivables	468	730
Amounts written off in-year	197	59

Note 4 Other operating income

	2022/23	2021/22
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	1,309	1,401
Education and training (excluding notional apprenticeship levy income)	13,544	12,054
Non-patient care services to other bodies	7,866	4,790
Reimbursements and top up funding	0	748
Income in respect of employee benefits accounted on a gross basis	133	1,469
Other contract income	10,474	7,200
Other non-contract operating income		
Education and training - notional income from apprenticeship fund	148	155
Receipt of capital grants, donations and assets	100	631
Charitable and other contributions to expenditure	1,227	1,712
Total other operating income	**34,801**	**30,160**

	2022/23	2021/22
Other Income includes:	**£000**	£000
Car Parking income	**1,478**	957
Catering	**708**	666
Pharmacy sales	**168**	136
Staff accommodation rental	**579**	491
Non-clinical services recharged to other bodies	**285**	235
Crèche services	**344**	316
Clinical tests	**2,221**	1,812
Clinical excellence awards	**172**	138
Other income not already covered (recognised under IFRS 15)	**4,519**	2,449
	10,474	7,200

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

	2022/23	2021/22
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	896	7,046
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:	2022/23	2021/22
	£000	£000
within one year	544	939
after one year, not later than five years	256	414
after five years	0	0
Total revenue allocated to remaining performance obligations	**800**	**1,353**

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:

	2022/23	2021/22
	£000	£000
Income from services designated as commissioner requested services	385,860	347,597
Income from services not designated as commissioner requested services	10,022	20,975
Total	**395,882**	**368,572**

Note 5 Operating expenses

	2022/23	2021/22
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	13,614	13,327
Purchase of healthcare from non-NHS and non-DHSC bodies	1,715	1,364
Staff and executive directors costs [1]	276,332	249,934
Remuneration of non-executive directors	141	152
Supplies and services - clinical (excluding drugs costs)	34,158	35,114
Supplies and services - general	9,273	8,733
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	37,327	32,811
Inventories written down	10	8
Consultancy costs	1,738	540
Establishment	2,404	1,322
Premises	11,517	9,384
Transport (including patient travel)	1,285	1,048
Depreciation on property, plant and equipment and right of use assets	15,635	11,914
Impairments net of (reversals)	(42)	(78)
Movement in credit loss allowance: contract receivables / contract assets[2]	(375)	848
Increase/(decrease) in other provisions	(304)	(329)
Change in provisions discount rate(s)	(149)	26
Audit fees payable to the external auditor		
audit services- statutory audit	131	74
other auditor remuneration[3]	0	0
Internal audit costs	131	151
Clinical negligence	16,003	15,562
Legal fees	99	242
Insurance	239	212
Research and development	1,243	1,232
Education and training	7,415	6,629
Operating lease expenditure -comparative	0	643
Operating lease expenditure -short term	137	0
Redundancy	0	168
Car parking & security	277	329
Hospitality	19	8
Losses, ex gratia & special payments[4]	412	321
Other services, e.g. external payroll	392	340
Other	321	1,440
Total	**431,098**	**393,469**

[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 £10,036k (2021/22 £9,205k) 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] Not disclosed in the accounts are other audit Fees of £2.5k for the Independent Examination of Medway Foundation Trust Charitable Fund note 1.19.

[4] Excludes £10k stock write down detailed in separate line -see note 23.

Note 5.1 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2,000k (2021/22: £2,000k).

Note 6 Employee benefits

	2022/23	2021/22
	£000	£000
Salaries and wages	216,548	196,071
Social security costs	24,252	21,075
Apprenticeship levy	1,067	976
Employer's contributions to NHS pensions	22,908	21,084
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	10,036	9,205
Pension cost - other	22	14
Temporary staff (including agency)	8,404	7,688
Total gross staff costs	**283,237**	**256,113**

Note 6.1 Directors remuneration and other benefits

	2022/23	2021/22
	£000	£000
Directors Remuneration	1,182	1,589
Social Security Costs	130	214
Employer contributions to NHS Pension scheme	87	112
Total remuneration	**1,399**	**1,915**

5 Directors are accruing pension benefits under the NHS Pension defined benefit scheme (2021/22; 11)

Note 6.2 Retirements due to ill-health

During 2022/23 there were 3 early retirements from the Trust agreed on the grounds of ill-health (5 in the year ended 31 March 2022). The estimated additional pension liabilities of these ill-health retirements are £276k (£433k in 2021/22).

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 two 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 are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State 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 2023, is based on valuation data as at 31 March 2022, updated to 31 March 2023 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 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

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 2022/23 amount to £22k (2021/22: £14k).

Note 8 Finance income

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

	2022/23	2021/22
	£000	£000
Interest on bank accounts	844	44
Total finance income	**844**	**44**

Note 9 Finance expenditure

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

	2022/23	2021/22
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	26	27
Finance leases	13	0
Interest on late payment of commercial debt	3	5
Total interest expense	**42**	**32**
Unwinding of discount on provisions	(16)	(11)
Total finance costs	**26**	**21**

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

	2022/23	2021/22
	£000	£000
Amounts included within interest payable arising from claims under this legislation	3	5

Note 10 Property, plant and equipment

Note 10.1 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**
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)**
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 10.2 Property, plant and equipment – 2021/22

	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 2021 - brought forward	**7,308**	**161,743**	**4,824**	**22,116**	**43,935**	**86**	**26,135**	**2,579**	**268,726**
Additions*	0	0	0	22,130	140	0	507	0	**22,777**
Reversals of impairments	0	78	0	0	0	0	0	0	**78**
Revaluations	234	1,126	(213)	0	0	0	0	0	**1,147**
Reclassifications	0	12,612	172	(28,169)	7,198	0	8,187	0	**0**
Valuation/gross cost at 31 March 2022	**7,542**	**175,559**	**4,783**	**16,077**	**51,273**	**86**	**34,829**	**2,579**	**292,728**
Accumulated depreciation at 1 April 2021 - brought forward	**0**	**0**	**0**	**0**	**29,294**	**84**	**15,926**	**2,131**	**47,435**
Provided during the year	0	6,066	250	0	3,406	1	2,079	112	**11,914**
Revaluations	0	(6,066)	(250)	0	0	0	0	0	**(6,316)**
Accumulated depreciation at 31 March 2022	**0**	**0**	**0**	**0**	**32,700**	**85**	**18,005**	**2,243**	**53,033**
Net book value at 31 March 2022	**7,542**	**175,559**	**4,783**	**16,077**	**18,573**	**1**	**16,824**	**336**	**239,695**
Net book value at 31 March 2021	**7,308**	**161,743**	**4,824**	**22,116**	**14,641**	**2**	**10,209**	**448**	**221,291**

Note 10.3 Property, plant and equipment financing – 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
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 10.4 Property, plant and equipment financing – 2021/22

	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	7,542	175,559	4,783	16,077	17,019	1	16,824	321	238,126
Owned - donated/granted	0	0	0	0	1,554	0	0	15	1,569
Total net book value at 31 March 2022	**7,542**	**175,559**	**4,783**	**16,077**	**18,573**	**1**	**16,824**	**336**	**239,695**

Note 11 Donations of property, plant and equipment

Note 11.1 Donations

	2022/23	2021/22
Donations	**£000**	**£000**
Additions - donations of physical assets (non-cash)	0	556
Additions - assets purchased from cash donations/grants	100	75
Total Donations	**100**	**631**

Note 12 Revaluations and impairments of property, plant and equipment

The date of the latest valuation of land, buildings and dwellings was 31 March 2023.
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 1.8.2 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 an increase of £20,923k, £23,081k revaluation net of £2,158k impairments.

Note 12.1 Revaluations

	2022/23	2021/22
Changes in market price	**£000**	**£000**
Land	513	234
Buildings including dwellings	22,568	7,229
Total Revaluations	**23,081**	**7,463**

Note 12.2 Impairments

In 2022/23 net impairment reversals of £42k have occurred as result of a full revaluation of The Trust estate, this includes;

	2022/23	2021/22
	£000	**£000**
Impairments charged to revaluation reserve	**2,200**	**0**
Impairments charged to operating expenditure	76	0
Impairment reversals credited to operating expenditure	(118)	(78)
Net impairment reversal credited to operating expenditure	**(42)**	**(78)**
Total Net Impairments	**2,158**	**(78)**

Note 13 Right of Use assets - 2022/23

	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022 - brought forward	**0**	**0**	**0**	**0**	**0**	**0**
IFRS 16 implementation - adjustments for existing operating leases / subleases	1,618	208	0	0	0	1,826
Valuation/gross cost at 31 March 2023	**1,618**	**208**	**0**	**0**	**0**	**1,826**
Accumulated depreciation at 1 April 2022 - brought forward	**0**	**0**	**0**	**0**	**0**	**0**
Provided during the year	779	119	0	0	0	898
Accumulated depreciation at 31 March 2023	**779**	**119**	**0**	**0**	**0**	**898**
Net book value at 31 March 2023	**839**	**89**	**0**	**0**	**0**	**928**

Note 13.1 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.

	2022/23 £000
Carrying value at 31 March 2022	**0**
IFRS 16 implementation - adjustments for existing operating leases	1,826
Interest charge arising in year	13
Lease payments (cash outflows)	(970)
Carrying value at 31 March 2023	**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 13.2 Maturity analysis of future lease payments at 31 March 2023

	Total 31 March 2023 £000
Undiscounted future lease payments payable in:	
- not later than one year;	817
- later than one year and not later than five years;	52
- later than five years.	0
Total gross future lease payments	**869**
Finance charges allocated to future periods	0
Net lease liabilities at 31 March 2023	**869**

Note 13.3 Commitments in respect of operating leases at 31 March 2022 (IAS 17 basis)

This note discloses costs incurred in 2021/22 and commitments as at 31 March 2022 for leases the trust previously determined to be operating leases under IAS 17.

	2021/22 £000
Operating lease expense	
Minimum lease payments	643
Total	**643**

	31 March 2022

	£000
Future minimum lease payments due:	
- not later than one year;	430
- later than one year and not later than five years;	550
- later than five years.	0
Total	**980**
Future minimum sublease payments to be received	0

Note 13.4 Initial application of IFRS16 on 1 April 2022

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.
The standard has been applied using a modified retrospective approach without the restatement of comparatives. Practical expedients applied by the Trust on initial application are detailed in the leases accounting policy in note 1.

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95%.

Reconciliation of operating lease commitments as at 31 March 2022 to lease liabilities under IFRS 16 as at 1 April 2022

	1 April 2022 £000
Operating lease commitments under IAS 17 at 31 March 2022	**980**
Impact of discounting at the incremental borrowing rate	
IAS 17 operating lease commitment discounted at incremental borrowing rate	**977**
Less:	
Commitments for short term leases	(5)
Commitments for leases of low value assets	(7)
Other adjustments:	
Other adjustments[1]	861
Total lease liabilities under IFRS 16 as at 1 April 2022	**1,826**

[1]correction of immaterial prior period error in IAS 17 disclosure (£114k) and contracts reassessed as containing a lease on transition (£975k)

Note 14 Trade and Other Receivables

	2022/23 £000	2021/22 £000
Current		
Contract receivables[1]	29,131	15,092
Allowance for impaired contract receivables / assets	(4,088)	(4,861)
Prepayments (non-PFI)	2,975	2,687
Interest receivable	145	20
VAT receivable	529	594
Clinician pension tax provision reimbursement funding from NHSE	4	23
Other receivables	390	334
Total current trade and other receivables	**29,086**	**13,889**
Non-current		
Contract receivables[1]	462	369
Allowance for impaired contract receivables / assets	(115)	(88)
Clinician pension tax provision reimbursement funding from NHSE	433	319
Total non-current trade and other receivables	**780**	**600**
Of which receivables from NHS and DHSC group bodies:		
Current	21,949	8,303
Non-current	433	319

[1]Contract receivables includes invoiced £16,272k (2021/22 £10,775k) and unvoiced accruals of £12,859k (2021/22 £4,317k), overall increase of £14,039k relates to NHSE funding for the proposed national pay deal and ICB annual funding relating to various projects i.e. step down beds, community diagnostics, virtual wards

Allowances for Credit Losses

	Contract receivables and contract assets	
	2022/23 £000	**2021/22 £000**
Allowances as at 1 April - brought forward	**4,949**	**5,225**
New allowances arising	1,302	2,186
Reversals of allowances	(1,677)	(1,338)
Utilisation of allowances	(371)	(1,124)
Allowances as at 31 Mar	**4,203**	**4,949**
Loss recognised in expenditure	**(375)**	**848**

*The Impairment allowance relates to £3,681k Non NHS (2021/22 £4,524k) and £522k Injury Cost Recovery Scheme (2021/22 £425k)) 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

	2022/23	2021/22
	£000	£000
Drugs	1,756	1,664
Consumables	4,619	4,332
Total inventories	**6,375**	**5,996**
of which:		
Held at lower of cost and NRV	6,375	5,996

Inventories recognised in expenses for the year were £71,485k (2021/22: £67,453k)

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 2022/23 the Trust received £940k of items purchased by DHSC (2021/22 £1,003k)

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.

	2022/23	2021/22
	£000	£000
At 1 April	**33,455**	**49,184**
Net change in year	1,287	(15,729)
At 31 March	**34,742**	**33,455**
Broken down into:		
Cash at commercial banks and in hand	79	364
Cash with the Government Banking Service	34,663	33,091
Total cash and cash equivalents as in Statement of Financial Position	**34,742**	**33,455**

Note 17 Trade and Other Payables

	2022/23 £000	2021/22 £000
Current		
Trade payables[1]	13,024	7,785
Capital payables[2]	9,794	5,231
Accruals	16,723	14,460
Social security costs[1]	3,271	0
Other taxes payable[1]	3,370	0
PDC dividend payable	417	445
Pensions contributions payable[1]	3,122	1
Other payables	564	225
Total current trade and other payables	**50,285**	**28,147**
Of which payables from NHS and DHSC group bodies:		
Current	7,545	5,703

[1] In 2022/23 Trust returned to making payments to suppliers, HMRC and Pensions within contractual terms i.e. within 30 days/1 month in arrears, during COVID payments were made early, on approval.

[2]Includes £3,995k of capital accruals (2021/22 £3,649k)

Note 17.1 Better Payment Practice Code

	2022/23 Number	2022/23 £000	2021/22 Number	2021/22 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	58,897	129,566	61,357	136,657
Total non-NHS trade invoices paid within target	56,239	124,632	56,906	124,128
Percentage of non-NHS trade invoices paid within target	95.5%	96.2%	92.7%	90.8%
NHS Payables				
Total NHS trade invoices paid in the year	914	32,988	1,007	52,199
Total NHS trade invoices paid within target	801	31,696	689	47,406
Percentage of NHS trade invoices paid within target	87.6%	96.1%	68.4%	90.8%

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

	2022/23 £000	2021/22 £000
Current		
Deferred income: contract liabilities	800	1,353
Total other current liabilities	**800**	**1,353**

Note 19 Borrowings

	2022/23 £000	2021/22 £000
Current		
Capital Loans from the Department of Health and Social Care	136	136
Lease liabilities	817	0
Total current borrowings	**953**	**136**
Non-current		
Capital Loans from the Department of Health and Social Care	1,898	2,025
Lease liabilities	52	0
Total non-current borrowings	**1,950**	**2,025**
Total borrowings	**2,903**	**2,161**

*Includes £23k (2021/22 £10k) 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 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 IFRS 16 on 1 April 2022	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**

	TOTAL £000	DHSC Loans £000	Lease Liabilities £000
Carrying value at 1 April 2021	**2,288**	**2,288**	**0**
Cash movements:			
Financing cash flows - payments and receipts of principal	(126)	(126)	0
Financing cash flows - payments of interest	(28)	(28)	0
Non-cash movements:			
Application of effective interest rate (interest charge arising in year)	27	27	0
Carrying value at 31 March 2022	**2,161**	**2,161**	**0**

Note 20 Provisions for liabilities and charges

	Pensions relating to staff	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2022	**1,364**	**66**	**581**	**2,011**
Transfers by absorption	0	0	0	**0**
Change in the discount rate	(546)	0	0	**(546)**
Arising during the year	521	156	0	**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	**1,110**	**176**	**264**	**1,550**
Expected timing of cash flows:				
- not later than one year;	79	176	264	**519**
- later than one year and not later than five years	481	0	0	**481**
- later than five years.	550	0	0	**550**
Total	**1,110**	**176**	**264**	**1,550**

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.

	Pensions relating to staff	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2021	**1,518**	**225**	**936**	**2,679**
Change in the discount rate	26	0	0	**26**
Arising during the year	75	33	0	**108**
Utilised during the year	(92)	(133)	0	**(225)**
Reversed unused	(152)	(59)	(355)	**(566)**
Unwinding of discount	(11)	0	0	**(11)**
At 31 March 2022	**1,364**	**66**	**581**	**2,011**
Expected timing of cash flows:				
- not later than one year	116	66	581	**763**
- later than one year and not later than five years	476	0	0	**476**
- later than five years.	772	0	0	**772**
Total	**1,364**	**66**	**581**	**2,011**

Note 20.1 Clinical negligence liabilities

At 31 March 2023, £213,444k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Medway NHS Foundation Trust (31 March 2022: £321,264k).

Note 21 Contingent assets and liabilities

	2022/23 £000	2021/22 £000
Value of contingent liabilities		
NHS Resolution legal claims	(31)	(46)
Gross value of contingent liabilities	**(31)**	**(46)**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**(31)**	**(46)**
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 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 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

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2022		
Loans from the Department of Health and Social Care	2,161	2,161
Trade and other payables excluding non financial liabilities	27,446	27,446
Provisions under contract	989	989
Total at 31 March 2022	**30,596**	30,596

Note 22.3 Maturity of financial liabilities

	2022/23	2021/22
	£000	£000
In one year or less	45,070	28,280
In more than one year but not more than five years	802	815
In more than five years	1,527	1,616
Total	**47,399**	**30,711**

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

	2022/23		2021/22 Restated	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Fruitless payments	1	10	1	8
Bad debts and claims abandoned	31	211	9	61
Stores losses and damage to property	12	171	14	217
Total losses	**44**	**392**	**24**	**286**
Special payments				
Ex-gratia payments	19	30	23	63
Special severance payments[1]	0	0	2	100
Extra-statutory and extra-regulatory payments	1	0	0	0
Total special payments	**20**	**30**	**25**	**163**
Total losses and special payments	**64**	**422**	**49**	**449**

[1] 2021/22 restated, nil previously reported

Note 24 Gifts

No gifts of more than £300,000 have been declared in 2022/23 (£0k 2021/22).

Note 25 Third party assets

The Trust held £0k cash at bank and in hand at 31 March 2023 (£0k at 31 March 2022) 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. £8,168K is payable this year (£6,976k 2021/22)

Note 27 Capital commitments

There are capital commitments in 2022/23 totalling £6,208k to report (£7,163k in 21/22).

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:

- Board members of the trust
- The Department of Health and Social Care
- Other NHS providers
- CCGs 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 2021/22 to disclose

Note 29 Events after the reporting date

There are currently no events after the reporting date.