Agenda

NHS Medway NHS Foundation Trust

Public Trust Board Meeting

Wednesday, 24 July 2024 at 12:30 – 15:30 Trust Board Room, Gundulph Offices

Item	Subject	Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Introduction and Apologies	Chair	Verbal	12:30	Note
1.2	Quorum				
1.3	Declarations of Interest				
2.	**Minutes of last meeting and Action Log**				
2.1	Minutes of 15 May 2024	Chair		12:35	Approve
2.2	Action Log – none for July 2024				-
2.3	Chief Executive Update	Chief Executive		12:40	Note
2.4	Council of Governors Report (May 2024)	Lead Governor		12:50	Assurance
2.5	Constitution Amendments 2024 (***Appendix in Appendices Pack***)	Company Secretary	3	12:55	Approve
3.	**Board Story Presentation**				
3.1	End of Life Care on Lister Ward – Dr Rosie Chester	Associate Director of Patient Experience		13:00	Note
4.	**Board Assurance Reports**				
4.1	Quality Assurance Committee (June and July 2024)	Chief Medical Officer, Chief Nursing Officer (Interim), Committee Chair		13:20	Assurance
4.2	People Committee (May 2024)	Chief People Officer, Committee Chair		13:25	Assurance
4.3	Audit and Risk Committee (June 2024)	Company Secretary, Committee Chair		13:30	Assurance
4.4	Finance, Planning and Performance Committee (May and June 2024)	Chief Finance Officer, Committee Chair		13:35	Assurance
5.	**Public Board Papers**				
5.1	Maternity Workforce Oversight Report (***Appendix in Appendices Pack***)	Chief Nursing Officer (Interim)	60	13:40	Assurance
5.2	Maternity CNST Compliance Assurance Report - Updates and Actions				Assurance
5.3	Learning from Deaths – Quarterly Update	Chief Medical Officer		14:00	Assurance

5.4	Strategy Review and Summary	Director of Strategy and Partnerships		14:20	Note
~ WELLBEING BREAK - 10 minutes ~					
5.5	Finance Report (Month 2) (***Appendix in Appendices Pack***)	Chief Financial Officer	85	14:40	Note
5.6	Financial Recovery Plan Report –			14:45	Note
5.7	Annual Report and Accounts (***Appendix in Appendices Pack***)	Company Secretary/ Chief Financial Officer	94	14:50	Note
5.8	Health and Safety Annual Report (***Appendix in Appendices Pack***)	Chief Nursing Officer	212	15:00	Assure
6. Performance, Risk and Assurance					
6.1	Integrated Quality Performance Report – June 2024	All Executives	To follow	15:10	Note
6.2	Risk Register (***Appendix in Appendices Pack***)	Company Secretary	242	15:20	Note
6.3	Board Assurance Framework (***Appendix in Appendices Pack***)		279		Note
7. Closing Matters					
7.1	Questions from the Council of Governors and Public	Chair	Verbal	15:20	Note
7.2	Escalations to the Council of Governors				
7.3	Reflection				
7.4	Any Other Business				
7.5	Date and time of next meeting: Tuesday, 10 September 2024				

Key – Patient First Domains

Quality
Patients
People
Sustainability
System and Partnership

Medway NHS Foundation Trust

Constitution

List of amendments (May 2024) V3.0

Document reference	Description of amendment
S. 22.2.2	Number amended to reflect the current board composition.
S.24.7	Removal of the ability to reset tenure following a change in role. Now in line with best practice.
Annex - 5 S.2.8.1	Number amended to reflect the current board composition.

Contents

1. Interpretation and definitions

1.1 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.

1.2 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.

1.3 In this constitution:

In 2006 Act	Means the National Health Service Act of 2006
In 2012 Act	Means the Health and Social Care Act of 2012
In 2022 Act	Means the Health and Care Act of 2022
Accounting Officer/Accountable Officer	Means the person who from time to time discharges the functions specified in paragraph 25 (5) of Schedule 7 to the 2006 Act
Annual Members Meeting	Is identified in paragraph 10 of the Constitution
Auditor	Means the person appointed to audit the accounts of the Foundation Trust, who is called the auditor in the 2006 Act
Board of Directors	Means the Board of Directors as constituted in accordance with the Constitution.
Constitution	Means this Constitution and annexes to it
Co-opted Governor	Means those Governors appointed by partners of the Foundation Trust
Council of Governors	Means the Council of Governors as constituted in accordance with this constitution, which has the same meaning as the Board of Governors in the 2006 Act
Director	Means a member of the Board of Directors
Elected Governors	Means those Governors elected by the public and the classes of the staff constituency
Financial Year	Means each successive period of 12 months beginning on 01 April
The Trust	Means Medway NHS Foundation Trust
Health Service Body	Shall have the meaning ascribed to it in Section 65 (1) of the 2006 Act

License	Means a license issued by NHS England under Section 88 of the Health and Social Care Act 2012
Member	Means a member of the Foundation Trust
NHS Foundation Trust	Means the Code of Governance published by NHS
Code of Governance	England or such similar or further guidance as may be published from time to time
Public Governor	Means a Governor elected by the members of one of the public constituencies
Registered dentist	Means a registered dentist within the meaning of the Dentists Act 1984
Registered Medical Practitioner	Means a fully registered person within the meaning of the Medicines Act 1983 who holds a license to practice under the Act
Regulatory Framework	Means the 2006 Act, the 2012 Act, the Constitution and the Trust's license as granted by NHS England
Secretary	Means the Company Secretary of the Foundation Trust or any other person appointed to perform the duties of The Company Secretary, including a joint, assistant or deputy secretary
Significant Transaction	Means investments, divestments or other transactions compromising more than 25% of the assets, income or Capital of the NHS Foundation Trust in line with NHS England's Compliance Framework
Staff Constituency	Means (collectively) those members comprising of the Staff constituency
Staff Governor	Means a Governor elected by the members of one of the classes of the staff constituency

This document should be read in conjunction with the model rules for the elections for Governors.

2. Name

2.1 The name of this foundation Trust is Medway NHS Foundation Trust (the Trust).

3. Principal purpose

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 The provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 The promotion and protection of public health

3.4 The Trust may also carry on activities, other than those mentioned in the above paragraph, for the purpose of making additional income available in order better to carry on its principal purpose.

4. Powers

4.1 The powers of the Trust are set out in the 2006 Act, the 2012 Act and the 2022 Act.

4.2 The powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5. Membership and constituencies

5.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1.1 A public constituency

5.1.2 A staff constituency

6. Application for membership

6.1 An individual who is eligible to become a member of the Trust may do so on application to the Trust.

7. Public Constituency

7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.

7.2 Those individuals who live in an area specified as an area for any public constituency are referred to collectively as the Public Constituency.

7.3 The minimum number of members in each area for the Public Constituency is specified in Annex 1.

7.4 Membership of a public constituency is subject to Section 9 (Restriction on membership and Termination of Membership).

8. Staff Constituency

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided they:

8.1.1 are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 have been continuously employed by the Trust under a contract of employment for at least 12 months

8.2 Individuals who exercise functions for the purposes of the Trust otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

8.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into nine descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified in Annex 2 and being referred to as a class within the Staff Constituency.

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

8.6 An individual who is:

8.6.1 Eligible to become a member of the staff Constituency; and

8.6.2 Invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency, shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless they inform the Trust that they do not wish to do so.

8.7 Membership of the staff constituency is subject to Section 9 (Restriction on membership and Termination of Membership).

9. Restriction on membership and Termination of membership

9.1 An individual who is a member of a constituency or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

9.2 An individual who ceases to reside in any area specified in Annex 1 shall cease to be a member of the constituency.

9.3 A person may not become or continue as a member of the Trust if they;

9.3.1 are under 16 years of age;

9.3.2 are detained at one of Her Majesty's prisons;

9.3.3 have had his/her name added to and not removed from a list prepared under the Sexual Offenders Act 1997;

9.3.4 fail or cease to fulfil the criteria for membership of any of the constituencies;

9.3.5 have been involved in an act of violence against staff or other members of the Trust or an act of damage against its property;

9.3.6 have been identified as a vexatious complainant against the Trust;

9.3.7 do not uphold the values of the Trust;

9.3.8 have been previously expelled from membership and have not been subsequently re-admitted by the Council of Governors.

9.4 The Trust's decision is final as to whether or not an individual qualifies for membership of the constituency.

9.5 A member of the Trust will cease to be a member if they;

9.5.1 resign by notice to the Membership Officer;

9.5.2 fail to demonstrate that they wish to continue as a member following enquiries made in accordance with a process approved by the Council of Governors;

9.5.3 dies;

9.5.4 are expelled from membership by a resolution of two-thirds of the Council of Governors. Once expelled no person will be re-admitted as a member unless a resolution to that effect is approved by a resolution of more than half of the Council of Governors.

9.6 It is the responsibility of each member to ensure that they are and remain eligible for membership of the Trust and if a member becomes aware of their ineligibility they should inform the Trust as soon as practicable. However, if the Trust is on notice that a member may be disqualified from membership, the Trust shall make reasonable enquiries to establish the case.

9.7 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

10. Annual Members' Meeting

10.1 The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

11. Council of Governors – composition

11.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed Governors.

11.2 The composition of the Council of Governors is specified in Annex 3.

11.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a

constituency, by their class within that constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

12. Council of Governors - election of Governors

12.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Rules for Elections.

12.2 The Model Rules for Elections, as published from time to time by the Department of Health, form part of this constitution. The Model Election Rules should be read in conjunction with this constitution.

12.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this constitution for the purposes of paragraph 41 of the constitution (amendment of the constitution).

12.4 An election, if contested, shall be by secret ballot.

13. Council of Governors – tenure

13.1 An elected Governor may hold office for a period of up to 3 years.

13.2 An elected Governor shall be eligible for re-election at the end of his/her 3-year term.

13.3 An elected Governor shall only be able to serve a maximum of two terms or 6 (six) years.

13.4 An elected Governor shall cease to hold office if they cease to be a member of the constituency or class by which they was elected.

13.5 An appointed Governor may hold office for a period of up to 3 years.

13.6 An appointed Governor shall be eligible for re-appointment at the end of his/her 3-year term.

13.7 An appointed Governor shall only be able to serve a maximum of two terms or 6 (six) years.

13.8 An appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him/her.

14. Council of Governors - disqualification and removal

14.1 A person may not become or continue as a member of the Council of Governors if they have, or are:

14.1.1 been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

14.1.2 had a moratorium period under a debt relief order applied (under Part 7A of the Insolvency Act).

14.1.3 made a composition or arrangement with, or granted a Trust deed for, his/her creditors and has not been discharged in respect of it.

14.1.4 within the preceding five years been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her.

14.1.5 failed to attend three general meetings of the Council of Governors in a 12 month period, unless the Council of Governors is satisfied that the absences were due to reasonable causes and that attendance at future meetings will begin again immediately or within a reasonable period of time.

14.1.6 been dismissed within the preceding two years, otherwise than by reasons of redundancy, from employment with a public body (paid or otherwise).

14.1.7 been appointed as an executive or non-executive Director of the Trust or a Governor, non-executive Director, Chair or Chief Executive of another NHS organisation.

14.1.8 the spouse, partner, parent or child of a Governor.

14.1.9 a member of a Local Authority's Scrutiny Committee covering health matters.

14.1.10 a person who is a medical practitioner and who has been removed from the register of medical practitioners held by the General Medical Council in accordance with the Medical Act 1983, or has been suspended from that register, and not subsequently had his/her name returned to that register.

14.1.11 incapable by reason of continuing mental incapacity, illness or injury of managing and administering his/her property and affairs.

14.1.12 refused to sign a declaration in the form specified by the nominated Member's Office of the particulars of their qualification to vote as a member and that they are not prevented from being a member.

14.1.13 refused to undertake without reasonable cause any training that the Council of Governors requires all Governors to undertake.

14.1.14 failed to sign and deliver to the Nominated Officer a statement in the prescribed form confirming acceptance of the Code of Conduct for Governors.

14.1.15 any conflicts of interest that may make them unsuitable.

14.1.16 fail to disclose any conflict of interest required to be disclosed in meetings of the Council of Governors.

14.1.17 a person whose name has been added to and not removed from a list prepared under the Sexual Offences Act 1997.

14.1.18 no longer eligible to be a member of a constituency or if appointed, that person is no longer sponsored by the relevant organisation.

14.1.19 had their name removed from a relevant list of medical practitioners pursuant to Paragraph 10 of the National Health Service (Performers Lists) Regulations 2004 or Section 151 of the 2006 Act (or similar provision elsewhere), and has not subsequently had their name included in such a list.

14.1.20 subject to disqualification under the Company Directors Disqualification Act 1986.

14.1.21 been convicted of an offence under the Bribery Act 2010, the modern Slavery Act 2015 or a crime involving dishonesty.

14.2 Governors must be at least 16 years of age at the date that they are nominated for election or appointment.

14.3 A Governor may resign from office at any time during his/her term of office by giving notice in writing to the Chair such notice specifying the date of resignation.

14.4 A Governor may be removed from office by resolution of two-thirds of governors present at a Council of Governors General Meeting in the following circumstances:

14.4.1 For any of the reasons listed in section 14.1 above.

14.4.2 They is found to act in way which contravenes the Code of Conduct.

14.4.3 They acts in a way that is incompatible with the values of the Trust or is prejudicial to the reputation of the Trust or the NHS or fails to discharge his/her responsibilities as a Governor.

14.5 A staff Governor who is suspended from staff duties for any reason will also be suspended from their role as a Governor for the duration of their suspension. Whilst a staff Governor is under suspension, They cannot attend meetings of the Council of Governors in any capacity, but missing any meetings of the Council of Governors will not count as failure to attend for the purpose of 14.1.5 above

15. Appointment of a Lead Governor

15.1 The Trust may appoint a Lead Governor.

15.2 The duties of the Lead Governor shall be:

15.2.1 To lead the Council of Governors only in circumstances where it is not appropriate for the Chair, the Deputy-Chair / Senior Independent Director or other non- executive Director to do so.

15.2.2 To act as the point of contact for the regulator in circumstances where it would inappropriate for the regulator to contact the Chair.

15.3 The Lead Governor shall have no other duties unless agreed otherwise by the Board of Directors and the Council of Governors.

15.4 The Lead Governor shall normally hold office for a period of two years

16. Casual Vacancies

16.1 A casual vacancy is a vacancy that arises because a Governor does not complete his/her term of office for any reason. A vacancy that arises because the term of office of a governor has expired and they has not been re-elected or re-appointed is not a casual vacancy.

16.2 The validity of any act of the Council of Governors is not affected by any vacancy amongst the Council of Governors or by any defect in the appointment of any Governor.

16.3 Where there is a casual vacancy of the Council of Governors for whatever reason:

16.3.1 Where the vacancy is for an appointed Governor, the appointing organisation will be requested to appoint a replacement to hold office for the remainder of the term in accordance with the agreed appointment processes; and

16.3.2 Where the vacancy is for an elected Governor, the next highest polling candidate at the most recent elections to fill the seat will be invited to take up the seat for the remainder of the period of office at which time they may seek re-election.

17. Indemnity

17.1 Members of the Council of Governors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their official functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust. The Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of the members of the Council of Governors.

18. Dispute resolution procedure

18.1 The Trust is to establish a dispute resolution procedure in respect of any disputes arising between the Council of Governors and the Board of Directors that shall be approved by both the Council of Governors and the Board of Directors.

19. Council of Governors – duties of Governors

19.1 The duties of the Council of Governors as set out in the amendments to the 2006 Act made by the 2012 Act are:

19.1.1 To hold the non-executive directors individually and collectively to account for the performance of the Board of Directors. Refer to the Terms of Reference for the Council of Governors for further detail on the mechanisms which enable the Non-Executive Directors to be held to account.

19.1.2 To represent the interests of the members of the Trust as a whole and the interests of the public.

19.2 The duties of the Council of Governors as set out in the 2006 Act are:

19.2.1 To appoint or remove the Chair and the other non-executive directors at a general meeting.

19.2.2 Decide the remuneration and allowances, and the other terms and

conditions of office, of the non-executive directors.

19.2.3 Appoint or remove the auditor at a general meeting.

19.2.4 Approve the appointment of a chief executive.

19.2.5 Receive the annual accounts, any report of the auditor relating to the annual accounts, and the annual report at a general meeting.

19.2.6 Provide their views to the Board of Directors in relation to the forward plan for the Trust.

19.2.7 Approve significant transactions.

19.2.8 Approve mergers, acquisitions or dissolutions.

19.2.9 Consider and vote on amendments to the constitution.

19.3 The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

20. Council of Governors - meetings of Governors

20.1 The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 24) or, in his/her absence, the Deputy Chair (appointed in accordance with the provisions of paragraph 25), shall preside at meetings of the Council of Governors.

20.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

20.3 For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

20.4 The standing orders for the practice and procedure of the Council of Governors, as may be varied from time to time, are attached at Annex 4.

21. Council of Governors - travel expenses

21.1 Governors shall not receive remuneration for acting as Governors but the Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Board of Directors.

22. Board of Directors – composition

22.1 The Trust is to have a Board of Directors, which shall comprise both executive and non-executive Directors.

22.2 The Board of Directors is to comprise:

22.2.1 A Non-Executive Director Chair

14 22.2.2 No fewer than 5 (fi

22.2.3 ve) nor more than 6 (six) other non-executive Directors; and

22.2.4 A maximum of 5 (five) executive Directors.

22.3 The Chief Executive shall be the Accounting Officer.

22.4 One of the Executive Directors shall be the Chief Finance Officer.

22.5 One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

22.6 One of the Executive Directors is to be a registered nurse or a registered midwife.

22.7 The Board of Directors should include an appropriate combination of Executive and Non-Executive Directors (and in particular, independent Non-Executive Directors) such that the Non-Executive Directors should be in a majority.

22.8 The Board of Directors may appoint suitable persons from Academic institutions or from industry or commerce as Associate Non-Executive Directors as required from time to time to assist the Board and its Committees. The Associate Non-Executive Directors shall not be voting members of the Board nor count towards a quorum and attend only by invitation from the Board.

23. Board of Directors – General Duty

23.1 The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the Trust as a whole and for the public.

23.2 The Board of Directors will also have regard to the content of the NHS Foundation Trust Code of Governance 2014 and any future versions.

24. Board of Directors - appointment and removal of Non-Executive Directors, Associate Non-Executive Directors, including the Chair

24.1 A person may be appointed as a Non-Executive Director, Associate Non-Executive Director only if:

24.1.1 They are a member of the Public or patient Constituency, or

24.1.2 They are not disqualified by virtue of paragraph 27 below.

24.2 The Council of Governors at a general meeting of the Council of Governors shall appoint the Chair of the Trust and the other Non-Executive Directors, Associate Non-Executive Directors, by approval of a majority of those present.

24.3 Removal of the Chair or another Non-Executive Director, Associate Non-Executive Director shall require the approval of two-thirds of those present at a Council of Governors' General Meeting.

24.4 The appointment and terms of appointment of a Non-Executive Director, Associate Non-Executive Director, including the Chair, will be overseen by a Governors Nominations and Remuneration Committee as set out in Annex 4 of this constitution and will be overseen by the Chair of Council of Governors.

24.5 Non-Executive Directors, Associate Non-Executive Director, including the Chair, should be determined as independent on appointment. The Chair's independence on appointment to the role of Chair should consider any previous tenure served as a non-Executive Director. The criteria for independence are set out in the NHS Foundation Trust Code of Governance.

24.6 The Council of Governors should keep the independence of Non-Executive Directors and Associate Non-Executive Directors under review. This will predominantly be undertaken by the Governors Nominations and Remuneration Committee, overseen by the Council of Governors.

24.7 Non-Executive Directors and Associate Non-Executive Directors should serve a maximum of two three-year terms. Only in exceptional circumstances should a further term of 12 (twelve) months be granted.

24.8 A Governors Nominations and Remuneration Committee overseen by the Chair will review the appointments process in advance of each recruitment process, however this will include as a minimum:

24.8.1 A shortlisting and interview panel comprised of four to six Governors.

24.8.2 Inclusion of non-voting panel members at each stage of the process to include an external advisor, the Chief People Officer (or deputy), the Chair or Senior Independent Director, and Company Secretary (or deputy).

25. Board of Directors - appointment of the Deputy Chair

25.1 The Non-Executives and the Council of Governors will be consulted by the Chair in relation to the appointment of a Deputy Chair.

26. Board of Directors - appointment and removal of the Chief Executive and other Executive Directors

26.1 The Non-Executive Directors shall appoint or remove the Chief Executive Officer.

26.2 The appointment of the Chief Executive Officer shall require the approval of a simple majority of the Council of Governors.

26.3 The Trust Nominations and Remuneration Committee shall appoint or remove the other Executive Directors.

27. Board of Directors – disqualification

27.1 A person may not become or continue as a member of the Board of Directors who:

27.1.1 has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

27.1.2 a moratorium period under a debt relief order applied (under Part 7A of the Insolvency Act 1986).

27.1.3 has made a composition or arrangement with, or granted a Trust deed for, his/her creditors and has not been discharged in respect of it.

27.1.4 within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him;

27.1.5 Is a member of the Council of Governors;

27.1.6 Is the spouse, partner, parent or child of a member of the Board of Directors;

27.1.7 Is the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

27.1.8 is a medical practitioner and who has been removed from the register of medical practitioners held by the General Medical Council in accordance with the Medical Act 1983, or has been suspended from that register, and not subsequently had his/her name returned to that register;

27.1.9 In the case of a non-executive Directors they are no longer a member of one of the public or patient constituencies;

27.1.10 has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

27.1.11 has had a tenure of office as a Chair or as a member or Director of a health service body terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

27.1.12 In the case of a non-executive Director they have refused without reasonable cause to fulfil any training requirement established by the Board of Directors;

27.1.13 has refused to sign and deliver to the Nominated Officer a statement in the prescribed format confirming acceptance of a Code of Conduct for Directors.

28. Board of Directors – meetings

28.1 Meetings of the Board of Directors shall be held in public unless the Board determines otherwise.

28.2 Before holding a meeting in public, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting in public, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

28.3 The standing orders for the practice and procedure of the Board of Directors are attached at Annex 5.

29 Board of Directors - conflicts of interest of Directors

29.1 The duties that a Director of the Trust has by virtue of being a director include the duty to avoid a situation in which the director has (or can have) a direct or indirect

interest that conflicts (or possibly may conflict) with the interests of the Trust. A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity:
The duty referred to in sub-paragraph 29.1 is not infringed; if

28.3.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

28.3.2 The matter has been authorised in accordance with the constitution

28.3.3 The duty referred to in sub-paragraph 29.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

28.3.4 In sub-paragraph 29.2, "third party" means a person other than:

29.1.1.1 The Trust

29.1.1.2 A person acting on its behalf

28.3.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

28.3.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

28.3.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

28.3.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

28.3.9 A director need not declare an interest:

29.1.1.3 If it cannot reasonably be regarded as likely to give rise to a conflict of interest.

29.1.1.4 If, or the extent that, the directors are already aware of it.

29.1.1.5 If, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered.

- By a meeting of the Board of Directors, or
- By a committee of the directors appointed for the purpose under the constitution

30 Board of Directors - remuneration and terms of office

30.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive Directors.

30.2 The Trust Nomination and Remuneration Committee shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

31 Registers

31.1 The Trust shall have:

31.1.1 a register of members showing, in respect of each member, the constituency to which They belongs and, where there are classes within it, the class to which They belongs;

31.1.2 A register of members of the Council of Governors;

31.1.3 A register of interests of Governors;

31.1.4 A register of Directors and Non-Executive Directors; and

31.1.5 A register of interests of the Directors and Non-Executive Directors.

32 Admission to and removal from the registers

32.1 The Trust Secretary will oversee the arrangements for additions and removals from the registers.

33 Registers - inspection and copies

33.1 The Trust shall make the registers specified in paragraph 31 above available for inspection by members of the public, except in the circumstances set out at paragraph 34 or as otherwise prescribed by regulations.

33.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of:

33.2.1 Any other member of the Trust, if they so requests.

33.3 So far as the registers are required to be made available:

33.3.1 They are to be available for inspection free of charge at all reasonable times; and

33.3.2 A person who requests a copy of or extract from the registers is to be provided with a copy or extract.

33.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

34 Documents available for public inspection

34.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

i. A copy of the current constitution;

ii. A copy of the latest annual accounts and of any report of the auditor on them;

iii. A copy of the latest annual report;

34.2 All documents required by paragraphs 22(1)(g) to 22(10(p) inclusive of Schedule 7 to the 2006 Act (relating to special administration) shall be available for inspection by

members of the public free of charge at all reasonable times.

34.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

34.4 If the person requesting a copy or extract under this paragraph is not a Member of the Trust, the Trust may impose a reasonable charge for providing the copy or extract.

35 Auditor

35.1 The Trust shall have an auditor.

35.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors by approval of a simple majority of those present.

36 Audit and Risk committee

36.1 The Trust shall establish a committee of non-executive Directors as an Audit and Risk Committee to perform such monitoring, reviewing and other functions as are appropriate.

37 Annual accounts

37.1 The Trust must keep proper accounts and proper records in relation to the accounts.

37.2 NHS England may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

37.3 The accounts are to be audited by the Trust's auditor.

37.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHS England may with the approval of the Secretary of State direct.

37.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

38 Annual report, forward plans and non-NHS work

38.1 The Trust shall prepare an Annual Report and send it to NHS England.

38.2 The Trust shall give information as to its forward planning in respect of each financial year to NHS England and the Integrated Care Board.

38.3 The document containing the information with respect to forward planning referred to in paragraph 38.5 shall be prepared by the directors.

38.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

38.5 Each forward plan must include information about –

i. The activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on; and

ii. The income it expects to receive from doing so.

38.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 38.5.1 the Council of Governors must:

i. Determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

ii. Notify the directors of the Trust of its determination.

38.7 A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

39 Presentation of the Annual Accounts and Reports to the Governors and members

39.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

i. The annual accounts

ii. Any report of the auditor on them

iii. The annual report

39.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

39.3 The Trust may combine a meeting of the Council of Governors with the Annual Members' Meeting.

40 Instruments

40.1 The Trust shall have a seal.

40.2 The seal shall not be affixed except under the authority of the Company Secretary or the Chief Executive of the Trust.

41 Amending the Constitution

41.1 The Trust may make amendments of its constitution only if:

i. More than half of the members of the Council of Governors of the Trust voting approve the amendments, and

ii. More than half of the members of the Board of Directors of the Trust voting approve the amendments.

iii. Amendments made under paragraph 41.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

iv. Where an amendment is made to the constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

1. At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

2. The Trust must give the members an opportunity to vote on whether they approve the amendment.

3. If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

4. Amendments by the Trust of its constitution are to be notified to NHS England. For the avoidance of doubt, NHS England's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

42 Mergers etc., significant transactions

42.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the council of governors.

42.2 The Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transition.

42.3 In paragraph 42.2, the following words have the following meanings:

i. "Significant Transaction" means a transaction which meets all of any one of the tests below:

1. The fixed asset test; or

2. The turnover test; or

3. The gross capital test (relating to acquisitions or divestments).

ii. The fixed asset test is met if the assets which are subject of the transaction exceed 25% of the fixed assets of the Trust.

iii. The turnover test is met if, following the completion of the relevant transaction, the income of the Trust will increase or decrease by more than 25%.

iv. The gross capital test is met if the gross capital of the company or business being acquired or divested represents more than 25% of the capital of the Trust following completion (where "gross capital" is the market value of the relevant company or business shares and debt securities, plus the excess of current liabilities over current assets, and

the Trust's capital is determined by reference to its balance sheet).

v. For the purposes of calculating the tests in this paragraph 42, figures used to classify assets and profits must be the figures shown in the latest published audited consolidated accounts.

vi. A transaction:

1. Includes all agreements (including amendments to agreements) entered into by the Trust.

2. Excludes a transaction in the ordinary course of business (including the renewal, extension or entering into an agreement in respect of healthcare services carried out by the Trust).

3. Excludes any agreement or changes to healthcare services carried out by the Trust following a reconfiguration of services led by the commissioners of such services.

4. Excludes any grant of public dividend capital or the entering into of a working capital facility or other loan, which does not involve the acquisition or disposal of any fixed asset of the Trust.

5. ANNEX 1 - THE PUBLIC CONSTITUENCY

1.1 The Trust has three public constituencies. Members of the public shall be eligible for membership of the Public Constituencies as shown in the table below:

Area	Minimum number of members
Medway	70
Swale	30
Rest of England and Wales	10

The overall number of public members will not fall below 400 in total nor below the minimum in each area identified in this Annex.

ANNEX 2 - THE STAFF CONSTITUENCY

2.1 The minimum number of Members for the Staff Constituency is set out below:

Staff Constituency	Minimum number
Total	1,950

ANNEX 3 - COMPOSITION OF COUNCIL OF GOVERNORS

The Council of Governors will consist of 25 Governors, which shall comprise of both elected Governors and appointed Governors as set out below: **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 Christchurch 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

ANNEX 4 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

CONTENTS

1. STATUTORY AUTHORITY

1.1. Medway NHS Foundation Trust is a public benefit corporation established under the NHS Act 2006 and authorised by NHS England on 1 August 2006 to act as an NHS Foundation Trust.

1.2. The Constitution requires the Council of Governors to adopt Standing Orders for the regulation of its procedures and business. These Standing Orders have been agreed by the Board of Directors and the Council of Governors and have been approved by NHS England.

1.3 Governors are required to comply with the requirements of these Standing Orders at all times.

2. INTERPRETATION

2.1 Save as permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive and Trust Secretary).

2.2 Words importing the masculine gender only shall include the feminine gender and words importing the singular shall import the plural and vive-versa.

2.3 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and in addition:

a) **Accounting OFFICER** shall be the officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

b) **BOARD** means the Board of Directors, formally constituted in accordance with this Constitution and consisting of a Chair, and Non-executive Directors, appointed by the Council of Governors and the Executive Directors, appointed by the Non-executive Directors and (except for his/her own appointment) by the Chief Executive.

c) **BUDGET** shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

d) **CHAIR** is the person appointed by the Council of Governors as a Non-Executive Chair to lead the Board of Directors, and Council of Governors, to ensure it successfully discharges its overall responsibility for the Trust as a whole.

e) **CHIEF EXECUTIVE** shall mean the Accounting officer of the Trust.

f) **COMMITTEE OF THE COUNCIL OF GOVERNORS** means a committee formed by the Council of Governors with specific Terms of Reference, chair and membership.

g) **COMMITTEE OF THE BOARD** means a committee formed by the Board with specific Terms of Reference, Chair and Membership.

h) **DIRECTOR** means a person appointed to the Board of Directors

i) **DIRECTOR OF FINANCE** shall mean the Chief Finance Officer of the Trust who will ensure compliance with Standing Financial Instructions.

j) **FUNDS HELD ON TRUST** shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Schedule 3 and 4 para 14.1c National Health Service Act 2006. Such funds may or may not be charitable.

k) **GOVERNOR** means a person elected or appointed to the Council of Governors.

l) **COUNCIL OF GOVERNORS** means the Council of Governors, formally constituted in accordance with this Constitution meeting in public and presided over by the Chair.

m) **MEMBER** means a person registered as a member of one of the constituencies of the Trust as outlined in this Constitution.

n) **NHS ENGLAND** is the body corporate known as NHS England under the 2022 Act.

o) **MOTION** means a formal proposition to be discussed and voted on during the course of a meeting.

p) **NOMINATED OFFICER** means an officer charged with the responsibility for discharging specific tasks within Standing Orders in line with the Health Acts.

q) **NON-EXECUTIVE DIRECTOR** is a person appointed by the Council of Governors to be a member of the Board of Directors. This includes the Chair of the Trust.

r) **OFFICER** means an employee of the Trust

s) **SOs** means Standing Orders

t) **SFIs** means Standing Financial Instructions

u) **TRUST** means Medway NHS Foundation Trust.

v) **TRUST SECRETARY** this role will act as independent adviser to the Board and NHS England the Trust's compliance with its terms of authorisation and constitution.

w) **DEPUTY-CHAIR** means the Non-Executive Director appointed by the Council of Governors to carry out the duties of the Chair if they is absent for any reason.

3. COMPOSITION OF THE COUNCIL OF GOVERNORS

3.1 The composition of the Council of Governors shall be in accordance with the Trust's Constitution.

3.2 Role of the Chair of the Trust

The Chair shall not be a member of the Council of Governors however, in accordance with the regulatory framework; they will preside over meetings of the Council of Governors.

3.3 Role of the Deputy-Chair of the Trust

In respect of meetings of the Council of Governors, where the Chair has died or has otherwise ceased to hold office or where they have been unable to perform his/her duties as a Chair owing to illness, absence from England and Wales or any other cause, references to the Chair shall, so long as there is no Chair able to perform his/her duties, be taken to include to the Deputy-Chair.

3.4 Removal of the Chair or Deputy-Chair of the Trust

It shall be for the Council of Governors to determine the period of office for the Chair and Deputy-Chair, which shall normally be for a period of up to three years after which the Council of Governors shall review the appointment. Should there be the requirement to remove the Chair or Deputy-Chair of the Council of Governors this shall be carried out in accordance with SO 4.9.6.

4. MEETINGS OF THE COUNCIL OF GOVERNORS

4.1 Frequency of Meetings

The Council of Governors will meet in a general meeting on no less than four occasions each year at times and places that the Council of Governors may determine.

4.2 Duration of Meetings

The business of meetings will be conducted efficiently and in a timely manner and will not last longer than three hours. Any business not conducted within three hours will be adjourned until the next meeting.

4.3 Admission of the Public and Press

4.3.1 Meetings shall be open to members of the public and the press. Members of the public and press shall be required to withdraw from the meeting upon the Council of Governors resolving as follows:

"Representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of business to be transacted, publicity on which would be prejudicial to the public interest."

4.3.2 The Chair shall give such directions as They thinks fit in regard to the arrangements for meetings and accommodation of the public and the press so as to ensure that the business of the Council of Governors is conducted without interruption and disruption. Without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Council of Governors resolving as follows:

"That in the interests of public order the meeting adjourn for [the period specified] to enable the Council of Governors to complete business without the presence of the public."

4.3.3 The Chair may exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the reasonable conduct of the meeting.

4.3.4 Nothing in these Standing Orders shall require the Council of Governors to allow members of the public or press to record proceedings in any manner, other than in writing, or to make any oral report of proceedings as they take place without the prior agreement of the Council of Governors.

4.3.5 The Council of Governors may invite the Chief Executive and Directors of the Trust to attend any meeting of the Council of Governors to respond to questions from Governors on the affairs of the Trust.

4.4 Calling Meetings

Notwithstanding section 4.1 above, the Chair may call a meeting of the Council of Governors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Governors, has been presented to him, or if without so refusing, the Chair does not call a meeting within fourteen days after such requisition to do so, such one-third or more Governors may call a meeting forthwith. A requisition from Governors under this section may be submitted electronically provided that such requisition includes the names and electronic signatures of the Governors issuing it.

4.5 Notice of Meetings

4.5.1 Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it and signed by the Chair or by an officer of the Trust authorised by the Chair to sign on his/her behalf, shall be delivered to every Governor or sent by post to the normal place of residence of such Governor to arrive at least five clear working days before the meeting.

4.5.2 Lack of service of the notice on any Governor shall not affect the validity of the meeting.

4.5.3 In the case of a meeting called by the Governors in default of the Chair, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified in the notice.

4.5.4 Before each meeting of the Council of Governors a public notice of the time and place of the meeting, along with the agenda, shall be available on the

Trust's website, at least seven days before the meeting.

4.6 **Setting the Agenda**

4.6.1 The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors.

4.6.2 A Governor who wishes for an item to be included on an agenda for a meeting of the Council of Governors shall make a written request to the Chair at least ten clear working days before the meeting. Requests made less than ten clear working days before a meeting may be included on the agenda solely at the discretion of the Chair.

4.6.3 The Council of Governors will agree an annual schedule of work proposed by the Board of Directors to ensure that the Council of Governors discharge their statutory responsibilities as Governors.

4.7 **Chair of the Meeting**

4.7.1 At any meeting of the Council of Governors, the Chair, if present, shall preside. If the Chair is absent from the meeting, or if they are disqualified from participating because of a declared conflict of interest, the Deputy- Chair, if they are present, shall preside. If both the Chair and Deputy- Chair are absent or disqualified, the Council of Governors may choose an appropriate individual from among the remaining non-executive Directors or the Lead Governor to preside.

4.8 **Notice of Questions**

4.8.1 Governors may ask the Chair, a Non-Executive Director, another Governor or Executive Director questions about matters which are directly in relation to a matter over which the Council of Governors has powers or duties or which affects the area covered by the Trust.

4.8.2 A Governor may only ask a question under paragraph 4.8.1 if either;

a) they have given at least 14 working days' notice in writing of the question to the Trust Secretary. For the purposes of this Standing Order, receipt of any such questions via electronic means is considered acceptable;

b) the question relates to urgent matters, they have the consent of the person to whom the question is to be put and the content of the question is given to the Company Secretary by 10.00am on the day of the meeting (if the meeting is scheduled for the afternoon) or by 2.00pm on the preceding day (if the meeting is scheduled for the morning). Urgent is defined as a matter which will adversely affect the Trust within the next seven days.

4.8.3 A Governor may ask any question through the Chair without notice upon a report from an Executive Director, or other officer of the Trust, when that item is being received or under consideration by the Council of Governors. Unless the Chair decides otherwise no statements will be made other than those

which are strictly essential to define the question, which should last no longer than three minutes. The Chair may reject any question from any Governor if in his/her opinion the question is substantially the same as the question which has already been put to the meeting or a previous meeting of the Council of Governors.

4.8.4 An answer may take the form of a direct oral answer; where the desired information is in a publication of the Trust or other published work, a reference to that publication; where the reply cannot conveniently be given orally, a written answer circulated later to the questioner; or a brief oral answer supplemented by a written answer circulated later to the Governor who has raised the question.

4.8.5 A Governor asking a question under paragraphs 4.8.1 above may ask one supplementary question (lasting no longer than three minutes) without notice of the person to whom the first question was asked. The supplemental question must arise directly out of the reply

4.9 Notices of Motion

4.9.1 A Governor of the Trust desiring to move a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda, subject to SO 4.5.

4.9.2 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.9.3 Notice of motion to amend or rescind any resolution (or the general substance of any resolution), which has been passed within the preceding six calendar months, shall bear the signature of the members of the Council of Governors who give it and also the signature of four other members of the Council of Governors. When any such motion has been disposed of by the Council of Governors it shall not be competent for any member of the Council of Governors, other than the Chair, to propose a motion to the same effect within six months.

4.9.4 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto. The mover of a motion shall have strictly no more than five minutes to move a motion and strictly no more than three minutes for a right of reply.

4.9.5 When a motion is under discussion or immediately prior to discussion it shall be open to a member of the Council of Governors to move:

a) An amendment to the motion.

b) The adjournment of the discussion or the meeting.

c) That the meeting proceeds to the next business.

d) That the motion shall be now put.

Such a motion, if seconded, shall be disposed of before the motion which was originally under discussion or about to be discussed.

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

In the case of motions under c) and d), to ensure objectivity motions may only be put by a member of the Council of Governors who has not previously taken part in the debate.

4.9.6 A motion to remove the Chair or a non-executive Director must be seconded by 10 members of the Council of Governors.

4.9.7 The following motions may be moved without notice:

a) in relation to the accuracy of the minutes;

b) to change the order of business in the agenda;

c) to refer something to an appropriate body or individual;

d) to appoint a working group arising from an item on the agenda for the meeting;

e) to receive reports or adopt recommendations made by the Board of Directors;

f) to withdraw a motion;

g) to amend a motion;

h) to proceed to the next business;

i) that the question be now put;

j) to adjourn a debate;

k) to adjourn a meeting;

l) to suspend a particular Standing Order; a rule may be suspended by motion on notice or without notice if at least one half of the whole number of Governors of the Council of Governors are present. Suspension can only be for the duration of the meeting;

m) to exclude the public and press in accordance with Standing Orders 4.3

n) to not hear further a Governor, or to exclude them from the meeting. If a Governor persistently disregards the ruling of the Chair by behaving improperly or offensively or deliberately obstructs business, the Chair may move that the Governor be not heard further. If seconded, the motion will be voted on without discussion. If the Governor continues to behave improperly after such a motion is carried, the Chair may move that either the Governor leaves the meeting

room or that the meeting is adjourned for a specified period. If seconded, the motion will be voted on without discussion;

o) to give the consent of the Council of Governors where its consent is required by the Constitution.

4.10 Chair's Ruling

4.10.1 Statements of members or Governors made at the meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

4.11 Voting

4.11.1 Every question at a meeting shall be determined by a majority of the votes of the Governors present and voting on the question with the exception of a decision to remove the Chair or a non-executive Director which requires the approval of two thirds of the Governors present and voting.

4.11.2 In the case of an equality of votes, the person presiding over the meeting shall have a second or casting vote.

4.11.3 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

4.11.4 If at least one-third of the Governors present so request, the voting on any question may be recorded to show how each Governor present voted or abstained.

4.11.5 In no circumstances may a Governor, who is absent at the time of the vote, vote by proxy.

4.12 Minutes

4.12.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

4.12.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.12.3 Minutes shall be circulated to all Governors. The minutes of meetings shall be made available to the public except for minutes relating to business conducted when members of the public are excluded under the terms of section 4.3 of these Standing Orders.

4.13 Suspension of Standing Orders

4.13.1 Except where this would contravene any statutory provision, any one or more of the Standing Orders may be suspended at any meeting, providing

that at least two-thirds of the Governors are present and that a majority of those present vote in favour of suspension.

4.13.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

4.13.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Governors.

4.13.4 No formal business may be transacted while Standing Orders are suspended.

4.13.5 The Audit and Risk Committee shall review every decision to suspend Standing Orders.

4.14 Record of Attendance

4.14.1 The names of the Governors present at the meeting shall be recorded in the minutes.

4.15 Quorum

4.15.1 No formal business shall be transacted at a general meeting of the Council of Governors unless at least one-third of the Governors are present including at least one-third of the Governors from the public constituency.

4.15.2 If a Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest, they shall no longer count towards the quorum. If a quorum is not then available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at the meeting. Such a position shall be recorded in the minutes of the meeting. The meeting will then proceed to the next business.

4.15.3 For the clarification of doubt, the requirements of this section will not apply to development meetings of the Council of Governors, held for briefing and training purposes, unless such a meeting intends to act as a general meeting and transact formal business. In that event these Standing Orders apply in full to the consideration of any such business.

4.15.3 The Chair of a meeting of the Council of Governors may adjourn a meeting of the body if a quorum is either not present within thirty minutes of the appointed time of commencement or is not maintained for the duration of the meeting.

5. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

5.1 Emergency Powers

5.1. The powers which the Council of Governors has retained to itself within these Standing Orders may in emergency be exercised by the Chair after having consulted at least five elected members of the Council of Governors. The exercise of such powers by the Chair shall be reported to the next formal meeting of the Council of Governors for ratification.

5.2 **Appointment of Committees**

5.2.1 The Council of Governors may appoint to the committees described in section 5.2.5 of these Standing Orders, consisting wholly of Governors.

5.2.2 The Standing Orders of the Council of Governors, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committees established by the Council of Governors.

5.2.3 Each committee shall have such terms of reference and powers and be subject to such conditions as the Council of Governors shall determine. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.2.4 The Council of Governors shall approve the appointments to each of the committees it has constituted.

5.2.5 The standing committees to be established by the Council of Governors are:

a) (Governors) Nominations, Remuneration Committee

6 CONFIDENTIALITY

6.1 A member of the Council of Governors or an attendee on a committee of the Council of Governors shall not disclose a matter dealt with by, or brought before, the committee without its permission or until the committee shall have reported to the Council of Governors or shall otherwise have concluded on that matter.

6.2 A member of the Council of Governors or a non-member of the Council of Governors in attendance at a committee shall not disclose any matter dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or committee resolves that it is confidential.

7 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

7.1 **Declaration of Interests**

If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as They becomes aware of it.

7.1.1 Interests referred to in 7.1 which should be regarded as “relevant and material” include but are not restricted to:

a) Directorships, including non-executive directorships held in limited companies (with the exception of dormant companies);

b) Ownership, part-ownership or directorships of companies, businesses or consultancies that carry out or are likely to carry out business with the Trust;

c) Majority or controlling shareholdings in an organisation that carries out business with the Trust or is likely to carry out business with the Trust;

d) A position of authority in a charity or voluntary organisation in the field of health or social care that carries out business with the Trust or is likely to carry out business with the Trust;

e) Any connection with a voluntary or other organisation contracting or likely to contract for Trust services;

f) To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks.

7.1.2 If Governors have any doubt about the relevance of an interest, this should be discussed with the Chair or Trust Secretary who will advise on whether or not the interest should be disclosed.

7.1.3 For the avoidance of doubt, the above relevant and material interests extend to the spouse or partner of a Governor and declaration of such interests will be required.

7.1.4 At the time Governors' interests are declared, they should be recorded in the minutes of the Governor Body meetings. Any changes in interests should be declared at the next board meeting following the change occurring.

7.1.5 During the course of a meeting, if a conflict of interest is established, the Governor concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

7.2 **Register of Interests**

7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Governors. The Register will include details of all directorships and other relevant and material interests which have been declared by Governors, as defined in SO 7.1.

7.2.2 Governors must notify the Trust Secretary of any changes to their declared interests. Such notification must be made to the Trust Secretary within seven days of the change becoming known.

7.2.3 The Trust Secretary will ensure that such notifications are entered into the Register within seven days.

7.2.4 The Trust Secretary will conduct an annual review of the Register and report the outcome to the Council of Governors

7.2.5 The Register will be available for inspection by members of the public at the Trust's headquarters.

8. DISABILITY OF GOVERNORS IN PROCEEDINGS ON ACCOUNT OF

PECUNIARY INTEREST

8.1 Subject to the following provisions of this Standing Order, if a Governor has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Council of Governors at which the contract or other matter is the subject of consideration, They shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

8.2 The Trust shall exclude a Governor from a meeting of the Council of Governors while any contract, proposed contract or other matter in which They has a pecuniary interest, is under consideration.

8.3 For the purpose of this Standing Order a Governor shall be treated, subject to SO 8.4, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

- They, or a nominee of his/her, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

- They is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration; and

- In the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

8.4 A Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

- Of his/her membership of a company or other body, if they have no beneficial interest in any securities of that company or other body.

- Of an interest in any company, body or person with which They is connected as mentioned in SO 7.3 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

8.5 Where a Governor:

- Has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

- The total nominal value of those securities does not exceed 5% of the total nominal value of the issued share capital of the company or body.

- If the share capital is of more than one class, the total nominal value of shares of any one class in which They has a beneficial interest does not exceed one-

hundredth of the total issued share capital of that class

- This Standing Order shall not prohibit him from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

8.6 Standing Order 8 applies to a committee or sub-committee of the Council of Governors as it applies to the Council of Governors itself and applies to any member of any such committee or sub-committee (whether or not They is also a Governor) as it applies to a Governor.

9 DISPUTES BETWEEN THE COUNCIL OF GOVERNORS AND THE BOARD OF DIRECTORS

9.1 Conflicts between the Board of Directors and the Council of Governors will be resolved through the Trust's Dispute Resolution Procedure.

10. VARIATION AND AMENDMENT OF STANDING ORDERS

10.1 These Standing Orders shall be amended only if:

10.1.1 A notice of motion under Standing Order 4.8 has been given; and

10.1.2 A majority of three-quarters of Governors present at the meeting at which the matter is put vote in favour of the changes; and

10.1.3 The variation proposed does not contravene a statutory provision or a direction made by the Regulator of NHS Foundation Trusts; and

10.1.4 The amendment is agreed by the Board of Directors; and

10.1.5 The amendments agreed by the Board of Directors are approved by NHS England.

ANNEX 5 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

CONTENTS

1. Introduction

a) Statutory Framework

The Medway NHS Foundation Trust (the Trust) is a public benefit corporation which is established under the NHS Act 2006 and authorised by NHS England on 1 August 2006 to act as a NHS Foundation Trust. The principal places of business of the Trust is Medway Maritime Hospital.

The Constitution requires the Board to adopt Standing Orders for the regulation of its proceedings and business. In addition the "Directions on Financial Management in England" (HSG (96)12) require health bodies to adopt Standing Financial Instructions setting out the responsibility of individuals. Although not mandatory on NHS Foundation Trusts, the Board will continue to apply them as a key element of its governance arrangements.

b) Delegation of Powers

Under the Standing Orders relating to the Arrangements for the Exercise of Functions SO 4 the Board exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 5 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit or as NHS England may direct. Delegated Powers are covered in a separate document (Reservation of Powers to the Board and Delegation of Powers). That document has effect as if incorporated into the Standing Orders.

2. Standing Orders

SO1 Interpretation

1.1 Save as permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive and Company Secretary).

1.2 Words importing the masculine gender only shall include the feminine gender and words importing the singular shall import the plural and vive-versa.

1.3 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and in addition:

a) **ACCOUNTABLE OFFICER** shall be the officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

b) **BOARD** means the Board of Directors, formally constituted in accordance with this Constitution and consisting of a Chair, and Non-Executive Directors, appointed by the Governors' Body and the Executive Directors, appointed by the Non-Executive Directors and (except for his/her own appointment) by the Chief Executive.

c) **BUDGET** shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

d) **CHAIR** is the person appointed by the Council of Governors as a Non-Executive Chair to lead the Board of Directors, and Council of Governors, to ensure it successfully discharges its overall responsibility for the Trust as a whole.

e) **CHIEF EXECUTIVE** shall mean the accountable officer of the Trust.

f) **COMMITTEE OF THE COUNCIL OF GOVERNORS** means a committee formed by the Council of Governors with specific Terms of Reference, chair and membership.

g) **COMMITTEE OF THE BOARD** means a committee formed by the Board with specific Terms of Reference, Chair and Membership.

h) **DIRECTOR** means a person appointed to the Board of Directors

i) **DIRECTOR OF FINANCE** shall mean the Chief Finance Officer of the Trust who will ensure compliance with Standing Financial Instructions.

j) **FUNDS HELD ON TRUST** shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Schedule 3 and 4 para 14.1c National Health Service Act 2006. Such funds may or may not be charitable.

k) **GOVERNOR** means a person elected or appointed to the Council of Governors.

l) **COUNCIL OF GOVERNORS** means the Council of Governors, formally constituted in accordance with this Constitution meeting in public and presided over by the Chair.

m) **MEMBER** means a person registered as a member of one of the constituencies of the Trust as outlined in this Constitution.

n) **NHS ENGLAND** is the Independent Regulator of NHS Foundation Trusts appointed under the Health and Care Act 2022.

o) **MOTION"** means a formal proposition to be discussed and voted on during the course of a meeting.

p) **NOMINATED OFFICER** means an officer charged with the responsibility for discharging specific tasks within Standing Orders in line with the Health Act.

q) **NON-EXECUTIVE DIRECTOR** is a person appointed by the Council of Governors

to be a member of the Board of Directors. This includes the Chair of the Trust.

r) **OFFICER** means an employee of the Trust

s) **SOs** means Standing Orders

t) **SFIs** means Standing Financial Instructions

u) **TRUST** means Medway NHS Foundation Trust.

v) **TRUST/COMPANY SECRETARY** this role will act as independent advisor to the Board and NHS England on the Trust's compliance with its terms of authorisation and constitution.

w) Trust Nominations and Remuneration Committee means a Committee of the Non-Executive Directors.

x) **DEPUTY-CHAIR** means the Non-Executive Director appointed by the Chair to carry out the duties of the Chair if they are absent for any reason.

SO2 The Board of Director

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in Trust shall be in the name of the Trust as Corporate Trustee. In relation to funds held on Trust, powers exercised by the Trust as Corporate Trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.3 The Trust has the functions conferred on it by the NHS Act 2006, 2012 and 2022 and by its authorisation.

2.4 The Board of Directors is the Corporate Trustee for the Charity. Accountability for charitable funds held on Trust is to the Charity Commission and to the Secretary of State for Health. Accountability for non-charitable funds held on Trust is only to NHS England.

2.5 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in "Reservation of Powers to the Board" and have effect as if incorporated into the Standing Orders.

2.6 The Board of Directors will function as a unitary Board. The Board is collectively responsible for discharging the powers and for the performance of the Trust. Executive and non-executive Directors will have joint responsibility for every decision of the Board regardless of their individual skills or status.

2.7 The Role of Directors:

2.7.1 The role of the Directors as members of the Board is to set the direction of the Trust and NHS England and manage its performance in carrying out its statutory and other functions.

2.7.2 The executive Directors will exercise their authority in accordance with the terms of these Standing Orders, the Trust's Standing Financial Instructions, the Scheme of Reservation and Delegation.

2.7.3 The Chief Executive is responsible for the overall performance of the executive functions of the Trust. They is the Accounting Officer for the Trust and is responsible for ensuring that the requirements of the NHS Accounting Officer Memorandum are met.

2.7.4 The Chief Finance Officer is responsible for the provision of financial advice to the Trust and for the supervision of systems for financial accounting and control.

2.7.5 The Non-Executive Directors will not be granted nor seek to exercise any individual executive powers on behalf of the Trust. They may exercise authority when acting as members of, or when chairing, a committee of the Trust which has delegated powers.

2.7.6 The Chair is responsible for the operation and performance of the Board and will chair meetings of the Board when present. The Chair has certain delegated powers and must act within the terms of his/her appointment, the Standing Orders and the Standing Financial Instructions in exercising those powers and carrying out his/her duties.

2.7.7 The Chair will ensure that the business of the Board is dealt with in an effective and timely manner and that the Board is provided with appropriate information and advice to inform debate and decision.

2.7.8 The Board shall approve and keep under review a Statement of Division of Responsibility between the Chair and the Chief Executive which sets out the division of responsibility between them.

2.7.9 The Chair is also responsible for the leadership of the Council of Governors and for ensuring that it and the Board work effectively together.

2.8 Composition of the Board of Directors

2.8.1 The composition of the Board of Directors is set out in section 22 of the Trust's Constitution:

- A non-executive Director Chair
- A maximum of six other non-executive Directors; and

- A maximum of five executive Directors including:

    - The Chief Executive Officer (the Chief Accounting Officer)
    - One Executive Director of Finance (the Chief Finance Officer)
    - One Executive Director who is a registered medical or dental practitioner
    - One Executive Director who is a registered nurse or midwife

2.8.2 The Trust Secretary (or nominated deputy) will be in attendance at all meetings of the Board.

2.8.3 Other officers of the Trust may attend meetings of the Board by invitation.

2.9 Appointment of the Chair and Directors

2.9.1 The Chair and Non-Executive Directors are appointed by the Governors Nominations and remuneration Committee overseen by the Lead Governor of the Council of Governors.

2.9.2 The Trust Nominations and Remuneration Committee will appoint the Chief Executive Officer of the Trust subject to the approval of the Council of Governors.

2.9.3 The Trust Nominations and Remuneration Committee will appoint the Executive Directors.

2.10 Terms of Office of the Chair and Directors

2.10.1 The remuneration and terms of office of the Chair and Non-Executive Directors shall be decided by the Governors Nominations and Remuneration Committee.

2.10.2 The remuneration and terms of office of the Executive Directors will be determined by Trust Nominations and Remuneration Committee.

2.11 Appointment of Deputy- Chair and Senior Independent Director

2.11.1 The Chair may appoint one of the Non-Executive Directors to be Deputy-Chair for such a period, not exceeding the remainder of their term as Non-Executive Director of the Trust, as they may specify on appointing him/her.

2.11.2 The Chair may appoint one of the Non-Executive Directors to be Senior Independent Director for such a period, not exceeding the remainder of their term as Non-Executive Director of the Trust, as they may specify on appointing

him/her.

2.11.3 Any Non-Executive Director so elected to the above roles, may at any time resign from the office by giving notice in writing to the Chair, and the Directors of the Trust may thereupon appoint another Non-Executive Director as Deputy-Chair and/or Senior Independent Director in accordance with paragraph 2.9.

2.12 Powers of the Deputy- Chair

Where the Chair of an NHS Trust has died or has otherwise ceased to hold office or where They has been unable to perform their duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform their duties, be taken to include references to the Deputy-Chair. The Deputy Chair will normally be the chair of the Trust Nominations and Remuneration Committee and the Governors Nominations and Remuneration Committee.

2.13 The role of the Senior Independent Director

2.13.1 The Senior Independent Director ('SID') is a role undertaken by one of the Trust's independent Non-Executive Directors. The SID should be available to all stakeholders, particularly governors and members, should they have concerns which they feel unable to resolve via normal channels, such as through contact with the Chair or Chief Executive, or in circumstances in which such contact would be inappropriate.

2.13.2 The Senior Independent Director shall meet with the Trust Chair at least annually to evaluate their performance.

2.14 Joint Directors

Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for executive directorship or in relation to which an executive Director is to be appointed, those persons shall become appointed as an executive Director jointly, and shall count as one person for the purpose of Standing Order 2.9.

3 MEETINGS OF THE BOARD OF DIRECTORS

3.1 The Board will meet at sufficient intervals to properly discharge its duties. Meetings of the Board will be held in public unless the Board determines otherwise.

3.2 The public and representatives of the press shall be afforded the opportunity to attend all formal public meetings of the Board of Directors but shall be required to withdraw upon the Board resolving as follows:

3.2.1 "That representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest' (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960)."

3.2.2 The Chair shall give such direction as seen fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of

the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

3.2.3 "That in the interests of public order, the meeting adjourn for (the period) to enable the Board to complete business without the presence of the public' (Section 1(8) Public Bodies (Admission to Meetings) Act 1960)."

3.3 Nothing in these Standing Orders shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board.

3.4 Where the public is invited to attend a meeting of the Board, the Chair may exclude any member of the public from that meeting if they are interfering with or preventing the proper and reasonable conduct of the meeting.

3.5 Attendance at meetings by members of the press or public does not confer any right to ask questions or otherwise participate in the meeting unless invited to do so by the Chair.

3.6 Calling Meetings

3.6.1 Meetings of the Board shall be held at such times and places as the Board may determine.

3.6.2 The Chair may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to him, or if without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him, at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting.

3.7 Notice of Meetings

3.7.1 Before each meeting of the Board, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer of the Trust authorised by the Chair to sign on his/her behalf shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him at least five clear working days before the meeting.

3.7.2 Lack of service of the notice on any Director shall not affect the validity of a meeting.

3.7.3 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

3.7.4 Failure to serve such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

3.7.5 A public notice of the time and place of the meeting shall be displayed on the Trust's website at least five working days before the meeting.

3.7.6 Before holding a meeting, the Board of Directors will send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

3.8 Setting the Agenda

3.8.1 The Board may determine that certain matters shall appear on every agenda for a meeting of the Board and shall be addressed prior to any other business being conducted.

3.8.2 A director desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least ten clear working days before the meeting, subject to Standing Order 3.6. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

3.9 Chair of Meeting

3.9.1 At any meeting of the Board, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy-Chair, if there is one and they is present, shall preside. If the Chair and Deputy-Chair are absent such Non-Executive Director as the Directors present shall choose shall preside.

3.9.2 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy-Chair, if present, shall preside. If the Chair and Deputy-Chair are absent, or are disqualified from participating, such Non-Executive Director as the Directors present shall choose shall preside.

3.10 Annual Members Meeting

3.10.1 The Trust will publicise and hold an annual members meeting, in accordance with the terms of the Constitution.

3.11 Notices of Motion

3.11.1 A Director desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to Standing Order 3.6.

3.12 Withdrawal of Motion or Amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.13 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear

the signature of the Director(s) who gives it and also the signature of four other Directors. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months

3.14 Motions

3.14.1 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.14.2 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

a) An amendment to the motion

b) The adjournment of the discussion or the meeting

c) That the meeting proceed to the next business

d) The appointment of an ad hoc committee to deal with a specific item of business

e) That the motion be now put

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.15 Chair's Ruling

Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevance, regularity and any other matters shall be observed at the meeting.

3.16 Voting

3.16.1 Every question at a meeting shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

3.16.2 The arrangements for the casting of votes by joint Directors is set out in 3.17 below

3.16.3 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

3.16.4 If at least one-third of the voting Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

3.16.5 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

3.16.6 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.16.7 An officer who has been appointed formally by the Board to act up for an executive Director during a period of incapacity or temporarily to fill an executive Director vacancy, shall be entitled to exercise the voting rights of the executive Director. An officer attending the Board to represent an executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

3.16.8 Directors on the Board of Directors will have no formal voting rights on a decision nor the personal accountabilities associated with full Board membership.

3.16.9 No resolution shall be passed if it is opposed by all the Non-Executive Directors present or by all of the executive Directors present.

3.17 Joint Directors - Where a post of executive Director is shared by more than one person:

3.17.1 Both persons shall be entitled to attend meetings of the Trust; either of those persons shall be eligible to vote in the case of agreement between them;

3.17.2 In the case of disagreement between them no vote should be cast;

3.17.3 The presence of either or both of those persons shall count as one person for the purposes of determining the quorum of the meeting.

3.18 Minutes

3.18.1 The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

3.18.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.18.3 Minutes shall be circulated in accordance with the wishes of the Board and made available to the public.

3.19 Suspension of Standing Orders

3.19.1 Except where this would contravene any statutory provision or any direction made by NHS England, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one executive Director and one non-executive Director, and that a majority of those present vote in favour of suspension.

3.19.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.19.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Directors.

3.19.4 No formal business may be transacted while Standing Orders are suspended.

3.19.5 The Audit Committee shall review every decision to suspend Standing Orders.

3.20 Variation and Amendment of Standing Orders

3.20.1 These Standing Orders shall be amended only if:

- A notice of motion under Standing Order 3.11 has been given;
- No fewer than half the total of the Trust's non-executive Directors vote in favour of amendment;
- At least two-thirds of the voting Directors are present;
- The variation proposed does not contravene a statutory provision or provision of the authorisation or of the Constitution

3.21 Record of Attendance

The names of the Directors present at the meeting shall be recorded in the minutes.

3.22 Quorum

3.22.1 No business shall be transacted at a meeting of the Board unless at least one-third of the whole number of the voting Directors are present including at least one executive Director and one non-executive Director.

3.22.2 An officer in attendance for an executive Director but without formal acting up status may not count towards the quorum.

3.22.3 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 6 and 7) They shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one executive Director to form part of the quorum shall not apply where the executive Directors are excluded from a meeting (for example, when the Board considers the recommendations of the Remuneration and Terms of Service Committee).

3.22.4 The Chair may adjourn a meeting of the Board if a quorum is either not present within thirty minutes of the appointed time of commencement or is not maintained for the duration of the meeting.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 General Provision

Subject to a provision in the authorisation or the Constitution, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a

committee or sub-committee, appointed by virtue of SO 5 below or by a Director or an officer of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

4.2 Emergency Powers

The powers which the Board has retained to itself within these Standing Orders (SO 2) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two non-executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for ratification.

4.3 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board.

4.4 Delegation to Officers – Scheme of Delegation and Reservation of Powers

4.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still be accountable to the Board.

4.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board as indicated above.

4.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board or the Director of Finance or other executive Directors to provide information and advise the Board in accordance with any statutory requirements.

4.4.4 The arrangements made by the Board as set out in the "Reservation of Powers to the Board and Delegation of Powers" shall have effect as if incorporated in these Standing Orders.

5. COMMITTEES

5.1 Appointment of Committees

5.1.1 Subject to SO 2 and such directions as may be given by the regulator, the Trust may and, if directed by him, shall appoint committees of the Trust, consisting wholly or partly of Directors of the Trust or wholly of persons who are not Directors of the Trust.

5.1.2 A committee appointed under SO 5.1.1 may, subject to such directions as may

be given by the regulator or the Board appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include Directors of the Trust) or wholly of persons who are not members of the Board committee (whether or not they include Directors of the Trust).

5.1.3 The Standing Orders of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Board.

5.1.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions, as the Board shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.1.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.

5.1.6 The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines that persons, who are neither Directors nor officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board.

5.1.7 Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State or NHS England, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations laid down by the Secretary of State.

5.1.8 Without prejudice to the formation of any other committees or sub-committees as the Board may see fit, the following committees shall be established by the Board:

- Audit and Risk Committee
- Trust Nominations and Remuneration Committee
- Charitable Funds Committee

5.2 Confidentiality

5.2.1 A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter.

5.2.2 A Director of the Trust or a member of a committee shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee shall resolve that it is confidential.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Declaration of Interests

6.1.1 If a Director has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by

the Board, the Director shall disclose that interest to the Board as soon as They becomes aware of it.

6.1.2 Interests which should be regarded as "relevant and material" are:

a) Directorships, including non-executive directorships held in limited companies (with the exception of dormant companies);
b) Ownership, part-ownership or directorships of companies, businesses or consultancies that carry out or are likely to carry out business with the Trust;
c) Majority or controlling shareholdings in an organisation that carries out business with the Trust or is likely to carry out business with the Trust;
d) A position of authority in a charity or voluntary organisation in the field of health or social care that carries out business with the Trust or is likely to carry out business with the Trust;
e) Any connection with a voluntary or other organisation contracting or likely to contract for Trust services;
f) To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks.

6.1.3 If Directors have any doubt about the relevance of an interest, this should be discussed with the Chair.

6.1.4 At the time Directors' interests are declared, they should be recorded in the board minutes. Any changes in interests should be declared at the next board meeting following the change occurring.

6.1.5 Board directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the board's annual report.

6.1.6 During the course of a board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.2 Register of Interests

6.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Directors. The Register will include details of all directorships and other relevant and material interests which have been declared by Directors, as defined in SO 6.1.

6.2.2 Directors must notify the Trust Secretary of any changes to their declared interests. Such notification must be made to the Trust Secretary within ten days of the change becoming known.

6.2.3 The Trust Secretary will ensure that such notifications are entered into the Register within seven days.

6.2.4 The Trust Secretary will conduct an annual review of the Register and will report the outcome to the Board.

6.2.5 The Register will be available for inspection by the public at the Trust's headquarters.

7. DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 Subject to the following provisions of this Standing Order, if a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, They shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.2 The Board shall exclude a Director from a meeting of the Board while any contract, proposed contract or other matter in which They has a pecuniary interest, is under consideration.

7.3 For the purpose of this Standing Order a Director shall be treated, subject to SO 7.4, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

- They, or a nominee of his/her, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or
- They is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration; and
- In the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7.4 A Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

- Of his/her membership of a company or other body, if They has no beneficial interest in any securities of that company or other body;
- Of an interest in any company, body or person with which he/her is connected as mentioned in SO 7.3 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.5 Where a Director:

- Has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and
- The total nominal value of those securities does not exceed 5% of the total nominal value of the issued share capital of the company or body, and
- If the share capital is of more than one class, the total nominal value of shares of any one class in which he/her has a beneficial interest does not exceed 5% of the total issued share capital of that class,

7.6 Standing Order 7 applies to a committee or sub-committee of the Board as it applies to the Board itself and applies to any member of any such committee or sub-committee (whether or not he/her is also a Director of the Trust) as it applies to a Director of the Trust.

8. STANDARDS OF BUSINESS CONDUCT

8.1 All staff must comply with the requirements of the Trust's Policy on Business Conduct and Ethical Standards for Commercial Sponsorship. The following provisions should be read in conjunction with this document.

8.2 If it comes to the knowledge of a Director or an officer of the Trust that a contract in which he/her has any pecuniary interest not being a contract to which he/her is himself a party, has been, or is proposed to be, entered into by the Trust he/her shall, at once, give notice in writing to the Chief Executive of the fact that he/her is interested therein. In the case of married persons [or persons] living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.3 An officer must also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

8.4 The Chief Executive will ensure that the interests, employment or relationships declared by staff shall be entered in a register of interests of staff. The Register of Interests of Staff will be maintained by the Trust Secretary.

8.5 Canvassing of Directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

8.6 A Director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.7 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.8 Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

8.9 The Directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

8.10 On appointment, Directors (and prior to acceptance of an appointment in the case of executive Directors) should disclose to the Trust whether they are related to any other Director or holder of any office under the Trust.

8.11 Where the relationship of an officer or another director to a Director of the Trust is disclosed, the Standing Order headed `Disability of Directors in proceedings on account

of pecuniary interest' (SO 7) shall apply.

9. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

9.1 The Common Seal of the Trust shall be kept by the Trust Secretary in a secure place.

9.2 The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board, or of a committee thereof, or where the Board has delegated its powers.

9.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an officer nominated by him) and authorised and countersigned by the Chief Executive (or an officer nominated by him who shall not be within the originating directorate).

9.4 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Trust at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

10. SIGNATURE OF DOCUMENTS

10.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

10.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.

11. MISCELLANEOUS

11.1 It is the duty of the Chief Executive to ensure that existing Directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of SOs.

11.2 Standing Financial Instructions and Reservation of Powers to the Board and Delegation of Powers shall have the effect as if incorporated into Standing Orders.

11.3 Standing Orders shall be reviewed annually by the Trust. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

NHS
Medway
NHS Foundation Trust

Maternity Bi-Annual Workforce Report

May 2024

Patient FIRST

Executive Summary

NHS Medway NHS Foundation Trust

- CNST Year 6 continues the requirement for a bi-annual midwifery workforce paper to be presented to Trust Board.
    - The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels
    - This maternity staffing report will highlight frequency of maternity safer staffing red flags and the reasons for the red flags
    - The report also provides an accurate account of the current workforce status and includes an update from recommendations within the paper presented to Trust Board in January 2024.
    - Gaps within the clinical midwifery workforce are highlighted with mitigation in place to manage this.
- Vacancy remains high at 17.21 WTE. Trajectory in place and anticipate full establishment by May 2025 with graduation of displaced CCCU students from Surrey.
- Midwifery workforce risk (1133) remains the highest risk on the WCYP risk register at 20. This score has been agreed by the CNO and the risk now sits under the Safety domain.
- Ongoing compliance with 1:1 care in labour and supernumerary coordinator.
- Full Birthrate plus conducted in 2023 and PID to support recommendations from this paper is in final draft.
- Good compliance with Fetal Monitoring training and PROMPT for midwifery staff.

True North: People
Background to workforce report

Medway NHS Foundation Trust

Ambition: To provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels
Goal: To provide an accurate account of the current workforce status

Background:
The NHSR Maternity Incentive Scheme requires that MFT demonstrates an effective system of midwifery workforce planning to the required standard using the following standards prescribed within safety action 5 of the MIS:

a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years.

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.

d) All women in active labour receive one-to-one midwifery care.

e)Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.

True North: People

Safety Action 5: Midwifery Workforce BIRTHRATE PLUS JULY 2023
Ambition: Ensure midwifery workforce meets the needs of the service and can provide the best patient care
Goal: Ensure Midwifery workforce meets the required standard

Medway NHS Foundation Trust

Key Messages:

- MFT currently funds 212.57WTE clinical maternity staff (Bands 3-7), or which 196.91WTE are registrants
- Birthrate Plus (BR+) is a framework for maternity workforce planning and strategic decision-making
- The Birthrate Plus workforce tool was conducted in July 2023 and identified a shortfall in workforce to meet the recommended ratio of 1:25.

BirthRate Plus Methodology:

Birthrate Plus® is an evidence-based methodology based on national standards – in particular one-to-one care from a midwife for a woman during labour and delivery, together with the care of the new-born infant(s). It supports maternity services to identify the staffing they need to provide safe care. The methodology is sensitive to local factors, such as case mix and has been in use for over thirty years.

The methodology is based on research published in peer reviewed journals [1] and has been described as the 'gold standard' for maternity workforce planning [2]. The methodology was reviewed as part of the post Francis Inquiry safe staffing programme of work led by NHS England. In June 2016 Birthrate Plus® was endorsed by the National Institute for Clinical Excellence (NICE) following a review of the methodology against NICE guidelines on safe midwifery staffing for maternity settings. NICE noted that the resource encourages the use of professional judgement in the final determination of maternity safe staffing levels in line with the safe staffing guideline.

Birthrate Plus® doesn't specify or allocate a set number of hours per midwife for training and we would look to national policy or guidance to specify this.

There is information available nationally stating the specific components of training that each midwife should complete but there is currently no guidance available nationally which specifies the amount of training time each midwife should receive to complete this training.

However, each Trust has a locally agreed uplift to cover training, annual leave, sickness etc which ranges from 18-25% and this is included in the Birthrate Plus calculations.

True North: People

Safety Action 5: Midwifery Workforce BIRTHRATE PLUS JULY 2023
Ambition: Ensure midwifery workforce meets the needs of the service and can provide the best patient care
Goal: Ensure Midwifery workforce meets the required standard

Medway NHS Foundation Trust

% uplift	Skill mix %	RMs	MSWs	Variance
22%	Current 94.5 / 4.5	-8.60	-0.50	-9.10
	90 / 10	0.75	-9.85	--9.10
25%	Current 94.5 / 4.5	-14.81	-0.85	-15.66
	90 / 10	-5.15	-10.51	-15.66

Casemix	%Cat I	%Cat II	%Cat III	%Cat IV	%Cat V
2022/23	4.1	9.8	12.9	25.2	48.0
	26.8%			73.2%	
2018	38.0%			62.0%	

Actions & Improvements:

- A business case has been written to support the request for additional workforce budget to support Medway maternity in achieving the national agenda for maternity
- Work actively and in partnership with recruitment to maximise recruitment opportunities
- Continue to participate in International recruitment, Return to practice and retire and return

Key Messages:

- MFT currently funds 212.57WTE clinical maternity staff (Bands 3-7), or which 196.91WTE are registrants
- The Birthrate Plus workforce tool was conducted in July 2023 and identified a shortfall in workforce to meet the recommended ratio of 1:25.
- Based on the current 22% uplift this review identifies a short fall of 9.10WTE clinical roles and 4.18WTE non-clinical roles to achieve recommended staffing ratios
- The complexity of women has changed significantly since our last Birthrate plus review with the highest complexity of cases (category IV and V) rising from 62%- to 73%
- The long-term sickness rate for March 2024 is 5.24WTE

Issues, Concerns & Gaps:

- The service currently has a vacancy 17.21 WTE
- Maternity leave is currently 11.52 WTE which is not factored into the 22% uplift and so unfunded
- Gaps are attempted to be covered with bank and agency with varying degree of success
- The annual turnover factor is 9.03% which is lower than the Trust overall turnover (14.4%) and is impacted by the number of midwives who have retired.
- There has been a significant increase in nationally required maternity training which cannot be met within the 22% uplift. A 25% uplift would better support this training need.

True North: People
Planned vs Actual Midwifery Staffing levels

Medway NHS Foundation Trust

Ambition: Achieving safe and appropriate midwifery staffing through implementation of Birth Rate Plus
Goal: Outline the findings from the internal Birth-rate Plus review

		Month 2023/24								
Measure	Goal	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Midwife to Women Ratio - Funded	1:25	01:25	01:25	01:25	01:25	01:25	01:25	01:25	01:25	01:25
Actual Worked ratio		01.33	01:33	01:34	01:31	01:32	01:33	01:33	01:34	1:30

	Establishment	In post	Recruited to but not in post	Vacancy
Midwives Bands 5-7	181.89	157.62	7.06	17.21
MSW's Band 3	23.91	22.66	0.64	0.61
Total	205.8	180.28	7.7	17.82

Key Messages:

- The table presents the midwife to birth ratio which is determined by the number of births divided by the number of staff available each month.
- Based on the establishment, the mean midwife to birth ratio at MFT should be around 1:25 each month

Actions & Improvements:

- In order to support the workforce during this time of high unavailability and vacancy rates, the following measures have been introduced:
- Many specialist midwives have supported to work clinically which affects their specialist roles.
- The 7-day on call rota is working well which, in conjunction with the on call manager which equates to managerial support being available to the clinical teams 24/7.
- Bank shifts remain incentivised for midwives to encourage pick up and agency support
- Proposed EDI Lead role will support promoting MCOC for those families from BAME groups and those experiencing other social inequalities.

Issues, Concerns & Gaps:

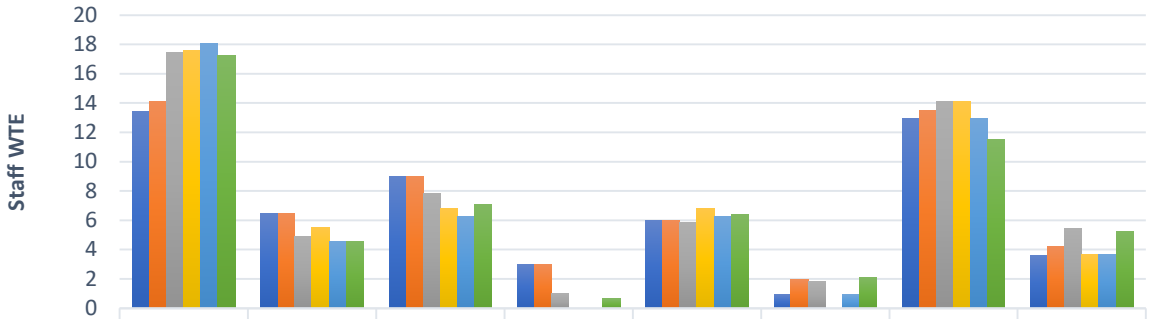
- Need to prioritise women most likely to experience poorer outcomes, including by ensuring most women from Black, Asian and Mixed ethnicity backgrounds and also those from the most deprived areas are placed on a MCoC pathway at the earliest opportunity

True North: People
Workforce Data October 2023 to March 2024

Ambition: to ensure that we recruit and retain the required workforce to deliver safe, high-quality care to our service users.

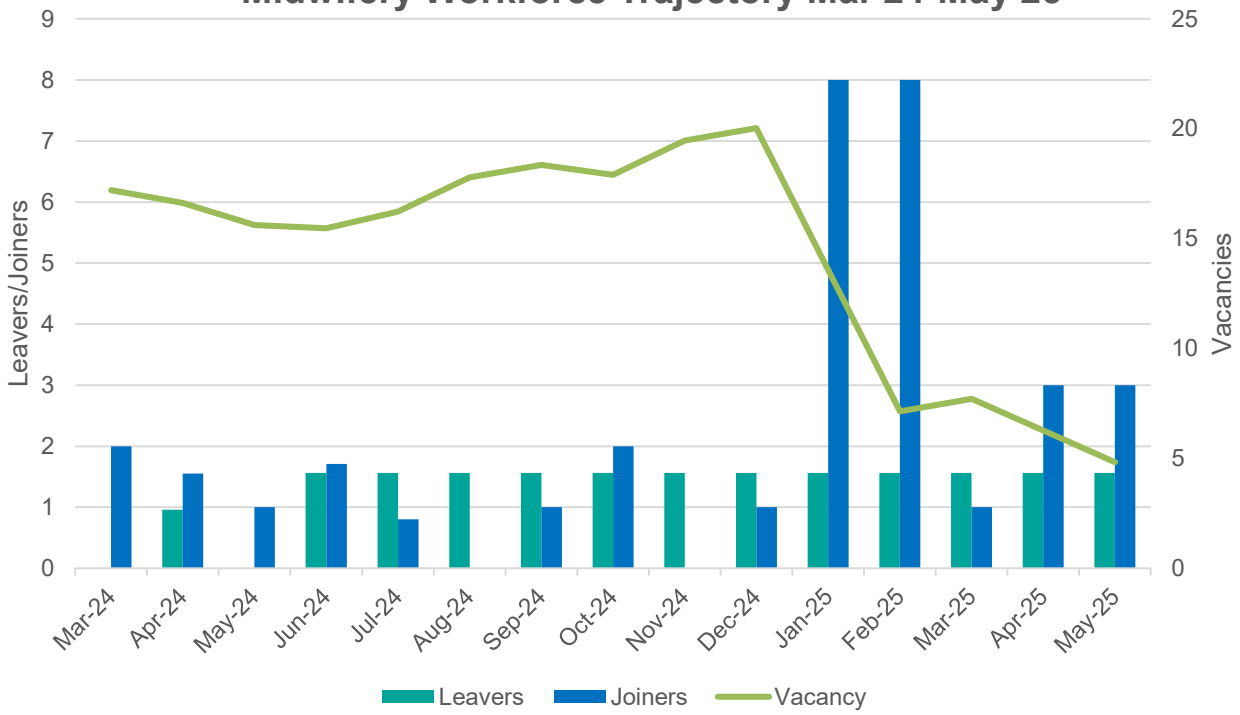
Goal: to ensure that MFT is a great place to work by prioritising staff support and wellbeing.

Midwifery Staffing Oct 23-Mar 24



	True vacancy	Secondments	Recruited	Start dates agreed	Awaiting employment checks	Leavers	Maternity Leave	Average Long Term Sick across month
Oct-23	13.43	6.44	9	3	6	0.96	12.96	3.61
Nov-23	14.15	6.44	9	3	6	1.96	13.48	4.18
Dec-23	17.45	4.89	7.82	1	5.82	1.8	14.12	5.47
Jan-24	17.57	5.53	6.82	0	6.82	0	14.12	3.64
Feb-24	18.09	4.57	6.26	0	6.26	0.96	12.96	3.65
Mar-24	17.21	4.57	7.06	0.64	6.42	2.12	11.52	5.24

Midwifery Workforce Trajectory Mar 24-May 25

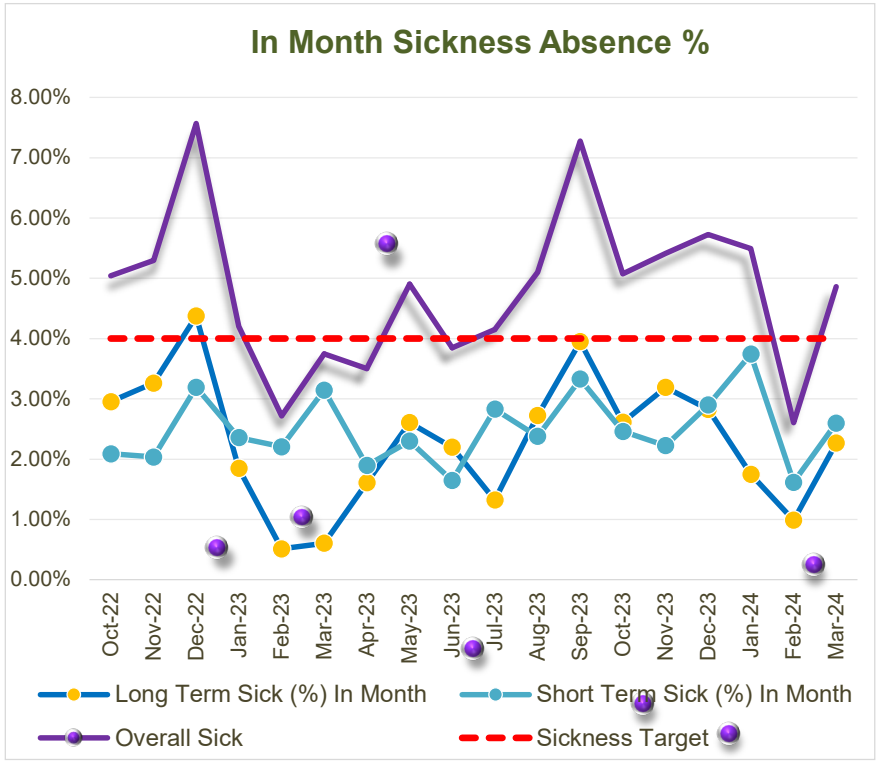


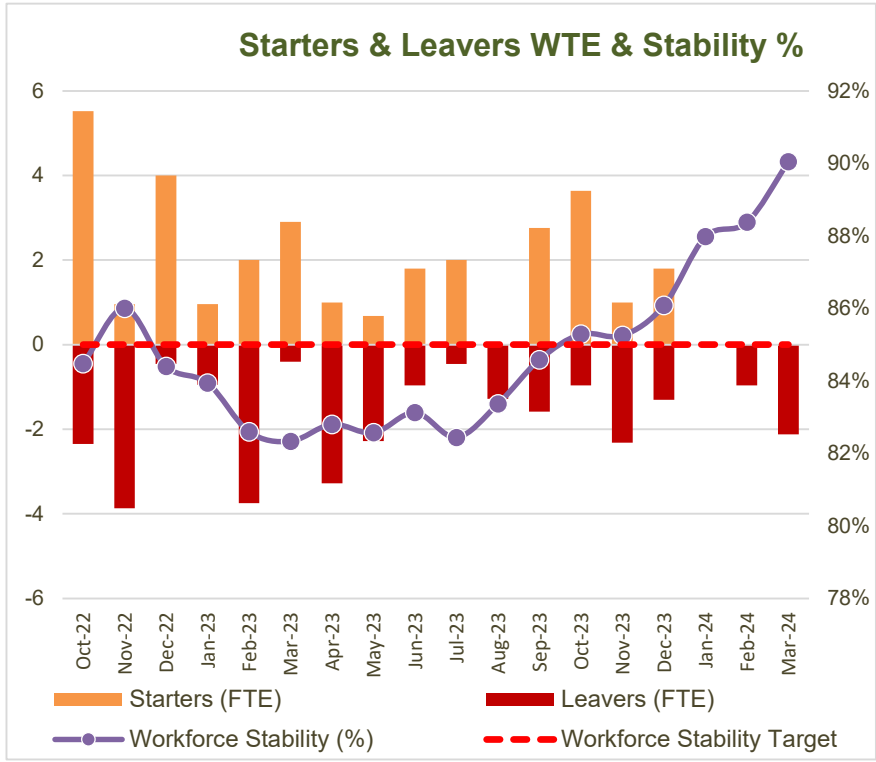
True North: People
Workforce Data October 2023 to March 2024

Medway NHS Foundation Trust

Ambition: to ensure that we recruit and retain the required workforce to deliver safe, high-quality care to our service users.

Goal: to ensure that MFT is a great place to work by prioritising staff support and wellbeing.





True North: People
Workforce Data October 2023 to March 2024

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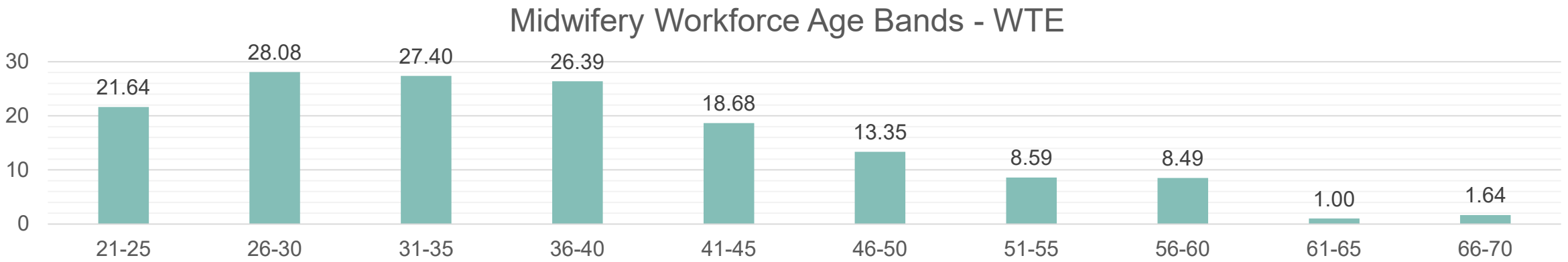

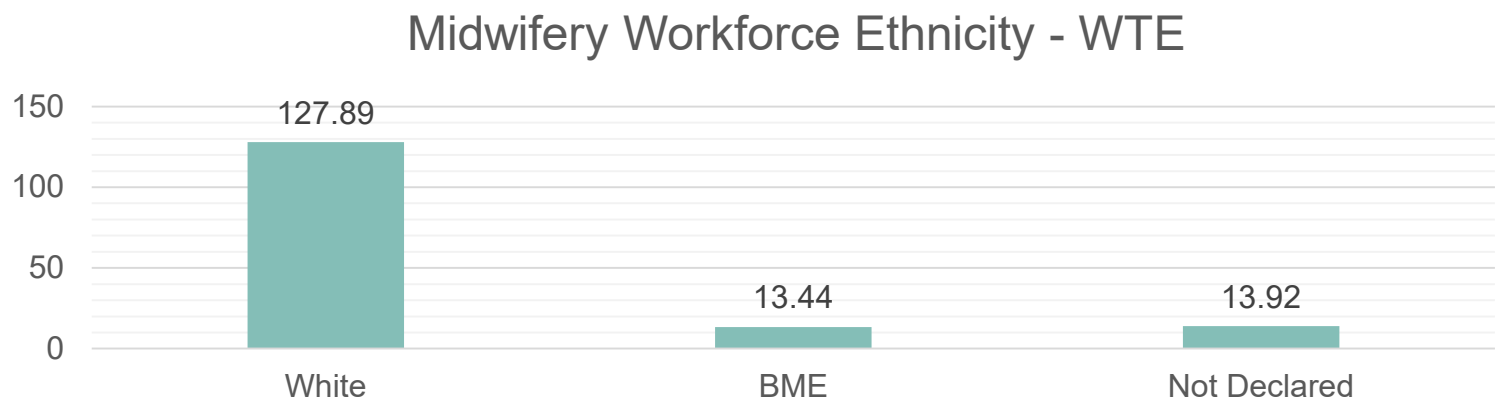

True North: People
Workforce Data October 2023 to March 2024

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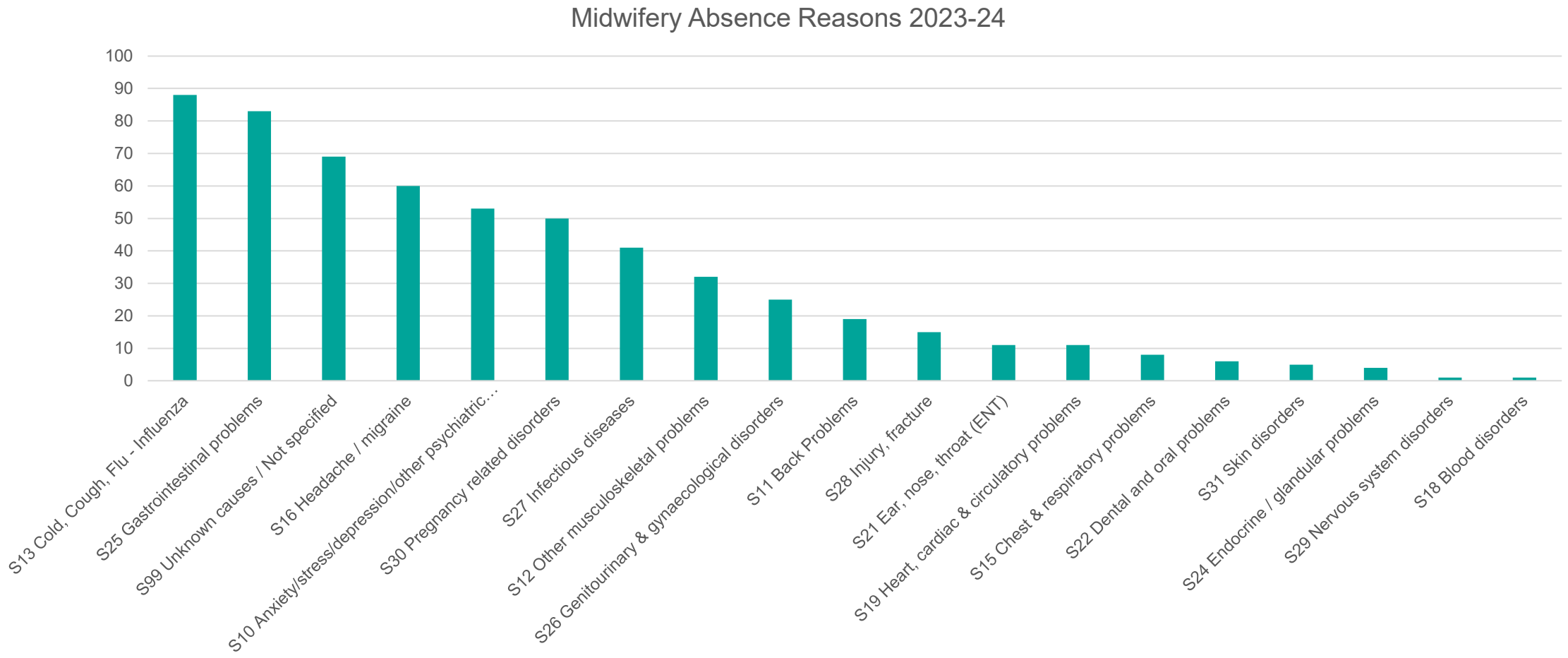


Recruitment and Retention

Ambition: to ensure that we recruit and retain the required workforce to deliver safe, high-quality care to our service users.

Goal: to ensure that MFT is a great place to work by prioritising staff support and wellbeing.

NHS Medway NHS Foundation Trust

Key Messages:

- The maternity team continue to actively recruit new staff
- Workforce stability is above Trust Target at 90.5%
- The service is currently working with the HEE Midwifery Apprentice Programme and have 2 recently qualified and 3 ongoing apprentices.
- Representatives of MFT have joined both Regional and National workforce webinars to ensure the most up to date measures are being undertaken to support staff back to work
- Working with Trust International nursing team to support dual qualified international staff to join maternity.
- Trajectory for recruitment aligns with graduation of previously displaced CCU students. This will relieve vacancy but newly qualified staff will require additional support.
- MFT piloting T-Levels to support young people to complete health qualifications within the hospital setting.
- SCORE survey for staff undertaken in November 2023. Action plan in place based on staff feedback, with focus on reducing Burnout and supporting staff wellbeing and development.
- Engagement in LMNS led staff-listening events and career opportunities including career cafes and shortened course.
- 1 RN on the RN to midwifery course.

Issues, Concerns & Gaps:

- 100% of the Midwifery workforce are female and over 80% of child-bearing age so maternity leave will, at times, be disproportionately higher than other workforce groups
- The risk ID 1133 in relation to midwifery staffing is currently 20 with increasing challenges in achieving the required baseline staffing levels in the Obstetric Unit , Midwifery Led Unit and Community services.
- 4 leavers in Jan-March 2024 : Moving to role closer to home x2, Moving to bank for flexibility; retiring.
- Large intake of newly qualified students requires additional preceptorship and support and ongoing development to support new and less experienced workforce.
- Removal of CCCU course reduces local midwifery course offer which may have negative long-term implications for recruitment.
- Staff feedback reflects the negative impact of current workforce challenges on colleagues.
- Staff sickness/absence above Trust Target.
- Unknown cause 3rd highest reason for absence recorded.
- Poor levels of diversity within workforce.

Recruitment and Retention

Ambition: to ensure that we recruit and retain the required workforce to deliver safe, high-quality care to our service users.

Goal: to ensure that MFT is a great place to work by prioritising staff support and wellbeing.

NHS Medway NHS Foundation Trust

Actions & Improvements:

- Funding for recruitment and retention midwife continued for 2024/25
- Monthly midwifery forum chaired by the DoM to encourage speaking up
- Monthly safety walk rounds by Local and Board Level Safety Champions to talk to teams on shift
- Monthly Midwifery update for colleagues on progress around recruitment and actions taken as a result of the midwifery forum and safety walk arounds.
- Birth-rate plus PID in final draft.
- Working with University of Greenwich, Surrey and other local providers to support strong relationship and ongoing student placements and recruitment.
- Working with LMNS to cultivate local placements from alternative providers.
- Repeat staff culture survey planned for June 2024.
- PMA team currently benchmarking against Labour Ward Coordinator framework to support and develop the skills of Labour Ward Coordinators and aspiring coordinators. This work will not only support the Labour Ward Coordinators, but strengthen the leadership on the unit and support newly qualified staff in their practice.
- All staff feedback collated on feedback log and actions allocated and outcomes fed back to staff. Actions to be grouped by theme and added to BAF to ensure appropriate oversight.
- Planned recruitment of EDI Midwife to support workforce and service users
- Ongoing engagement with Trust and LMNS quality and diversity workstreams.
- Continue to publish EDI data in workforce reports.
- Continue to embed inclusive recruitment process for band 7 and above to ensure that our interview panels are diverse.
- Support EDI champion work to develop our commitment towards equality and diversity in line with the 3-year delivery plan.
- Work with senior sisters and team leaders to ensure reasons for absence is recorded and can support staff back to work as soon as possible.
- Ensure staff absence is managed as per Trust Guidance.
- Improve talent management and succession mapping.
- Work with LMNS and Trust to support staff to engage in career cafes.
- Continue apprenticeship scheme.
- Continue to support culture and improvement work, including recognising and celebrating staff achievements “Star of the Month!”

True North: People
Birthrate Plus 4- hourly acuity tool

Medway NHS Foundation Trust

Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme

Key Messages:

- The pie chart shows Acuity RAG status for April 2023 to March 2024..
- The Intrapartum tool currently uses Red, Amber, and Green as determinants of acuity. A target of 85% for Green, when there is an adequate number of midwives available to provide the clinical care required by the women depending upon their needs, is considered to be appropriate
- The Delivery Suite data shows that for the periods when a data entry was made the unit was adequately staffed 53% of the time, with a slight improvement noted in the second half of the year, with April to September being 51% and October to March 2024 being 55%.
- The unit recorded negative acuity 47% of the time. With 9% of 2 or more MW's short
- Compliance with the rate for completion of the tool has fallen to 74% which is in below the 85% standard recommended by BR+.

Issues, Concerns & Gaps:

- Staff are moved from other areas to mitigate against the risk of staffing shortfalls however this may create red flags in these areas
- Data entry falls below the Birthrate Plus recommendations.

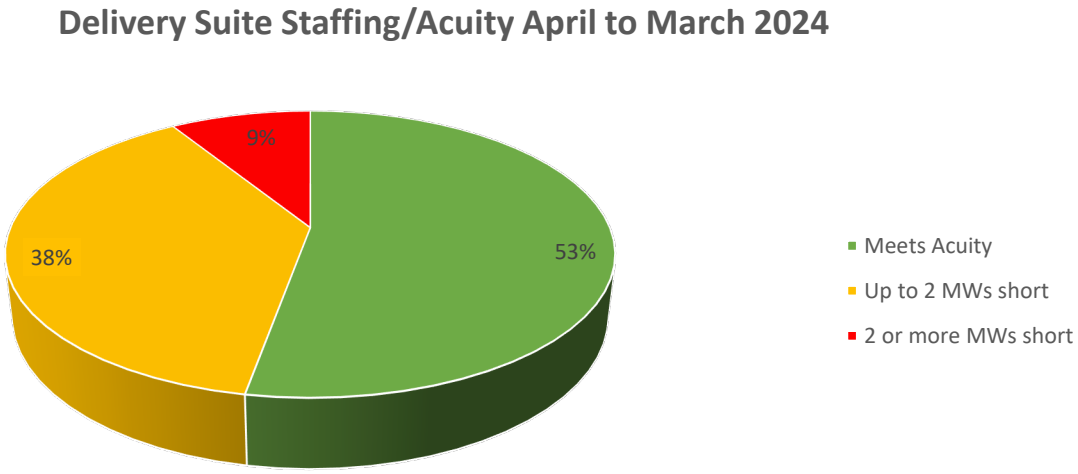
Actions & Improvements:

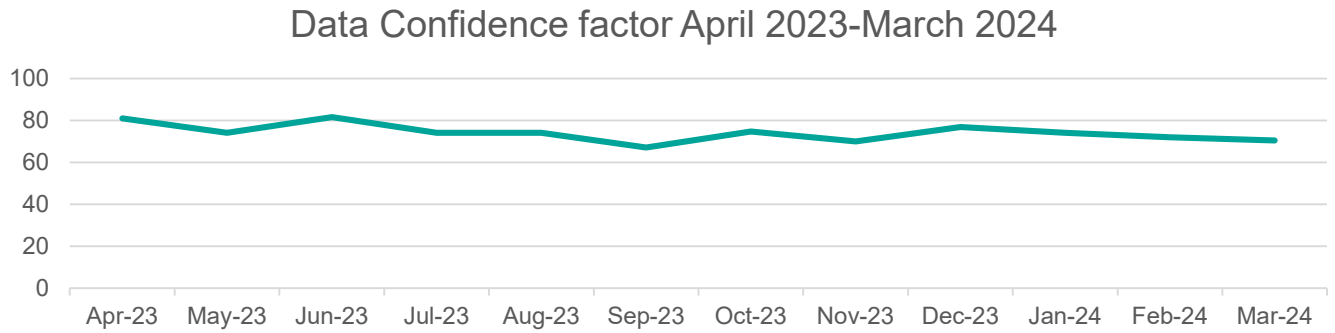
- The web-based birth rate plus acuity tool has been further be rolled out in Q4 2023/24 on our antenatal and postnatal wards supporting proactive assessment of women on the ward and matching them against the staff available.
- Reviewing Labour Ward Coordinator Framework to support development and Leadership skills of Labour Ward Coordinator.
- A clear and robust escalation policy is in place and twice daily oversight of the maternity unit's acuity verses staffing being monitored. Early interventions can be taken to maintain safety and activate deployment of staff to ensure care needs are maintained and safety remains the priority for the service

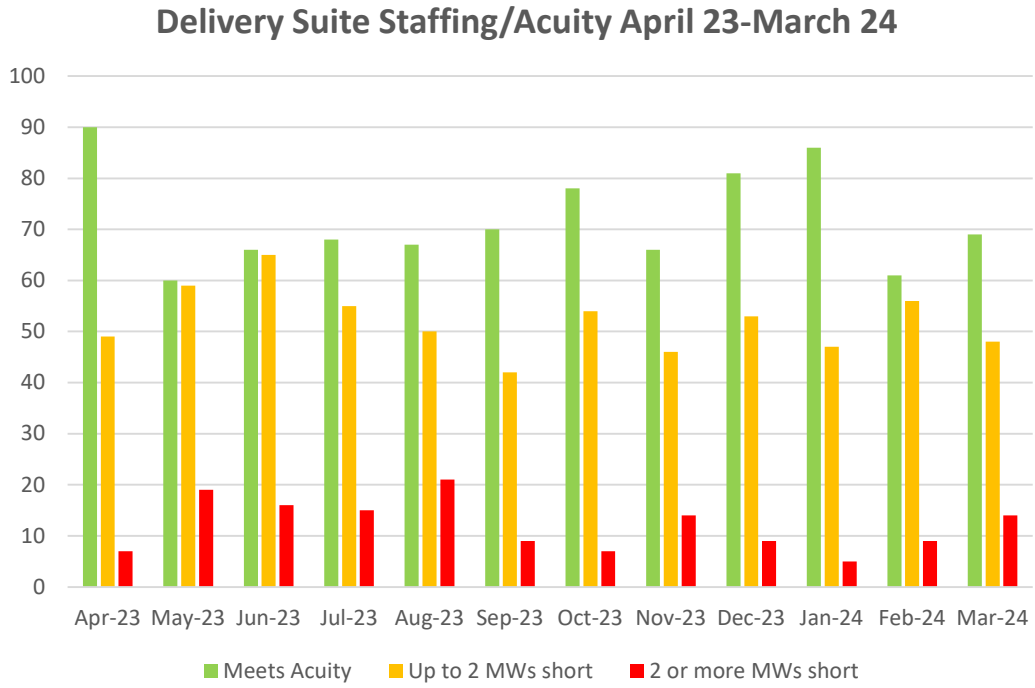
True North: People
Birthrate Plus 4- hourly acuity tool

NHS Medway NHS Foundation Trust

Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme





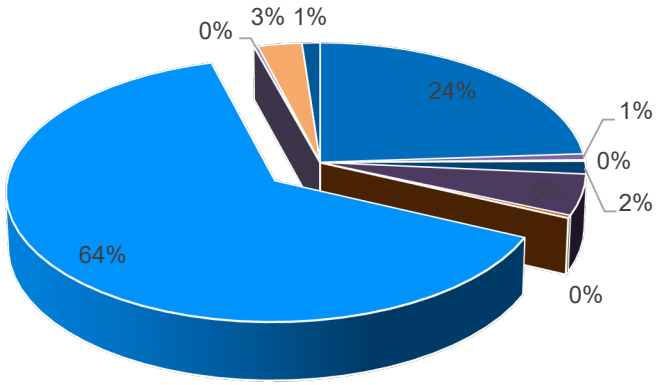


True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

Medway NHS Foundation Trust

Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme

Maternity Red Flags April 2023-March 2024



- Delayed or cancelled time critical activity
- Missed or delayed care (for example delay of 60 minutes or more in washing and suturing
- Missed medication during admission to hospital or MLU
- Delay in providing pain relief
- Delay between presentation and triage
- full clinical examinaination not carried out when preseting in labour
- Delay between admission for induction and beginning of process
- delayed recognition of and action on abnormal vital signs.
- Any occasion where 1 midwife is not able to provide continuous 1:1 care during established labour
- Coordinator unable to maintain supernumerary status

Key Messages:

- Red flags are recorded every 4 hours by the delivery suite coordinator on the birth-rate plus acuity tool. The same red flag may be recorded multiple times per shift (eg. Delay in induction of labour).
- The pie chart shows that 64% of red flags recorded from April 23 to September 24 were relating to delays in induction of labour.
- 24% of red flags relate to delay or cancelled time critical actives.
- 5% indicated a delay between presentation and triage and 2% indicated a delay in pain relief.

Issues, Concerns & Gaps:

- Staffing factors also contribute to red flags and poor acuity with inability to fill vacant shifts accounting for 64% of staffing factors in the reporting period.
- Delay in providing pain relief was also raised in the 2023 picker survey and will form part of this action plan.

Actions & Improvements:

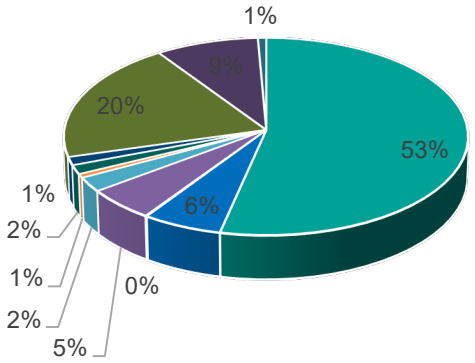
- To mitigate and resolve red flags and negative activity the coordinator records the following categories of action:
  - Staffing Actions
  - Clinical Actions
  - Management actions.
  - Details of these actions are included on the next slide.

True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme

Medway NHS Foundation Trust

Management Actions in response to red flags April 23-March 24

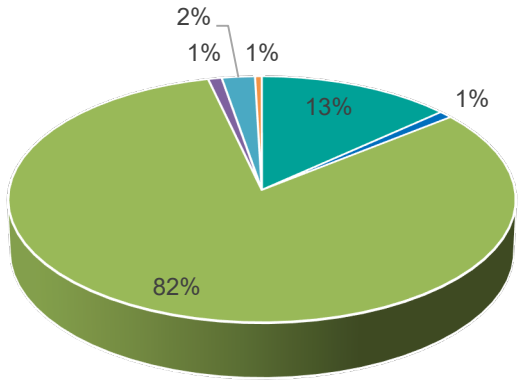


- Redeploy staff internally
- Redeploy staff from community
- Redeploy staff from training
- Staff unable to take allocated breaks
- Staff working beyond rostered hours
- Specialist midwife working clinically
- Manager/Matron working clinically
- Staff sourced from bank/agency
- Utilise oncall midwife
- Escalate to Manager on call
- Maternity Unit on divert

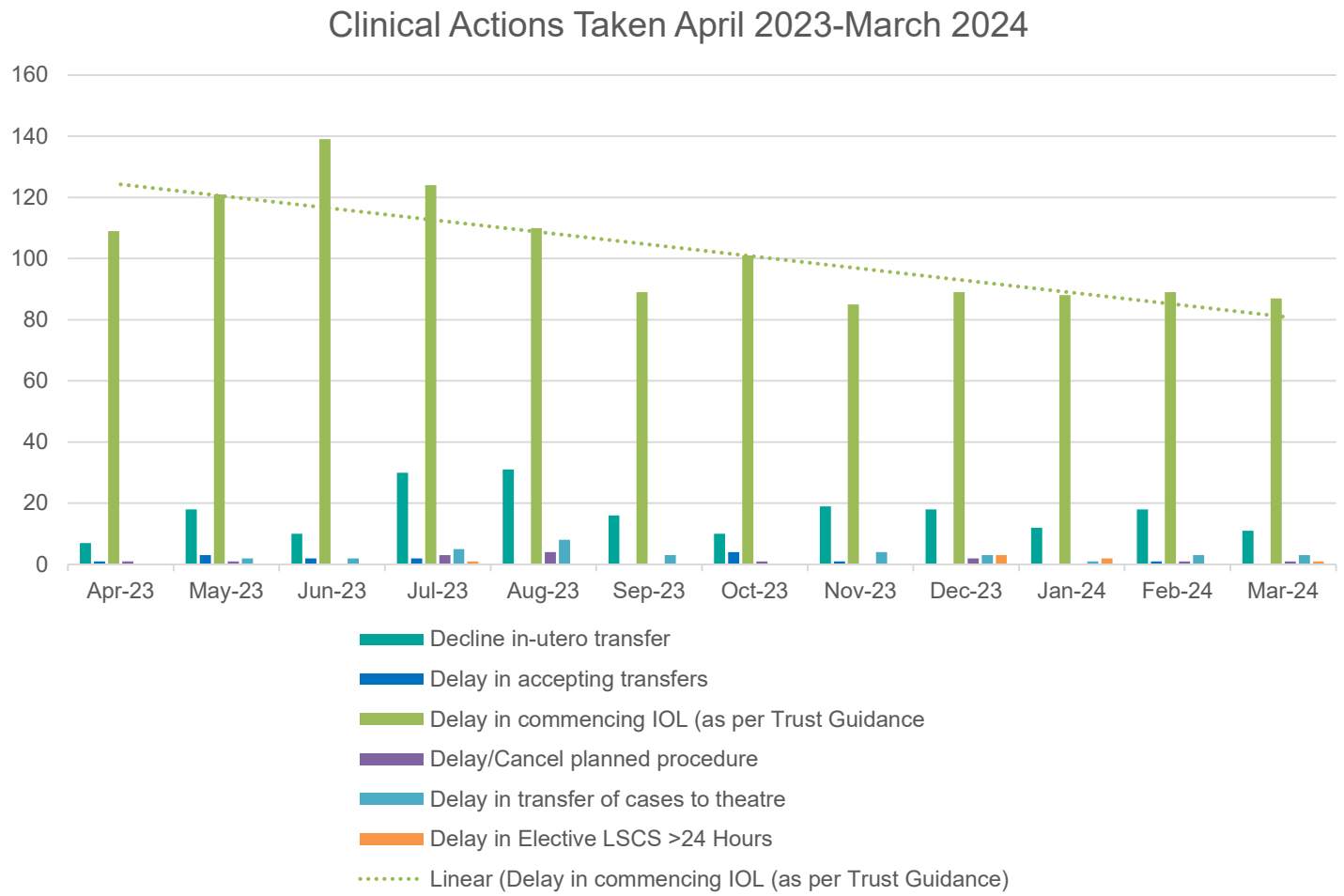
True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme

Clinical Actions Taken April 23-March 24



- Decline in-utero transfer
- Delay in accepting transfers
- Delay in commencing IOL (as per Trust Guidance
- Delay/Cancel planned procedure
- Delay in transfer of cases to theatre
- Delay in Elective LSCS >24 Hours

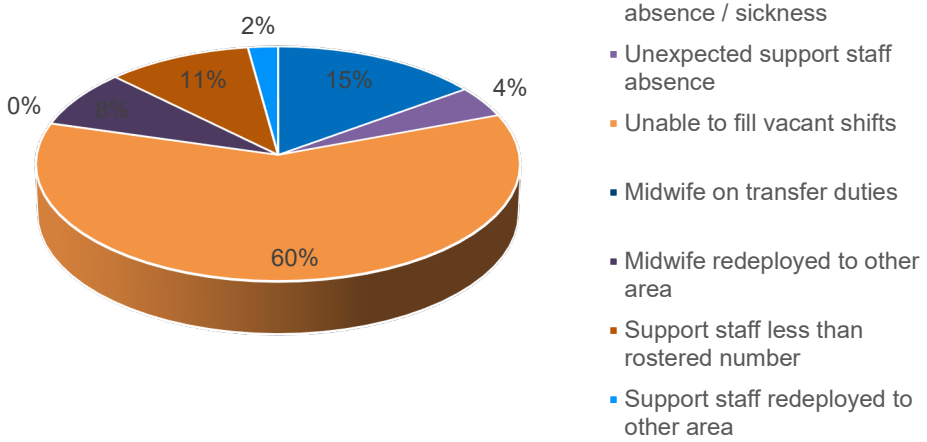


True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

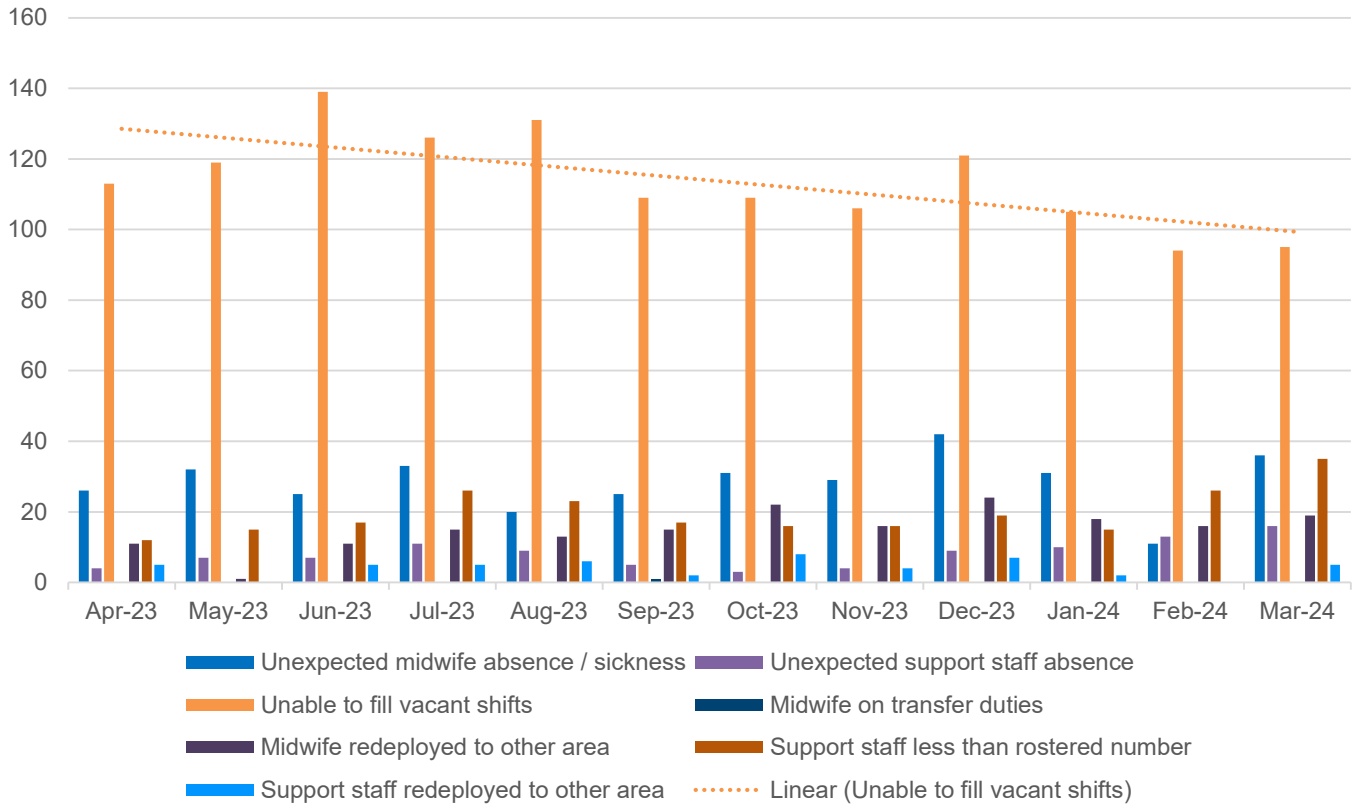
Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme

Medway NHS Foundation Trust

Midwifery Staffing factors March 2023-April 2024



Midwifery Staffing Factors April 23-March 24



True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme

Key Messages:

- Delay in IOL accounts fro 82% of clinical actions taken which aligns with the red flags raised for IOL delays across the 12 month reporting period. However, a downward trend in delays is noted. This aligns with the introduction of the revised IOL pathway in June 2023. Positive feedback received from both staff and service users on the management and communication on this new pathway.
- Decline in-utero transfer accounts for 13% of clinical actions taken between April and September 2023, this is to ensure safety of patients already admitted into our maternity service.
- 53% of management actions taken were to redeploy staff across the unit, however, there is a downward trend noted in the need to redeploy staff across the unit.
- 20% saw the utilisation of the on-call midwife which is reflective of the on-call review document completed in August 2023 which calls the hospital on-call team in the first instance before the community team are called in.
- 60% of staffing factors are reported as inability to fill vacant shifts, however again there is a downward trend noted across the reporting period.

Issues, Concerns & Gaps:

- Inability to take staff breaks is recorded as 5% of the time which is less than the reported occasions on which staff were unable to take breaks in our cultural survey.

Actions & Improvements:

- Breaks audit underway from twice daily bedstate to identify potential solutions to staff inability to take breaks.

True North: People
Delivery Suite Co-ordinator supernumerary status

Ambition: To ensure supernumerary status of the delivery suite co-ordinator.
Goal: To monitor compliance of supernumerary status and ensure there is an action plan in place of how the maternity service intends to achieve this .

	Compliance with Supernumerary status of coordinator as per CNST Guidance	Complaince with 1:1 Care in Labour as per CNST Guidance
Apr-23	100%	100%
May-23	100%	100%
Jun-23	100%	100%
Jul-23	100%	100%
Aug-23	100%	100%
Sep-23	100%	100%
Oct-23	100%	100%
Nov-23	100%	100%
Dec-23	100%	100%
Jan-24	100%	100%
Feb-24	100%	100%
Mar-24	100%	100%

Key Messages:

- Delivery suite supernumerary status is a core element of CNST Safety Action 5.
- In year 6, the requirement has changed to ensure that the coordinator is supernumerary on the rota and that the shift commences
- The twice daily bed state monitors the supernumerary status of the delivery suite co-ordinator to ensure that they have oversight of all activity within the service.
- If there is an occasion where the delivery suite co-ordinator does not have supernumerary status for more than 1 hour, this is escalated to the Midwifery Manager on call
- All occasions of coordinator not supernumerary have been reviewed, and these are very brief periods of caring for postnatal women whilst waiting for staff to mobilise to delivery suite, and therefore meet the requirements of CNST allowing the service to declare 100% compliance with supernumerary status.
- Compliance with 1:1 care in labour remains at 100%.

Issues, Concerns & Gaps:

- Backcopy and data rules issues noted from maternity information system and BI which is showing scores of less than 100%.

Actions & Improvements:

- Digital midwife working with BI to ensure backcopy/data exclusions eg. BBA are in place for 1:1 care in labour compliance.

Workforce – Training

Ambition: To ensure the maternity and neonatal workforce have the skills and knowledge to provide safe and evidence based care.

Goal: To ensure all staff are trained to the required compliance.

Medway NHS Foundation Trust

Key Messages:

- Fetal monitoring training 100% for obstetric doctors and 97.7% for midwives
- 2 PROMPT training days running per month to support >90% compliance (previously 1 day per month).
- Midwives, MSWs and Theatre staff >90% for PROMPT training.
- Anaesthetic and obstetric doctors <85%
- Midwifery essential skills 90% compliance.
- Increase in compliance with ABLS, NBLS training and Safeguarding adults, however the latter remains below Trust target.
- Overall compliance for Maternity and Neonatal Staff for mandatory training has increased to 86.76% in Quarter 4.
- CNST Year 6 reporting period for training compliance >90% is December 2023 to 30 November 2024.

Issues, concerns, gaps:

- Doctors strikes have prevented consultants from attending PROMPT training currently below 85% for all medical groups.
- A number of mandatory training topics remain below Trust target.
- Have not met training trajectory for Safeguarding Adults. 66.95 for all maternity and neonatal staff, 73% for Midwifery staff.

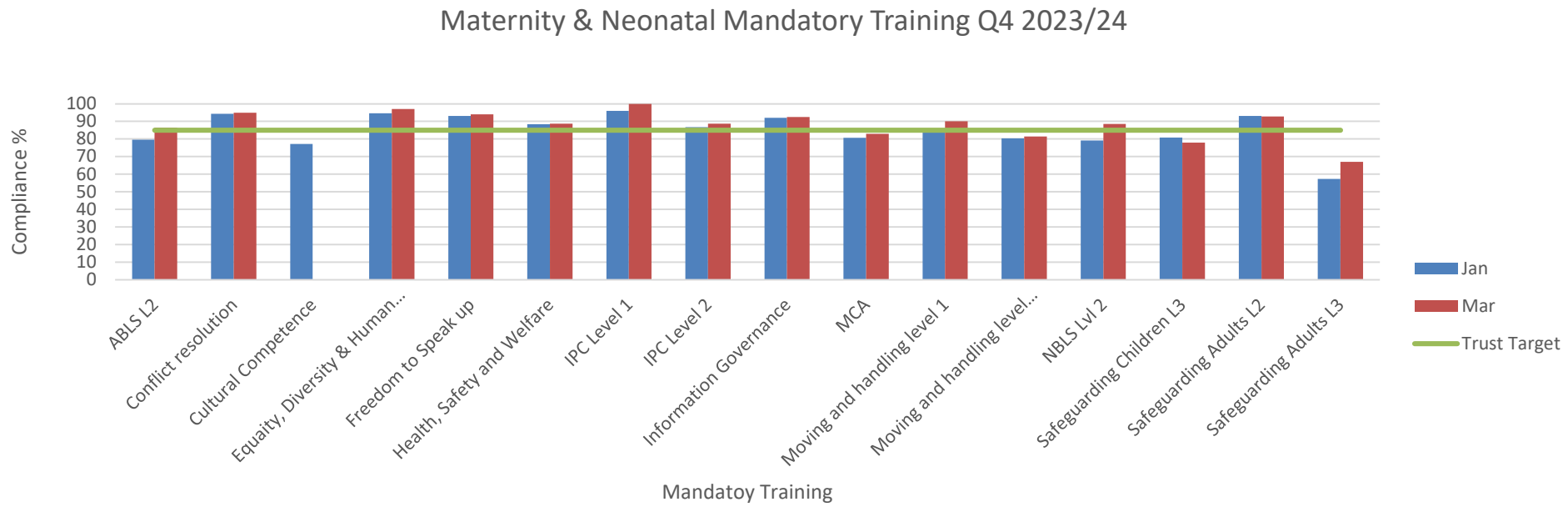
Actions and improvements

- Insitu SIM programme relaunched in January 2024 with MDT attendance supported.
- SBAR to be included in PROMPT and essential skills.
- All new starters receive PROMPT training within 3 months.
- Education team to flag with Service Manager and General Manager non-attendance by medical team to ensure rebooking. Midwifery non-attendance escalated to senior sister.
- Mandatory training compliance to form part of appraisal process
- Senior sisters to identify individual staff needs and to roster attendance to support compliance.
- Those with significant lapse in training compliance to have 1:1 review with matrons/clinical supervisor.
- Band 6 research midwife to complete keyworker course in February 2024 to be able to undertake workplace assessments for moving and handling training

Perinatal Surveillance Tool Q3 2023/24 – Training

Ambition: To ensure the maternity and neonatal workforce have the skills and knowledge to provide safe and evidence based care.
Goal: To ensure all staff are trained to the required compliance.

Medway NHS Foundation Trust



Fetal Monitoring Training and Assessment	Compliance December 2024	Compliance March 2024
Midwives	100%	**97.7%**
Obstetric Consultants	89%	**100%**
Doctors in training	80%	**100%**

PROMPT training Q4	Active Staff	Complaint	%
Midwives	178	161	**90%**
MA & MSW	51	47	**92%**
Theatre Nurses and ODNs	30	28	**93%**
Obs Consultants	22	16	**72%**
Obs SpR/SHO	34	29	**85%**
Aneaesthetic Consultant	7	5	**75%**
Aneas. SpR/SHO	23	19	**82%**
Total	**345**	**305**	**75%**

Essential Skills March 2024	Active Staff	Compliant	%
Midwives	178	161	90

Workforce Action Plan

Medway NHS Foundation Trust

No	Key lines of enquiry	Evidence Available	Gaps in Evidence/Assurance	Mitigating Actions /Comments	Action Due Date	Implementation Lead	BRAG
Maternity Workforce Action Plan 2023/24							
1	Review flexible working opportunities and capture		no gaps in assurance	Staff Survey undertaken July 23, JDS revised as part of cultural improvement action plan and flexible working included, leavers interviews now feed into workforce reports, flexible working opportunities included in all interview discussions.	31/08/2023	Quad	
2	Introduce yearly career MOT workshops to support personalised plan for all staff ensuring both developmental and succession planning.		PMA to support facilitating workshops	Awaiting PMAs to arrange workshops and diarise annual plan. Career Cafes arranged by Trust and LMNS – to replace PMA facilitated workshop.	30/03/2024	Lead PMA	
3	Utilise annual appraisal process to identify aspiring leaders and specialists to help with succession planning			Matrons collating aspiring leaders database from appraisals.	30/12/2023	Head of Midwifery	
4	Update escalation policy in place in line with the South East OPEL Framework	Guideline updated and in date	no gaps in assurance		31/07/2023	Intrapartum Matron	
5	Increase registered nurse establishment in maternity	8WTE Registered nurses now part of establishment. Competency pack for PN developed and in place.	no gaps in assurance		31/08/2023	Antenatal/postnatal Matron	

Workforce Action Plan

Medway NHS Foundation Trust

No	Key lines of enquiry	Evidence Available	Gaps in Evidence/Assurance	Mitigating Actions /Comments	Action Due Date	Implementation Lead	BRAG
Maternity Workforce Action Plan 2023/24							
6	Map the building blocks for MCoC in preparation for moving towards full implementation of the model in the future	Mapping complete and presented to MNSCAB	No gaps in assurance		31/08/2023	Consultant midwife	
7	Triangulate red flag data with FFT and datix	Triangulation reports forms part of monthly MNSCAB reporting/governance/risk slides.	No gaps in assurance		30/10/2023	Head of Midwiefry	
8	Review and Revise IOL A3 project.	IOL A3 project completed and demonstrating improved quality outcomes. Staff and patient feedback incorporated into plan.	No gaps in assurance	Continue to monitor outcomes from IOL QI project and present at MNSCAB.	30/09/2023	Consultant midwife	
9	Strengthen and develop student cohort to support continued growth of workforce.			Continue to engage with local Advanced Educational Institutes to support and grow student cohort. Work with additional Advanced Educational Institutes outside local area to increase student cohort	30/12/2024	Lead Midwife for Education	

Next Steps:

- Progress Business Case based on the Birth-rate+ recommendations.
- Continue to work with LMNS and HEI's to support student placements to ensure ongoing pipeline of newly qualified midwives.
- Continue to engage in international recruitment activity along with supporting staff development through apprenticeship schemes and RN to RM courses.
- Continue to monitor red flags and supernumerary labour ward co-ordinator and 1:1 care in labour.
- Continue to engage with LMNS workforce groups.
- Continue to seek staff feedback and provide staff with regular updates on outcomes following actions.
- Develop and strengthen preceptorship programme in anticipation of newly qualified starters in 2025.
- Develop 2024/2025 workforce action plan that is reflective of current service.

Finance report

For the period ending 31 May 2024

Contents

1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	(3,545)	(3,328)	217	The Trust is reporting a £3.3m deficit in May, this being £0.2m favourable to plan in month and £14k favourable year to date (YTD). The improvement in the position is predominantly due to the implementation of controls over temporary staffing expenditure.
Donated asset depreciation	22	12	(10)	
In-month total	**(3,523)**	**(3,316)**	**206**	
YTD total	**(6,920)**	**(6,905)**	**14**	
Efficiencies Programme				
In-month	948	794	(153)	The efficiency programme has under achieved in-month by £0.2m and by £0.5m YTD. There remains to be a balance of unidentified budget out efficiencies against the plan, although the impact of this has been reduced by temporary staffing spend decreases; this continues to be focused on by all services, as well as implementing controls to reduce the current run rate.
YTD	1,507	1,034	(473)	
Cash				
Month end	7,917	6,182	(1,735)	The cash balance is £1.7m adverse to plan. This is mainly due to lower than expected contract payments from lead commissioners. Payments have not yet been fully uplifted to reflect a new contract.
Capital				
YTD				The approved operational capital allocation from the system for 2024/25 is £15,471k; there is also a further £6,000k for leases. The operational capital includes an additional £2,000k as a result of targets achieved in 23/24, together with £700k towards the CDC project cost pressure. Estimated capital funding from other sources is £9,756k; this includes: - £4,390k PDC for EPR and CDC project cost pressure. - £5,319k Grant for decarbonation - £47k charitable donations.
Capex	2,311	1,805	(506)	
Leases	5,000	0	(5,000)	
Total	7,311	1,804	(5,516)	

2. Income and expenditure

£'000	In-month			Year-to-date		
	Plan	Actual	Var.	Plan	Actual	Var.
Clinical income	33,199	32,046	(1,154)	66,469	63,841	(2,628)
High cost drugs	2,196	2,519	323	4,321	4,945	625
Other income	2,725	2,942	217	4,836	6,088	1,251
Donated Asset Adjustment	-	13	13	-	19	19
Total income	**38,120**	**37,519**	**(600)**	**75,626**	**74,893**	**(734)**
Nursing	(10,368)	(10,424)	(56)	(20,651)	(21,007)	(356)
Medical	(8,315)	(8,311)	4	(16,478)	(16,230)	249
Other	(7,384)	(7,125)	258	(15,373)	(14,292)	1,081
Unidentified efficiencies	159	-	(159)	461	-	(461)
Total pay	**(25,908)**	**(25,861)**	**47**	**(52,042)**	**(51,529)**	**513**
Clinical supplies	(5,669)	(4,553)	1,116	(10,580)	(9,608)	972
Drugs	(1,181)	(1,170)	11	(2,324)	(2,077)	247
High cost drugs	(2,196)	(2,598)	(402)	(4,321)	(4,988)	(667)
Other	(4,659)	(4,330)	329	(9,147)	(8,938)	209
Unidentified efficiencies	331	-	(331)	589	-	(589)
Total non-pay	**(13,374)**	**(12,652)**	**721**	**(25,783)**	**(25,611)**	**172**
EBITDA	**(1,162)**	**(993)**	**169**	**(2,199)**	**(2,247)**	**(48)**
Non-operating exp.	**(2,382)**	**(2,335)**	**48**	**(4,765)**	**(4,655)**	**110**
Reported surplus/(deficit)	**(3,545)**	**(3,328)**	**217**	**(6,963)**	**(6,902)**	**62**
Adj. to control total	**22**	**12**	**(10)**	**44**	**(4)**	**(47)**
Control total	**(3,523)**	**(3,316)**	**206**	**(6,920)**	**(6,905)**	**14**

1. Clinical income reports an adverse position of £1.2m in-month; this is due to centrally held items from planning that have not yet materialised, including the mobile endoscopy funding/activity and under delivery of ERF stretch targets. High cost drugs favourable income is offset with expenditure reported in the non-pay section.

2. The in-month 'other income' favourable variance is mainly due to medical education income of £0.2m and £0.8m YTD, in addition to cancer alliance funding above plan of £0.2m.

3. Reporting across the Trust, the in-month pay run-rate has increased by £0.2m; this is mainly due to the consultant's pay award being actioned including the arrears for 2 months. (The March arrears were accrued for in the previous financial year).

4. The overall pay variance is breakeven in-month and £0.5m favourable to plan YTD; this includes £0.9m of reserves held centrally being phased into the position as well as overspending due to car park security £0.1m, housekeeping rotas currently under review £0.1m and medical education £0.1m (the latter being funded in other income).

5. Nursing staff report an adverse performance of £0.1m in-month and £0.4m YTD. The in-month run rate has improved by £0.1m and a reduction of 20 WTE as the Trust focuses to reduce the reliance on temporary staffing by reviewing ward rosters and bookings. The overspend continues to be from pressures in emergency and acute care (£0.3m) as well as Frailty (£0.2m).

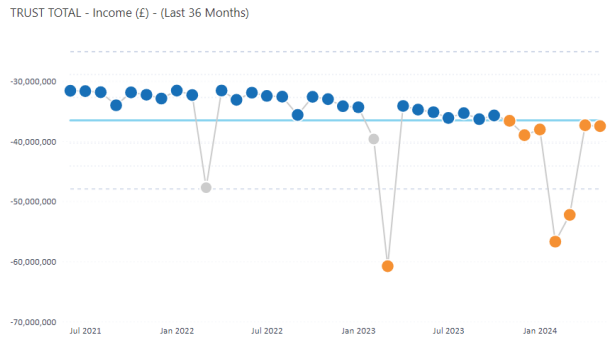
6. The 'clinical supplies' favourable variance includes the impact of reserves held centrally for North Kent Pathology Service (NKPS) and endoscopy.

7. During the month, the approved efficiency schemes have been actioned through the budgets, the remaining balance is reflected in the under delivery of the efficiency programme. It is expected the waste reduction panel will approve more schemes and this figure will continue to reduce as more budgets can be removed from divisions.

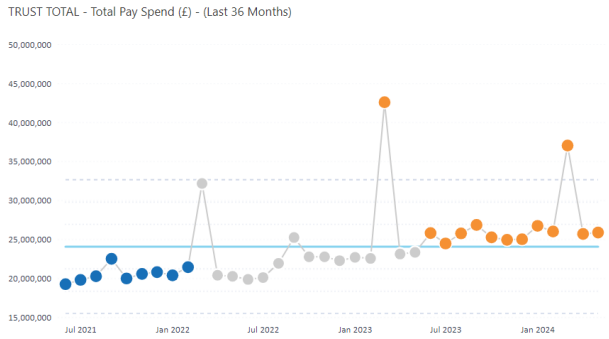
3. Run-rate

The charts below are examples of some of the statistical process control (SPC) charts available from the business intelligence platform; by analysing the changes in the run-rate over time, the divisions can understand different variations within particular areas of spend and whether results are as expected.

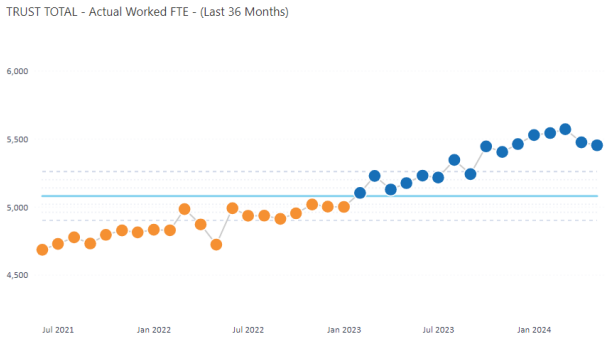
Income



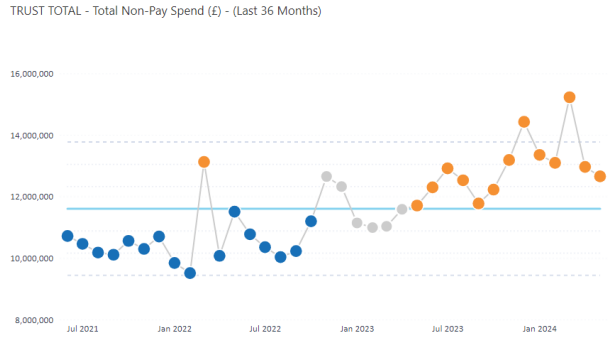
Pay



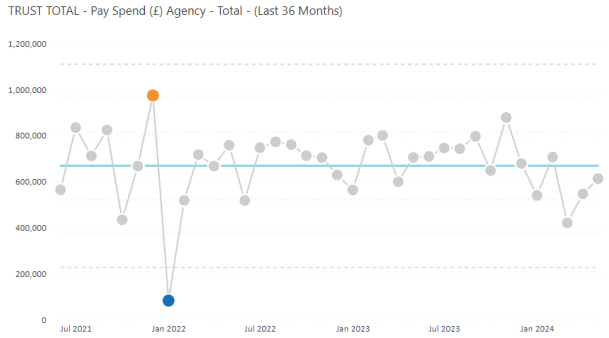
Full Time Equivalents worked



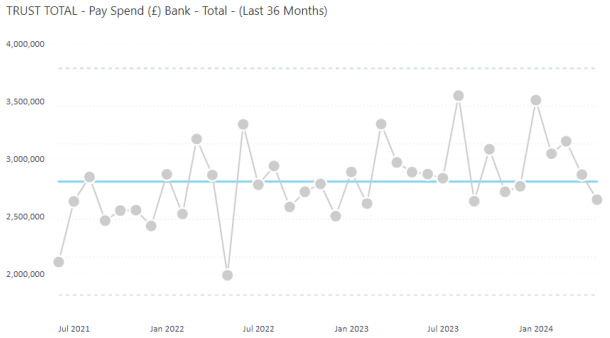
Non-pay



Agency

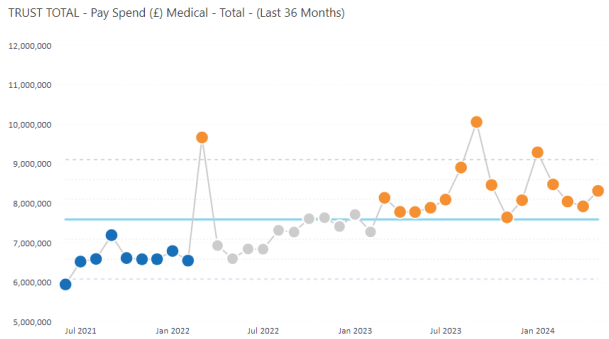


Bank

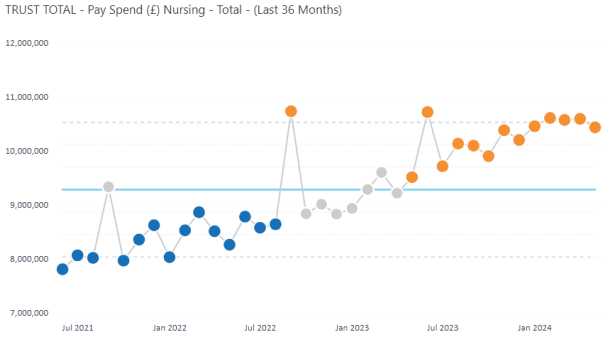


The pay spends results for March in each of the three years include the impact of the additional 6.3% pension costs, for which there is a corresponding increase to income as represented in the first chart. The total spend includes the impact of the pay awards and the gradual growth in the workforce, for example increases for escalation capacity, service transformation, ERF activity and approved business cases (CDC, Virtual Wards, Teletracking, etc.), as well as unfunded cost pressures and areas of overspending which have been addressed through budget setting and the financial stability breakthrough objective.
There was a reduction in April FTE of 89 when compared to March, and a further reduction of 18 FTE in May; the main drivers being 51 FTE fewer temporary staff and an increase of 33 FTE substantive staff. The tighter controls over rostering and bank bookings continues to be focused across all divisions.

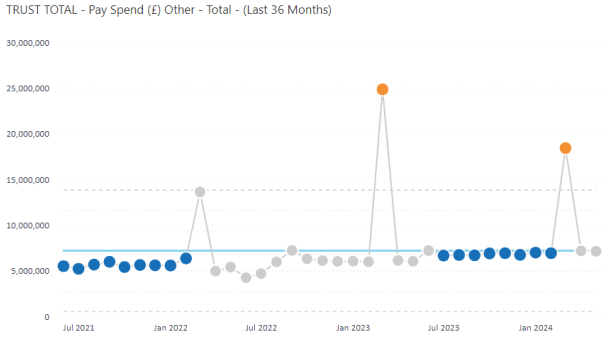
Medical pay total



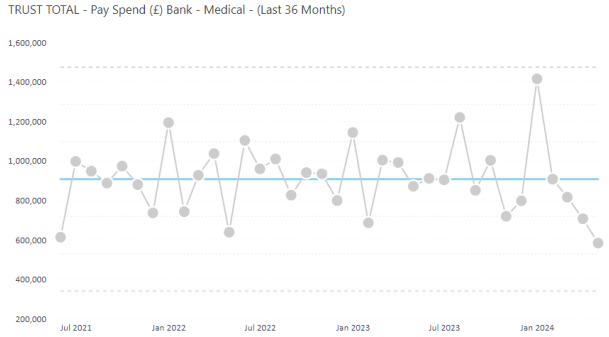
Nursing pay total



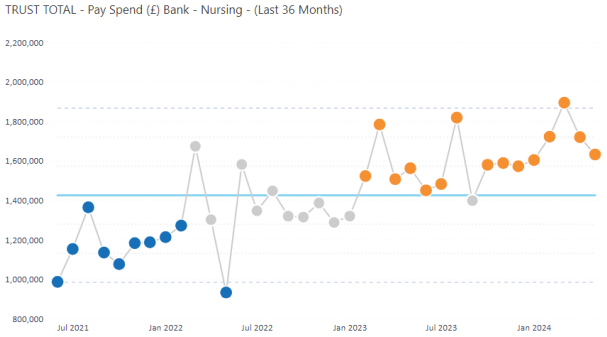
Other staff pay



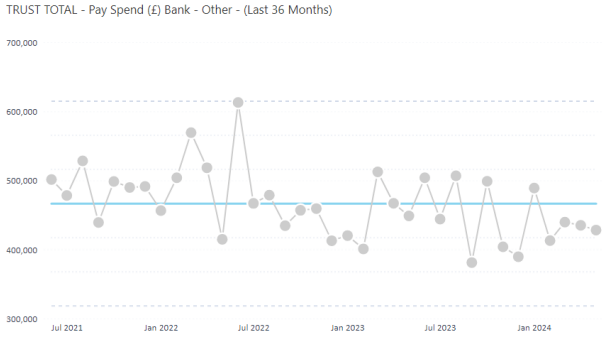
Medical bank



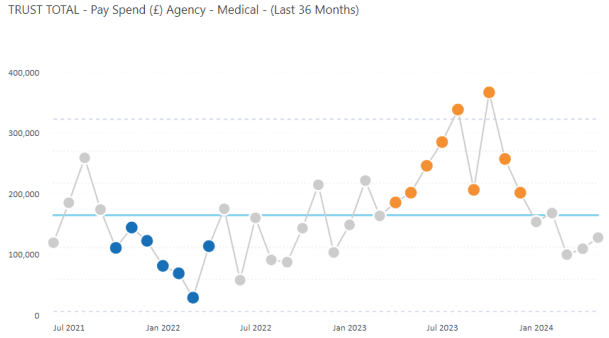
Nursing bank



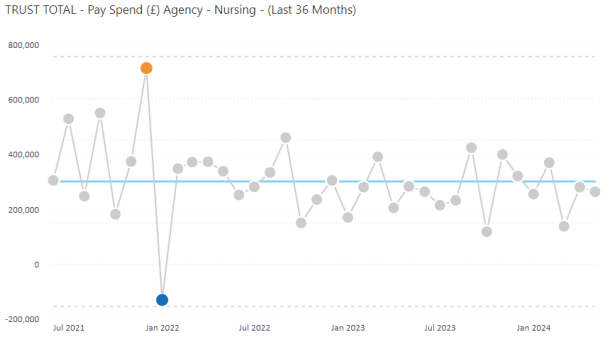
Other Staff bank



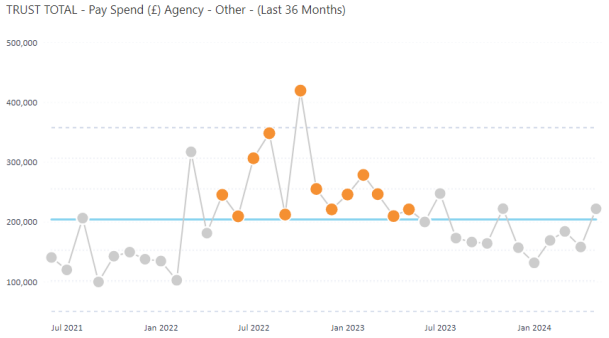
Medical agency



Nursing agency



Other Staff agency



Medical temporary staff usage in total has decreased in month by £0.1m in-month.

Nursing agency staff expenditure in-month has decreased following a focus across the Trust to implement controls to temporary staff.
The April bank spend include the increase in rates, of which the estimated impact in month is £0.2m.

The increase in other agency staff is due to higher housekeeping costs; there is an ongoing review of the staff rotas.

4. Balance sheet

Prior year end	£'000	Month end actual	Var on PY.
281,888	**Non-current assets**	**280,437**	**(1,451)**
6,556	Inventory	6,738	182
29,974	Trade and other receivables	33,311	3,337
21,042	Cash	6,182	(14,860)
57,572	**Current assets**	**46,231**	**(11,341)**
(357)	Borrowings	(100)	257
(57,938)	Trade and other payables	(50,198)	7,740
(1,166)	Other liabilities	(3,318)	(2,152)
(59,461)	**Current liabilities**	**(53,616)**	**5,845**
(3,073)	Borrowings	(3,073)	0
(1,307)	Other liabilities	(1,307)	0
(4,380)	**Non-current liabilities**	**(4,380)**	**0**
275,619	**Net assets employed**	**268,672**	**(6,947)**
489,836	Public dividend capital	489,836	0
(275,395)	Retained earnings	(282,300)	(6,902)
61,181	Revaluation reserve	61,136	(45)
275,619	**Total taxpayers' equity**	**268,672**	**(6,947)**

1. Non-current assets are £1.5m lower than year end, being the net impact of investment expenditure of £1.8m and £3.3m depreciation.

2. In month 2 the Trust has net current liabilities of £7.4m.

3. Trade and other receivables are £33.3m (87% of one month's income); £16.8m (50%) relates to invoices raised and awaiting payment.

4. Cash has decreased by £14.9m due to payment of prior year capital creditors (approx. £7.7m) and the I&E deficit (£6.9m).

5. Trade and other payables are £50.2m (122% of one month's expenditure); £27.5m (55%) relates to invoices received and awaiting payment

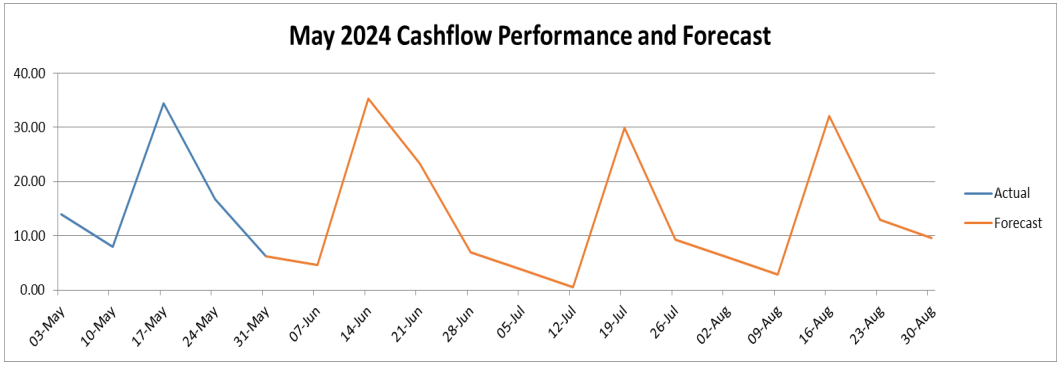
5. Cash

Due to the continuing deficit the Trust has now utilised all brought forward cash reserves. As costs are still forecast to continue in excess of income this means the Trust is required to access revenue support PDC to enable payments to staff and suppliers when due. Trusts in deficit have this option up to the value of their reported annual forecast at a cost of 3.5% dividend per annum; in addition, there is a negative impact on dividends retaining a low cash balance, i.e. low levels of cash increase the dividend payable.
The full cash support is planned mainly for Q1 and 2, at which point efficiency plans should take effect and enable the Trust to operate on a cash basis without support. If efficiency plans do not deliver then the overall revenue forecast would need to be revised quickly in order for the Trust to access further cash support.

It is an NHSE requirement of the cash support for the committee to be sighted on a 13-week cash flow (and as part of RSP, a rolling 12-month cash flow forecast) and to ensure that cash is a high priority in business activities and decisions being made, e.g. when agreeing to pay contracts in advance, creditor terms outside of standard NHS 30 days, billing for services provided regularly and efficiently, etc.

13 Week Forecast w/e

	Actual					Forecast												
£m	03/05/24	10/05/24	17/05/24	24/05/24	31/05/24	07/06/24	14/06/24	21/06/24	28/06/24	05/07/24	12/07/24	19/07/24	26/07/24	02/08/24	09/08/24	16/08/24	23/08/24	30/08/24
BANK BALANCE B/FWD	**17.67**	**13.94**	**7.94**	**34.40**	**16.74**	**6.19**	**4.64**	**35.30**	**23.28**	**6.93**	**3.72**	**0.56**	**29.88**	**9.29**	**6.05**	**2.89**	**32.11**	**12.88**
Receipts																		
NHS Contract Income	0.00	0.00	33.66	0.18	0.00	0.00	34.53	0.00	0.00	0.00	0.00	38.58	0.00	0.00	0.00	34.75	0.00	0.00
Other	0.27	0.22	0.57	0.28	0.31	1.14	0.48	0.25	0.54	0.25	0.31	0.47	0.54	0.25	0.31	0.47	0.54	0.25
Total receipts	**0.27**	**0.22**	**34.23**	**0.47**	**0.31**	**1.14**	**35.01**	**0.25**	**0.54**	**0.25**	**0.31**	**39.06**	**0.54**	**0.25**	**0.31**	**35.22**	**0.54**	**0.25**
Payments																		
Pay Expenditure (excl. Agency)	(0.48)	(0.50)	(2.56)	(15.19)	(7.03)	(0.49)	(0.45)	(11.06)	(13.89)	(0.46)	(0.46)	(4.19)	(21.07)	(0.49)	(0.46)	(0.46)	(24.35)	(0.49)
Non Pay Expenditure	(1.58)	(2.66)	(4.90)	(2.72)	(3.54)	(1.11)	(3.73)	(4.44)	(3.00)	(3.00)	(3.00)	(5.04)	(3.00)	(3.00)	(3.00)	(5.04)	(10.00)	(3.00)
Capital Expenditure	(1.95)	(3.05)	(0.31)	(0.16)	(0.28)	(1.09)	(0.18)	(1.02)	0.00	0.00	0.00	(0.50)	0.00	0.00	0.00	(0.50)	0.00	0.00
Total payments	**(4.01)**	**(6.21)**	**(7.77)**	**(18.06)**	**(10.86)**	**(2.69)**	**(4.35)**	**(16.51)**	**(16.89)**	**(3.46)**	**(3.46)**	**(9.74)**	**(24.07)**	**(3.49)**	**(3.46)**	**(6.01)**	**(34.35)**	**(3.49)**
Net Receipts/ (Payments)	**(3.73)**	**(6.00)**	**26.46**	**(17.59)**	**(10.54)**	**(1.55)**	**30.66**	**(16.26)**	**(16.35)**	**(3.21)**	**(3.16)**	**29.32**	**(23.53)**	**(3.24)**	**(3.16)**	**29.21**	**(33.81)**	**(3.24)**
Funding Flows																		
DH Revenue Support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	4.24	0.00	0.00	0.00	0.00	2.93	0.00	0.00	0.00	14.59	0.00
Working Capital Support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	0.00	(0.08)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**0.00**	**(0.08)**	**0.00**	**0.00**	**0.00**	**4.24**	**0.00**	**0.00**	**0.00**	**0.00**	**2.93**	**0.00**	**0.00**	**0.00**	**14.59**	**0.00**
BANK BALANCE C/FWD	**13.94**	**7.94**	**34.40**	**16.74**	**6.19**	**4.64**	**35.30**	**23.28**	**6.93**	**3.72**	**0.56**	**29.88**	**9.29**	**6.05**	**2.89**	**32.11**	**12.88**	**9.64**



The overall cash balance has decreased by £8.1m in May.

£35.3m of cash was received in month

£35.8m NHS contract income for the month and £1.5m cash receipts in relation to trading activities and settlement of prior period sales invoices.

£43.4m of cash was paid out by the Trust in month

£15.6m (36%) in direct salary costs to substantive and bank employees.

£10.2m (23%) employer costs to HMRC and NHSP.

£17.6m (41%) in supplier payments, including NHSR, Agency staff, capital and revenue non-pay.

6. Risks

An improvement of £1.1m has been requested from the Trust in its annual plan; this changes the most recently submitted plan to a deficit of £27.8m. The ongoing risks to delivery of the plan include:

- Full Identification, development, implementation and delivery of the efficiencies programme for 2024/25.
- Management and reduction of temporary staffing.
- Implementation of enhanced financial controls.
- Delivery of ERF activity.
- Impact of the cash balance if the plan is not delivered.
- Constrained capital allocation.

Progress continues with the counter measures as part of the Sustainability breakthrough objectives; monitoring and reporting of risks is provided to the Executive team.

7. Conclusions

The Finance, Performance and Planning Committee is asked to note the report and financial performance, which is a £3.3m deficit in-month being £0.2m favourable to plan; year to date the Trust is reporting on plan.

For the year ahead, the Trust must implement effective control processes to manage the run-rate, as well as identify efficiencies and reduce waste in order to deliver sustainable financial performance and the £27.8m deficit plan.

Paul Kimber
Acting Chief Financial Officer
June 2024

Patient FIRST

NHS
Medway
NHS Foundation Trust

Annual report 2023-24

Best of care
Best of people

Medway NHS Foundation Trust

Annual Report and Accounts

April 2023 to March 2024

Accounts are prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

Foreword from the Chief Executive

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

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

Patient First

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

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

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

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

More Care Closer to Home

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

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

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

Regulator Inspections

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

Harnessing Technology to Improve Care

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

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

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

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

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

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

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

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

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

……..
Jayne Black
Chief Executive

Foreword from the Chair

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

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

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

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

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

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

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

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

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

……

Mark Spragg
Chair

Performance Report

Overview

Purpose and Activities

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

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

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

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

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

Brief History

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

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

Key Issues and Risks

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

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

Going Concern

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

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

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

Summary of Performance

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

Key Performance Measures

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

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

Referral to Treatment (RTT)

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

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

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

DM01

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

Cancer

2023/24 Cancer Waiting Times Performance

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

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

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

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

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

Emergency Care Standard

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

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

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

Sustainability Report

The Trust's Carbon Footprint

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

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

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

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

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

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

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

The programme of works is a complex undertaking and will be carried out over two financial years, 2024/25 and 2025/26.

The Trust embeds sustainability into its operation through the implementation of its Green Plan. Introduced during the 2020-21 period, and endorsed by the Board, the Green Plan provides an organisation-wide strategy that outlines the Trust's plan of action that is necessary to achieve the targets within the Greener NHS Net Zero Programme. Progress on delivery of the Green Plan is provided to the Board through an annual summary report. Managements role in assessing and managing climate-related issues and the structure has been approved at Board level.

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

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

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

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

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

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

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

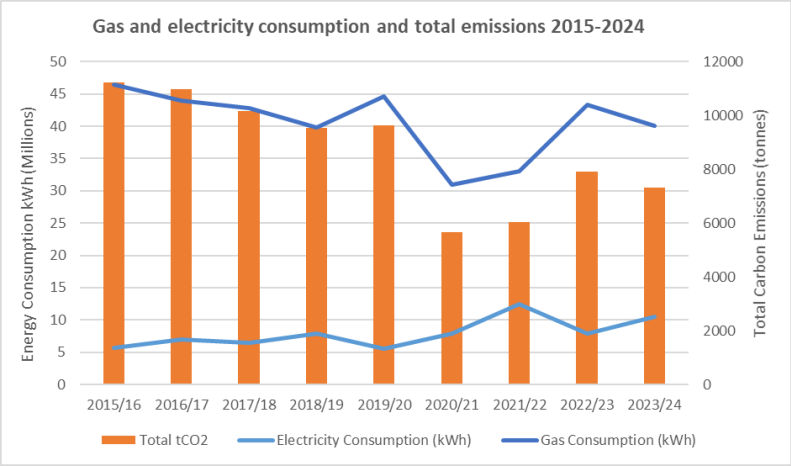
During the most recent year, 2023/24, the Trust spent a total of around £8.2million on electricity and gas. This increase in spending can be attributed to rising energy costs. Supply pressures on gas and generated electricity have directly resulted in significant increases in the unit costs charged by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

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

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

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

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



Community Engagement, Human Rights and Anti Bribery

Community Engagement

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

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

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

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

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

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

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

The Trust held its Annual Members' Meeting in September 2023; the Trust invites the community, alongside Governors, members and staff.

The Trust continues to build on community engagement and provides opportunities to engage with the wider community groups in areas that are harder to reach. This will ensure the Trust continues to learn and discover the amazing work that is taking place in the local community, and ensure community voices heard will be at the Trust.

Anti-Bribery and Fraud

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

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

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

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

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

Equality, Diversity and Human Rights

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

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

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

The Trust has also continued to develop its policies and procedures to promote equality of opportunity and outcomes. In this past year this has included strengthening the Trust's approach to Equality Impact Assessments, revising and extending the Reasonable Adjustment and Modified Duties Policy, and developing a comprehensive Anti-bullying, Harassment, Discrimination and Conflict Resolution Policy. The latter policy is supported by the development of a team of Dignity at Work Advisors,

drawn from a wide range of job roles and diverse backgrounds. 25 Advisors have been independently trained to support and advise staff who raise concerns about issues of dignity and discrimination at work.

Gender Pay Gap

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

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

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

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

Overview of Financial Performance

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

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

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

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

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

Income

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

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

Expenditure

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

in the current and preceding financial year), £2.4m on drugs costs (activity and inflation), £5.2m on premises (maintenance, repairs and cleaning) and £0.8m on clinical negligence insurance premiums.

Capital Expenditure Plan

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

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

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

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

Cash Flow and Balance Sheet

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

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

Financial Outlook

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

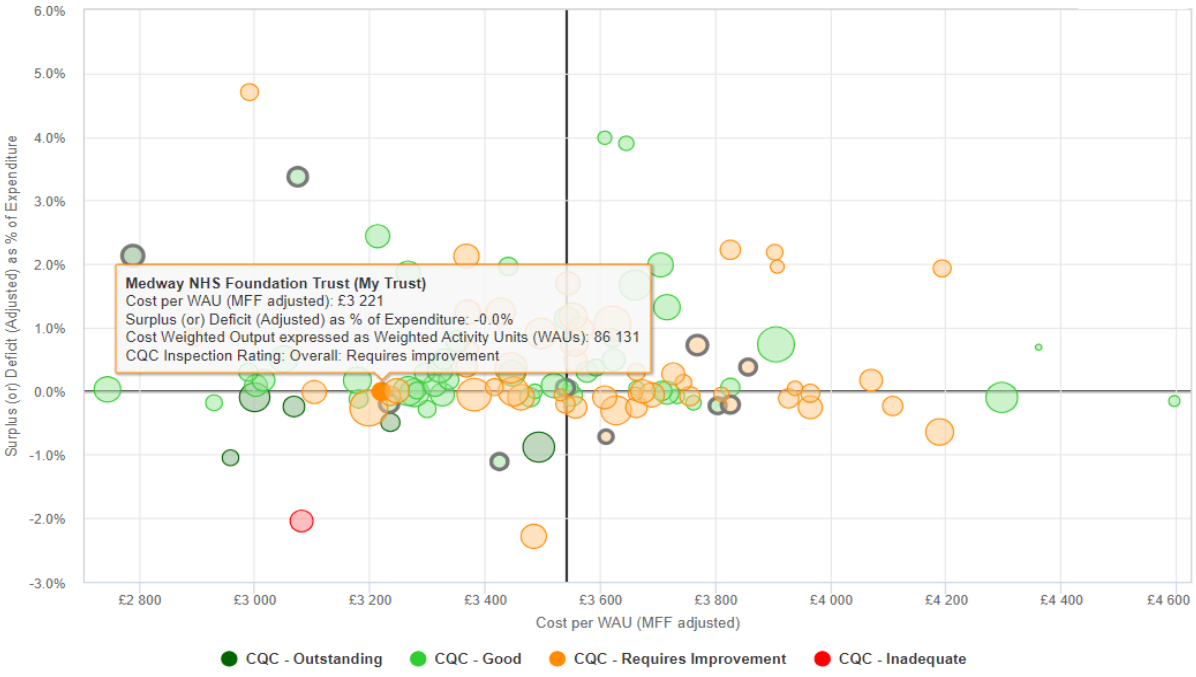
There are a number of key risks to the overall 2024/25 plan, each of which are high on the agenda of the Board. Specifically:

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

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

From nationally collected data it is known that in recent years the Trust has improved its efficiency position relative to Trusts up and down the country. This is represented by the chart below sourced

from the national model health system data. The Trust's cost per 'weighted activity unit' has reduced each year from a high of £3,832 in 2016/17 to £3,221 in 2021/22 (the last available period).



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

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

Overseas Operations JAYNE BLACK TO SIGN THIS SECTION

The Trust does not have any overseas operations.

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

Signed

ADD SIGNATURE AT FINALISATION

……..
Jayne Black
Chief Executive
DATE TBC 2024

Accountability Report

Directors' Report

Board of Directors

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

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

The Trust Board

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

Trust Board Governance

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

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

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

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

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

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

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

Board Appointments and Leavers

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

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

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

Decisions Delegated to the Executive Group

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

Statement about the Balance, Completeness and Appropriateness of the Board

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

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

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

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

Directors of Medway NHS Foundation Trust 2023/24

Non-Executive Directors

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

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

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

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

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

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

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

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

Experience and Qualifications
Practising Veterinary Surgeon, Graduate of the Royal Veterinary College.
BSc (Hons) in Physiology from King's College, London.
Former Veterinary Advisor for pharmaceutical company – developed an interest in the development of antimicrobial resistance and the strategies that can be used to slow this process.
Case examiner for the Royal College of Veterinary Surgeons Preliminary Investigation Committee from 2015.
Chair, Fitness to Practise Panel for the Nursing and Midwifery Council from 2017
Member - Institute of Chartered Accountants in England and Wales investigating Committee 2018.

Promotes responsible antibiotic use and infection control strategies through his work with the Bella Moss Foundation.
Assists in development of educational resources for the veterinary profession as a volunteer for the British Small Animal Veterinary Association.

Membership of Committees

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

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

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

Membership of Committees

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

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

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

Membership of Committees

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

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

Experience and Qualifications
Worked more than 35 years in a variety of healthcare settings, gaining wide experience across acute and community services. Held several senior/executive posts, including Director of Midwifery and Childrens' Services, Executive Director Nursing and Director of the Pan London Maternity Service Review. A leadership and management consultant and has spent a great deal of time mentoring and coaching individuals to help them reach their full potential.

Received a Silver Award for excellence in healthcare. In 2002, her charitable and leadership work was recognised by her receiving the European Social and Humanitarian award. In October 2022, she received the Zenith Global Healthcare Award as special recognition for global healthcare work.
Nominee for Nurse of the Year by the Jamaican Times UK Community Award in 2014.
Awarded an MBE in the Queen's Birthday Honours List in June 2014 for work and contribution to nursing and charity work.

Membership of committees

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

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

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

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

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

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

Membership of Committees

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

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

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

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

Membership of Committees

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

Non-voting Associate Non-Executives:

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

Executive Directors

Jayne Black, Chief Executive

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

Alan Davies, Chief Financial Officer

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

Leon Hinton, Chief People Officer

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

Evonne Hunt, Chief Nursing Officer (on secondment)

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

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

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

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

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

Alison Davis, Chief Medical Officer (and Caldicott Guardian)

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

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

Nick Sinclair, Chief Operating Officer (from April 2023)

Experience and Qualifications
Nick Sinclair was appointed as the Chief Operating Officer in April 2023. Nick trained as a Paramedic in Kent in 1994 and specialised in trauma management and urgent care. He held several operational and educational management roles within the ambulance service. He then moved to the acute sector leading significant improvement in Emergency Care standards and RTT performance and has held various senior leadership roles in operations.

He is a graduate from the Elizabeth Garrett Anderson, Masters in Healthcare Leadership programme and has qualified as a Service Improvement Practitioner.

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

Experience and Qualifications

Gavin trained as a registered nurse in Scotland and specialised in critical care. He has held several senior management positions in England and Wales in acute hospitals, integrated care organisations and with an NHS regulator.

He is a graduate from the national chief operating officer programme and has held several Board roles across England and Wales.

He holds a Masters degree in leadership and management, has a diploma in health emergency planning and is a quality improvement and service redesign practitioner.

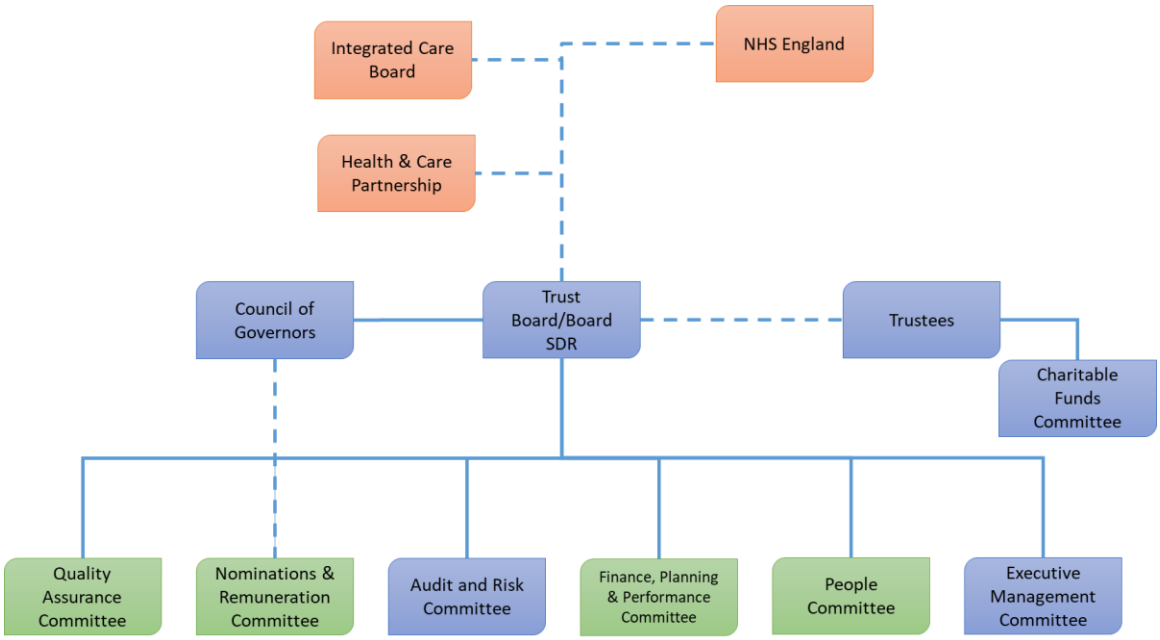
Trust Board Meetings

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

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

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

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



Committee Structure

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

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

of all activities within the Trust, and ensures compliance with regulatory requirements and best practice with patient safety, patient experience and clinical effectiveness.

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

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

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

Finance, Planning and Performance Committee

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

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

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

People Committee

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

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

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

Nominations and Remuneration Committee

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

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

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

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

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

Audit and Risk Committee Report

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

PRINCIPLES OF RESPONSIBILITY

Review of the Trusts Risk Management Processes

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

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

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

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

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

Financial Matters

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

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

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

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

External Audit

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

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

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

a) Basis for concluding that the Trust is a going concern.
b) External auditor effectiveness and independence.
c) External auditor reports on planning, a risk assessment, internal control and value for money reviews.
d) External auditor recommendations for improving the financial systems or internal controls.
e) Changes to Accounting Standards.

Internal Audit

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

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

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

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

Composition and Meetings

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

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

Code of Governance

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

Effectiveness of the Committee

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

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

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

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

External Audit

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

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

Independence of External Auditor

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

Internal Controls, Internal Audit and Counter-Fraud Services

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

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

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

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

The Head of Internal Audit Opinion 2023/24 was presented to the Audit and Risk Committee on 20 June for the period 01 April 2023 to 31 March 2024. An overall rating of "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. **PAUL KIMBER TO CONFIRM FOLLOWING 20 JUNE AUDIT AND RISK COMMITTEE**

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. **FIRM UP ONCE AUDIT AND RISK COMMITTEE APPROVE 20 JUNE**

Medway NHS Foundation Trust Volunteer Services

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

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

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

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

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

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

The Medway League of Friends

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

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

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

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

Governors' Report

Council of Governors

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

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

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

Membership of the Council of Governors

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

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

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

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

Elected Governors	Number
Medway	9
Swale	4
Rest of England and Wales	1

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

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

Meetings of the Council of Governors

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

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

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

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

Lead Governor

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

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

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

Committee of the Council of Governors

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

Attendance at Public Council of Governor Meetings

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

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

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

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

Dispute Resolution Process

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

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

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

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

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

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

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

Membership

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

Staff membership is available for staff members employed by the Trust if they have a permanent contract, a 12 month or longer fixed term contract (or less than 12 months, but have been in post for at least 12 months), have an honorary contract or are registered volunteers of the Trust and have been volunteering for at least 12 months. Staff members will automatically become members of the Trust in the 'Staff' constituency unless they opt out. If a staff member has public membership, the public membership will end.

In February 2024, the Trust had approximately 6,500 public members and 5,100 eligible staff members (total - 11,600) members. The breakdown of the public membership by constituency is:

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

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

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

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

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

Disclosures

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

Principal Activities of the Trust

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

Going Concern

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

Directors' Responsibilities

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

Safeguarding External Auditor Independence

This is detailed under the Audit and Risk Committee section.

Off Payroll Engagements

Information about off-payroll engagements can be found below.

Transactions with Related Parties

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

Political Donations

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

Statement on Better Payment Practice Code

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

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

Fees and Charges (Income Generation)

Please refer to the Annual Accounts.

Income Disclosures Required by Section 43 of the NHS Act 2006

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

NHS England Well-Led Framework
The CQC Well Led inspections involve an assessment of:

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

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

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

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

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

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

- Development of services and improvements to patient care
- Performance against key healthcare targets
- Monitoring of improvements in the quality of healthcare and the meeting of national and local targets, incorporating the Care Quality Commission assessments and reviews of the organisation and its responses to recommendations.
- Agreed targets with local commissioners, and details of key quality improvements.
- New and revised services
- Improvements in service following staff and patient surveys
- Improvements in patient/carer information
- Complaints handling

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

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

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

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

Statement as to Disclosure to Auditors

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

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

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

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

Signed

ADD SIGNATURE AT FINALISATION

……..
Jayne Black
Chief Executive
DATE TBC 2024

Remuneration Report

Annual Statement on Remuneration

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

Senior Managers Remuneration Policy

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

Director salaries were within benchmarked salary ranges. When new appointments are made the salary is determined by reference to the NHS England and NHS Providers benchmarking of executive director salaries, current market rates and internal relativities with executive directors/very senior managers. The only non-cash elements of executive remuneration packages are pension-related benefits accrued under the NHS Pensions Scheme. Contributions are made by both the employer and employee in accordance with the rules of the national scheme, which applies to all NHS staff under the scheme.

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

Salaries and Pension Entitlements of Senior Managers

Salaries and Allowances

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

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

M Spragg	Non-Executive Director	01/04/2023 – 31/10/2023	5-10	-	-	5-10	10-15	300	-	10-15
A Ward	Non-Executive Director		10-15	200	-	10-15	10-15	-	-	10-15
J Chong	Non-Executive Director		5-10	-	-	5-10	5-10	-	-	5-10
J Black	Chief Executive		195-200	-	-	195-200	180-185	-	-	180-185
A Davies	Chief Financial Officer		145-150	-	-	145-150	135-140	-	30-32.5	165-170
A Davis	Chief Medical Officer		225-230	-	-	225-230	220-225	-	50-52.5	270-275
L Hinton	Chief People Officer		130-135	-	45-47.5	175-180	120-125	-	40-42.5	160-165
E Hunt	Chief Nursing Officer	01/04/2023 – 03/12/2023	135-140	-	-	135-140	125-130	-	50-55	180-185
G MacDonald	Chief Operating/Delivery Officer		195-200	-	-	195-200	-	-	-	-
N Sinclair	Chief Operating Officer	From 03/04/2023	130-135	-	175-180	310-315	-	-	-	-
S Vaux	Chief Nursing Officer (Interim)		125-130	-	-	125-130	-	-	-	-

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

Total Pension Entitlement

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

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

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

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

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

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

Staff Costs

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

These figures have been audited.

Expenses of Governors and Directors

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

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

Fair Pay Multiple

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

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

	2023/24		
	25th Percentile	**Median**	**75th Percentile**
Salary Component of remuneration (£)	22,816	30,639	43,742
Total Contractual Remuneration (£)	22,816	30,639	42,618
Ratio (mid pint of highest paid director / total remuneration values	**9.97:1**	**7.43:1**	**5.33:1**

	2022/23		
	25th Percentile	**Median**	**75th Percentile**
Salary Component of remuneration (£)	21,730	29,180	41659
Total Contractual Remuneration (£)	21,730	29,180	40,588
Ratio (mid pint of highest paid director / total remuneration values	**10.24:1**	**7.63:1**	**5.48:1**

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

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

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

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

These figures have been audited.

Expenditure on Consultancy

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

Signed

ADD SIGNATURE AT FINALISATION

……..
Jayne Black
Chief Executive
DATE TBC 2024

Staff Report

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

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

These figures have been audited.

Employees by Gender and Sex – Male and Female Employees

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

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

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

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

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

Staff Group	2023/24	2022/23
	% of available FTE lost	% of available FTE lost
Additional professional, scientific and technical	**3.77%**	**4.81%**
Additional clinical services	**6.77%**	**7.13%**

Administrative and clerical	**4.22%**	**4.03%**
Allied health professionals	**3.85%**	**3.46%**
Estates and ancillary	**7.78%**	**7.41%**
Healthcare scientists	**0.27%**	**2.12%**
Medical and dental	**1.85%**	**2.15%**
Nursing and midwifery registered	**4.64%**	**5.29%**
Students	**0.00%**	**0.00%**

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

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

National NHS Staff Survey 2023

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

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

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

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

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

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

The seven People Promises:

Response Rate

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

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

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

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

Application of Modern Slavery Act

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

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

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

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

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

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

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

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

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

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

The Trusts approach to procurement and its supply chain includes:

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

Trade Union Facility Time

Trade Union Facility Time Disclosures

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

Table 1 – Relevant Union Officials

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

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

Table 2 - Percentage of time spent on facility time

How many of your employees who were relevant union officials during the relevant period spent:

a) 0%, b) 1% - 50%, c) 51% - 99% or d) 100% of their working hours on facility time?

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

Table 3 - Percentage of pay bill spent on facility time

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

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

Table 4 – Paid trade union activities

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

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

Staff Exit Packages

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

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

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

These figures have been audited 2023/24

Staff Policies

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

Policies and Standard Operating Procedures (SOP):

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

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

Code of Governance for NHS Provider Trusts

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

Code of Governance for NHS Provider Trusts - Self Assessment

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

A2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.	Comply
A2.7	The chair and board should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of all stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.	Comply
A2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	Comply
A2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	Comply
A2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement (directors are required to declare any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services. The trust must enter these into a register available to the public in line with Managing conflicts of interest in the NHS: Guidance for staff and organisations. In addition, NHS foundation trust directors have a statutory duty to manage conflicts of interest. In the case of NHS trusts, certain individuals are disqualified from being directors on the basis of conflicting interests).	Comply
A2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.	Comply
B2	**Provisions**	
B2.1	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	Comply
B2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.	Comply
B2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.	Comply
B2.4	A foundation trust chair is responsible for ensuring that the board and council work together effectively.	Comply

B2.5	The chair should be independent on appointment when assessed against the criteria set out in provision 2.6 below. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	Comply
B2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	Comply
B2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	Comply
B2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	Comply
B2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.	Comply
B2.10	Only the committee chair and committee members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	Comply
B2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the Chair appraisal framework.	Comply
B2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.	Comply
B2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	Comply

B2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on material additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.	Comply
B2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	Comply
B2.16	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, request further information if necessary, and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	Comply
B2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.	Comply
C2	**Provisions**	
C2.1	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust, and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the foundation trust should engage with NHS England to agree the approach.	Comply
C2.2	There may be one or two nominations committees. If there are two, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.	Comply
C2.3	The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.	Comply
C2.4	The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.	Comply
C2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	Comply
C2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have	Comply

	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.	
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	Comply

	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.	
C4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	Comply
C4.3	Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.	Comply
C4.4	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.	Comply
C4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.	Comply
C4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.	Comply
C4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	Comply
C4.8	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: Holding the non-executive directors individually and collectively to account for the performance of the board of directors communicating with their member constituencies and the public and transmitting their views to the board of directors contributing to the development of the foundation trust's forward plans. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.	Comply
C4.9	The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest that prevents the proper exercise of their duties. This should be shared with governors.	Comply

C4.10	In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where it has imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.	Comply
C4.11	The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	Comply
C4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	Comply
C4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.	Comply
C5	**Development, information and support**	
C5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors, and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.	Comply
C5.2	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. Directors should also be familiar with the integrated care system(s) that commission material levels of services from the trust. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.	Comply
C5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	Comply
C5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors.	Comply

	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.	
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	Comply

	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.	
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 • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if	Comply

	the external auditor provides non-audit services.	
D2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services. The council of governors is responsible for appointing external governors.	Comply
D2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Comply
D2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	Comply
D2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	Comply
D2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare	Comply
E	**Remuneration**	
E2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions. Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients. Pay-outs or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria that reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed, and must be limited to the lower of £17,500 or 10% of basic salary. For NHS foundation trusts, non-executive terms and conditions are set by the trust's council of governors. The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	Comply
E2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	Comply
E2.3	Where a trust releases an executive director, eg; to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Comply
E2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate	Comply

	loss. Appropriate claw-back provisions should be considered where a director returns to the NHS within the period of any putative notice.	
E2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity (severance payment includes any payment whether included in a settlement agreement or not, redundancy payment, a secondment arrangement, pay in lieu of notice, garden leave and pension enhancements).	Comply
E2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.	Comply
E2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.	Comply
E2.8	The council of governors is responsible for setting the remuneration of a foundation trust's non-executive directors and the chair.	Comply
AB2.1	The council of governors should meet sufficiently regularly to discharge its duties. Typically the council of governors would be expected to meet as a full council at least four times a year. Governors should make every effort to attend these meetings. The NHS foundation trust should take appropriate steps to facilitate attendance.	Comply
AB2.2	The council of governors should not be so large as to be unwieldy. The council of governors should be of sufficient size for the requirements of its duties. The roles, structure, composition and procedures of the council of governors should be reviewed regularly.	Comply
AB2.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Comply
AB2.4	The roles and responsibilities of the council of governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the council of governors towards members and other stakeholders and how governors will seek their views and keep them informed.	Comply
AB2.5	The chair is responsible for leadership of both the board of directors and the council of governors but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive and other executives and non-executives, as appropriate, to their meetings. In these meetings other members of the council of governors may ask the chair or their deputy, or any other relevant director present at the meeting, questions about the affairs of the NHS foundation trust.	Comply
AB2.6	The council of governors should establish a policy for engagement with the board of directors for those circumstances where they have concerns about the performance of the board of directors, compliance with the provider licence or other matters related to the overall wellbeing of the NHS foundation trust and its collaboration with system partners. The council of governors should input to the board's appointment of a senior independent director.	Comply
AB2.7	The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective, in particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear, unambiguous language.	Comply
AB2.8	The council of governors should only exercise its power to remove the chair or any non-executive directors after exhausting all means of engagement with the board of	Comply

	directors. The council should raise any issues with the chair with the senior independent director in the first instance.	
AB2.9	The council of governors should receive and consider other appropriate information required to enable it to discharge its duties, e.g. clinical statistical data and operational data.	Comply
AB2.10	The chair (and the senior independent director and other directors as appropriate) should maintain regular contact with the governors to understand their issues and concerns.	Comply
AB2.11	Governors should seek the views of members and the public on material issues or changes being discussed by the trust. Governors should provide information and feedback to members and the public at large regarding the trust, its vision, performance and material strategic proposals made by the trust board.	Comply
AB2.12	It is also incumbent on the board of directors to ensure governors have the mechanisms in place to secure and report on feedback that enables them to fulfil their duty to represent the interests of members and the public at large.	Comply
AB2.13	The chair should ensure that the views of governors and members are communicated to the board as a whole. The chair should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors and should expect to attend them if requested to do so by governors. The senior independent director should attend sufficient meetings with governors to hear their views and develop a balanced understanding of their issues and concerns.	Comply
AB2.14	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	Comply
AB2.15	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg; through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Comply
Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Comply

NHS System Oversight Framework

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

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

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

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

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

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

Statement of the Chief Executive's responsibilities as the Accounting Officer of Medway NHS Foundation Trust JAYNE BLACK TO APPROVE

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of an NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the 'NHS Foundation Trust Accounting Officer Memorandum' issued by NHS England.

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

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

- Observe the accounts direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the Trust's performance, business model and strategy
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable the Trust to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the Trust and for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

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

Signed

ADD SIGNATURE AT FINALISATION

……..
Jayne Black
Chief Executive
DATE TBC 2024

Annual Governance Statement 2023-2024

Scope of responsibility

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

The purpose of the system of internal control

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

Capacity to handle risk

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

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

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

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

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

The risk and control framework

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

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

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

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

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

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

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

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

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

These included:

- Effective mechanisms in place to act upon national safety alerts and recommendations
- The performance management framework, including an Integrated Quality and
- Performance Report across all aspects of the organisation.
- Analysis of patient experience, ward-level performance, incidents and complaints, monthly financial reporting and quality improvement activity
- Assurances provided through the work of the appropriate Risk and Assurance governance routes and reported to the Board and Committees.

- Learning from incidents and near misses and working with system partners to scrutinise response and actions.
- Risk assessments and analysis of risk registers and the Board Assurance Framework.
- Assurance from the Quality and Assurance Committee and the Audit and Risk Committee to the Board.
- Clinical audit, including national audits, audits arising from national guidance (for example from NICE), confidential enquiries and local audits related to patient safety and quality of care.
- Internal assurances through the internal audit activities and independent.
- External regulatory and assessment body inspections and reviews including the Care Quality Commission (CQC), Royal Colleges, Postgraduate Deanery, Information Commissioner's Office and Health and Safety Executive reports.
- Self-assessment against the compliance framework and CQC registration requirements, including well-led reviews.
- Freedom to speak up guardian and guardian of safe working hours (for doctors in training).
- Risk assessments of the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme.

Governance and Well-Led Framework

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

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

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

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

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

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

In the final quarter of the reporting year and in parallel to the internal Well-Led programme the Trust commissioned an independent external audit of its integrated governance and leadership

arrangements. The review generated 15 recommendations and these were captured in an action plan adopted by the Trust Executive Team. Recommendations included:

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

Using its Patient First methodology the trust undertook a full review of its integrated governance structures to reduce duplication, improve integration, and improve the flow of assurance and escalation of issues and risks. This work was completed in April 2024 and is being rolled out across the Trust.

As a result of both the internal Well-Led programme and the actions highlighted in the external audit significant progress has been made to ensure the Trusts integrated governance and leadership arrangements are operating effectively and in line with the national framework.

Quality Governance Arrangements

Annual Quality Account

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

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

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

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

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

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

Assessing the quality of performance information

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

Assurance on compliance with the Health and Social Care Act 2008

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

	Date	Rating
Safe	-	Requires Improvement
Effective	-	Requires Improvement
Caring	-	Good

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

Managing risks to data security

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

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

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

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

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

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

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

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

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

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

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

Register of Interest

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

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

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

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

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

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

Green Plan

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

Emergency Preparedness, Resilience and Response (EPRR)

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

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

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

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

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

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

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

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

Data quality and governance

The quality and assurance teams work closely with colleagues in the business intelligence team to ensure data provided to the Board is validated and accurate. Both teams have a variety of skills and expertise including analytics. This includes oversight by those with expertise in the relevant field; for example, the head of complaints would sign off any complaints data, ensure that correct processes have been applied to reporting the data from the system and that the data set is complete.

The quality and assurance teams collate data monthly from a variety of sources for the executive and trust management meetings and Integrated Quality and Performance Report. Primary sources include the local risk management system, which holds all incident, complaints, legal services, risks and safety alert databases.

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

A range of audits – internal and external – give assurance about the accuracy of data throughout the year. The Trust has a Quality and Patient Safety sub-committee where all data and information relating to quality of care and patient experience is reviewed. The Trust employs rigorous information assurance processes in the production of the monthly Integrated Quality and Performance Report at both clinical group and Trust level, including local and Trust-wide validation of data and national benchmarking where available. The Integrated Quality and Performance Report is published as part of the Board papers and is available on the Trust's website.

Review of Effectiveness JAYNE BLACK TO CONFIRM – ONCE REPORT FINALISED

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit and Risk Committee and its sub-committees and groups and the Quality Assurance Committee and its sub-committees and groups, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

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

The head of internal audit opinion 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. **CONFIRM AFTER 20 JUNE**

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

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

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

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

Conclusion

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

Signed

ADD SIGNATURE AT FINALISATION

……..
Jayne Black
Chief Executive
DATE TBC 2024

Annual Accounts

Medway NHS Foundation Trust

Annual Accounts for the year ended 31 March 2024

Foreword to the accounts

Medway NHS Foundation Trust

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

Signed ……

Name **Jayne Black**
Job title **Chief Executive Officer**
Date

Statement of Comprehensive Income

for the year ended 31 March 2024

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

Statement of Financial Position
as at 31 March 2024

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

The notes on pages 7 to 40 form part of these accounts

Signed .....

Name **Alan Davies**
Position **Chief Financial Officer**
Date

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

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

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

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

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

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

Income and expenditure reserve

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

Statement of Cash Flows

for the year ended 31 March 2024

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

Notes to the accounts

For the year ended 31 March 2024

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

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

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

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

Note 1.3 Revenue from contracts with customers

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

Note 1.3.1 Revenue from NHS Contracts

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

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

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

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

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

Note 1.3.2 Revenue from Research Contracts

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

Note 1.3.3 NHS Injury cost recovery scheme

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

Note 1.3.4 Other income

Education and Training Income

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

Grants and donations

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

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

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

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

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

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

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

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

Subsequent Expenditure

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

Note 1.6.2 Measurement

Valuation

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

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

Current values in existing use are determined as follows:

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

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

All land and buildings are restated to current value using professional valuations in accordance with IAS 16 every five years. A yearly interim valuation is also carried out. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. In accordance with this policy the valuation undertaken for 2023/24 was therefore a desktop revaluation.

The valuation exercise was carried out in March 2024 with a valuation date of 31st March 2024

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

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

Revaluation gains and losses

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

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

Impairments

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

Note 1.6.3 De-recognition

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

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

Note 1.6.4 Donated and grant funded assets

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

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

Note 1.6.5 Useful lives of property, plant and equipment

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

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

Note 1.7 Inventories

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

Note 1.8 Cash and cash equivalents

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

Note 1.9 Financial assets and financial liabilities

Note 1.9.1 Recognition

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

Note 1.9.2 Classification and measurement

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

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

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

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.
Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets the Trust recognises an allowance for expected credit losses.

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

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

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

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

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

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

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

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

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

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

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

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

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 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.

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

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

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

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

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

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

Note 1.12 Contingencies

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

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

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

Note 1.13 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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

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

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

Note 1.14 Value added tax
Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.15 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.
The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

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

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

Note 1.17.1 Sources of estimation uncertainty
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 2023/24.

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

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

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

Note 2 Operating segments

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

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

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

Note 3 Operating income from patient care activities

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

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

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

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

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

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

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

Note 3.2 Income from patient care activities (by source)

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

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

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

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

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

Note 4 Other operating income

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

	2023/24	2022/23

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

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

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

Note 4.2 Transaction price allocated to remaining performance obligations

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

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

Note 4.3 Income from activities arising from commissioner requested services

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

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

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

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

Note 5 Operating expenses

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

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

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

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

[4] Audit Fees are inclusive of VAT.

Note 5.1 Limitation on auditor's liability

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

Note 6 Employee benefits

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

Note 6.1 Directors remuneration and other benefits

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

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

Note 6.2 Retirements due to ill-health

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

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

Note 7 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

c) Alternative pension scheme

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

Note 8 Finance income

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

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

Note 9 Finance expenditure

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

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

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

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

Note 10 Property, plant and equipment

Note 10.1 Property, plant and equipment - 2023/24

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

Note 10.2 Property, plant and equipment - 2022/23

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

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

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

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

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

Note 11 Donations of property, plant and equipment

Note 11.1 Donations

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

Note 12 Revaluations and impairments of property, plant and equipment

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

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

Note 12.1 Revaluations

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

Note 12.2 Impairments

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

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

Note 13 Right of use assets

Note 13.1 Right of use assets 2023/24

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

Note 13.2 Right of use assets 2022/23

Note 13.2 Right of use assets 2022/23

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

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

Note 13.3 Reconciliation of the carrying value of lease liabilities

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

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

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

Note 13.4 Maturity analysis of future lease payments

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

Note 14 Trade and other receivables

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

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

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

Note 14.1 Allowances for credit losses

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

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

Note 15 Inventories

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

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

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

Note 16 Cash and cash equivalents

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

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

Note 17 Trade and other payables

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

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

Note 17.1 Better Payment Practice Code

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

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

Note 18 Other Liabilities

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

Note 19 Borrowings

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

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

Note 19.1 Reconciliation of liabilities arising from financing activities

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

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

Note 20 Provisions for liabilities and charges

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

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

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

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

Note 20.1 Clinical negligence liabilities

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

Note 21 Contingent assets and liabilities

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

Note 22 Financial instruments

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

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

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

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

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

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

Note 22.1 Carrying values of financial assets

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

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

Note 22.2 Carrying value of financial liabilities

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2024		
Loans from the Department of Health and Social Care	1,907	1,907
Obligations under finance leases	1,523	1,523
Trade and other payables excluding non financial liabilities	49,988	49,988
Provisions under contract	998	998
Total at 31 March 2024	54,416	54,416

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

Note 22.3 Maturity of financial liabilities

	2023/24	2022/23
	£000	£000
In one year or less	50,707	45,070
In more than one year but not more than five years	2,004	802
In more than five years	2,109	1,527
Total	**54,820**	**47,399**

Note 22.4 Fair values of financial assets and liabilities

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

Note 23 Losses and special payments

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

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

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

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

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

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

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

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

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

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Health and Safety Annual Report 2023/24

Adam Clark
Health & Safety Manager

CONTENTS

1 Executive Summary

1.1 The purpose of this report is to provide assurance on compliance with legislation and Trust policies to the Health, Safety & Security Group and the Trust Board. Included within the report is statistical analysis and key information regarding Health & Safety (H&S) activity, audit programme and progress, training compliance, reported incidents, RIDDOR and investigation outcomes across MFT, together with monitoring and responding to the health and safety needs of the Trust.

1.2 This is the fifth Health and Safety annual report produced. The report and purpose of it conforms to the Trust's Health and Safety Policy, Safety Representatives and Safety Committees Regulations 1977 and the Health and Safety (Consultation with Employees) Regulations 1996.

1.3 Of the 12 objectives set for 2023/24, 10 were achieved, as set out in Section 4 of the report

2 Introduction

2.1 The Health & Safety annual report covers the period 1st April 2023 to 31st March 2024. The report outlines key developments and the work that has been undertaken during this reporting period, and is an opportunity to consider work planned, and the objectives for the year ahead.

2.2 It reflects the Trust's compliance with the Board of Directors approved 'Statement of Intent' and Health & Safety Policy Statement, which requires those responsible for health and safety within the Trust premises and during Trust activities to:

- Comply with health and safety legislation;
- Implement health and safety arrangements;
- Comply with monitoring and reporting mechanisms appropriate to internal and external key stakeholders and statutory bodies;
- Develop partnership working and to ensure health and safety arrangements are maintained for all
- To ensure that the health and safety agenda is not only embedded, but embraced throughout the Trust using a variety of monitoring methods.

3 Overview of Legal Compliance

3.1 The table below outlines the main health & safety legislation and identifies the reactive and proactive work that the Trust has carried out in order to ensure compliance.

Legislation	Description of Actions/Level of Compliance	
Health & Safety at Work Act 1974	1. The Corporate Health & Safety Policy has been incorporated in to version 1 Health & Safety Handbook 2. Competent persons in place to provide advice. 3. Health, Safety & Security Group held monthly 4. Established Sharps Group	
Management of Health & Safety at Work Regulations 1999	1. Annual H&S Audit programme has recommenced with all priority 1 audits completed by end of the financial year 2.Annual H&S Improvement Plan (BAF) & HSE Action plan 96% complete	
Manual Handling Operations Regulations 1992	1. Training delivered by competent person 2. Some training now aligned to National Back Exchange Standards 3. Outstanding actions for Manual Handling on HSE action plan	
Display Screen Equipment Regulations 1992	1. DSE SOP within H&S handbook and accompanying self-assessment tool updated. 2. Health & Safety Team conduct 1:1 assessments and provide advice on request	

Personal Protective Equipment Regulations 2022	1.PPE SOP incorporated in to version 1 Health & Safety Handbook	
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)	1. Investigations have been implemented for all RIDDOR incidents and the findings are shared with the Health, Safety & Security Group. 2. RIDDOR reporting compliance not 100%	
Health & Safety Information for Employees Regulations (Amendment) 2009 Health & Safety Consultation with Employees Regulations 1996 Safety Representatives and Safety Committees Regulations 1977	1. Terms of reference have been reviewed for the Health, Safety & Security Group. 2. H&S Trade union H&S Reps in place 3. Attendance to the Health, Safety & Security Group is Poor. 5. Reports received on audits, action plan progress, KPIs and risk register 6. Health, Safety & Security Group acts as consultative committee for H&S policies	
Control of Substances Hazardous to Health 2002	1.COSHH audits completed weekly by departments 2. Adhoc spot checks completed by Health & Safety Team 3. H&S engage with departments as requested for product selection and risk assessment.	

4 2023/24 Health & Safety Objective Update

4.1 The achievement of the primary health and safety objectives for the year 2023/2024 are summarised below:

No.	Objective	What was achieved	
1.	Completion of the recruitment programme to bring the Health and Safety Team up to establishment.	Required staff were recruited	
2.	Successful completion of the Health & Safety audit programme in order to identify key themes and trends to inform the work-plan of 2023/24 and 24/25	Priority one audits completed by end of 2023/24 Financial year	
3.	To close-out the action plan for HSE BAF	HSE BAF current at 96% complete. Work is continuing to better engage action owners with a view to closing the final actions	
4.	To close out the action plan for H&S BAF (Workplace Health & Safety Standards Audit)	WHSSA currently at 82% complete, with meeting held with outstanding action owners. Work is continuing to better engage action owners with a view to closing the final actions	
5.	To expand the H&S metrics to include both leading and lagging indicators and to integrate these into the IQPR in order to improve data assurance.	Data fields from a number of Trust systems have been identified and shared with BI to support incorporation in to Governance & Patient Safety Dashboard	
6.	To establish a formal sharps working group with accountability to the Health, Safety & Security Group, in order to ensure robust	Sharps group inaugural meeting held 17th March	

	governance and monitoring arrangements in place.		
7.	To review and update the Health & Safety policy and associated SOPs and to consolidate into a 'Handbook'.	The Health & Safety policy and associated SOPs were consolidated into a 'Handbook'.	
8.	To recommence Health & Safety Keyworker sessions in order that departments have access to H&S advise at support at source.	Training sessions for Health & Safety Keyworkers were presented	
9.	To undertake a gap analysis against the National Back Exchange Standards and to redesign Moving & Handling training provision against the standards, with a plan to be fully aligned within the next 2years.	A gap analysis against the National Back Exchange Standards was completed, aligned with a 2year improvement plan.	
10.	To continue the provision of Moving & Handling training, with a focus being on role-specific training based on risk assessment	Moving & Handling training, with a focus being on role-specific training based on risk assessment is currently being rolled out.	
11.	To work to increase near miss incident reporting to demonstrate positive H&S culture.	A daily cleanse is completed by the Safety Team, which helps identify mis-categorised near misses. Reporting of incidents is also raised during the Safety Audits	
12.	To work with the Integrated Governance Team to re-design the DATIX incident investigation	The Safety Team continue to work with the Integrated Governance Team to re-design	

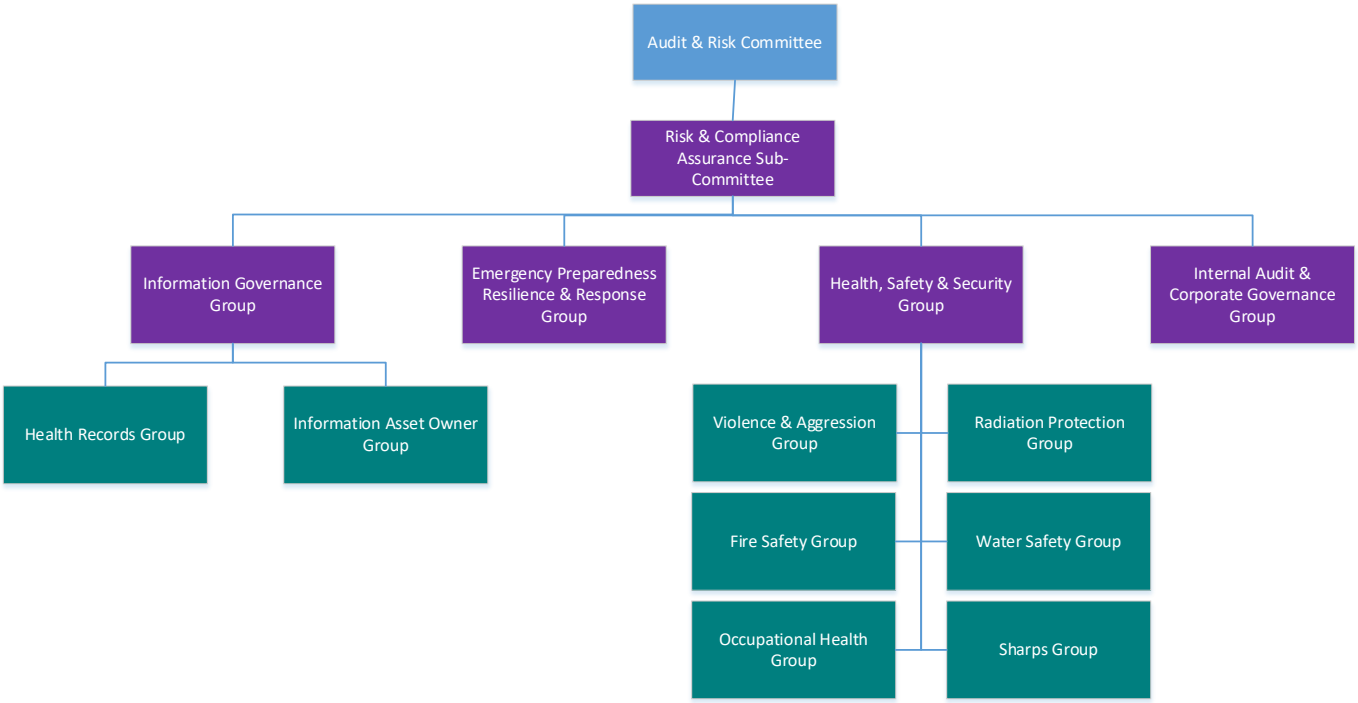
	for sharps, allowing better analysis of data, to understand hot-spots and trends.	the DATIX incident investigation form.	

5 Governance Arrangements

5.1 The Director with delegated responsibility for Health & Safety within the Trust is the Chief Nursing Officer.

5.2 The Health, Safety & Security Group is established on the authority of the Risk, Compliance and Assurance Sub-Committee to assist the Trust Board in fulfilling its responsibilities in relation to the Health and Safety at Work. It will fulfil its purpose by having responsibility for:

- Oversight of the systems and controls governing fire, security and health & safety, reviewing key performance indicators to assess their adequacy and identifying where improvements need to be made.
- Establishing and maintaining standards of health and safety and welfare in keeping with legal requirement and in accordance with Trust policy.
- Providing the Trust with an overarching view of health and safety and to provide assurance that non-clinical risks are effectively manage on behalf of the Trust.



5.3 The Health, Safety & Security Group has 6 established sub-groups, from which assurance and escalation reports are received, these include:

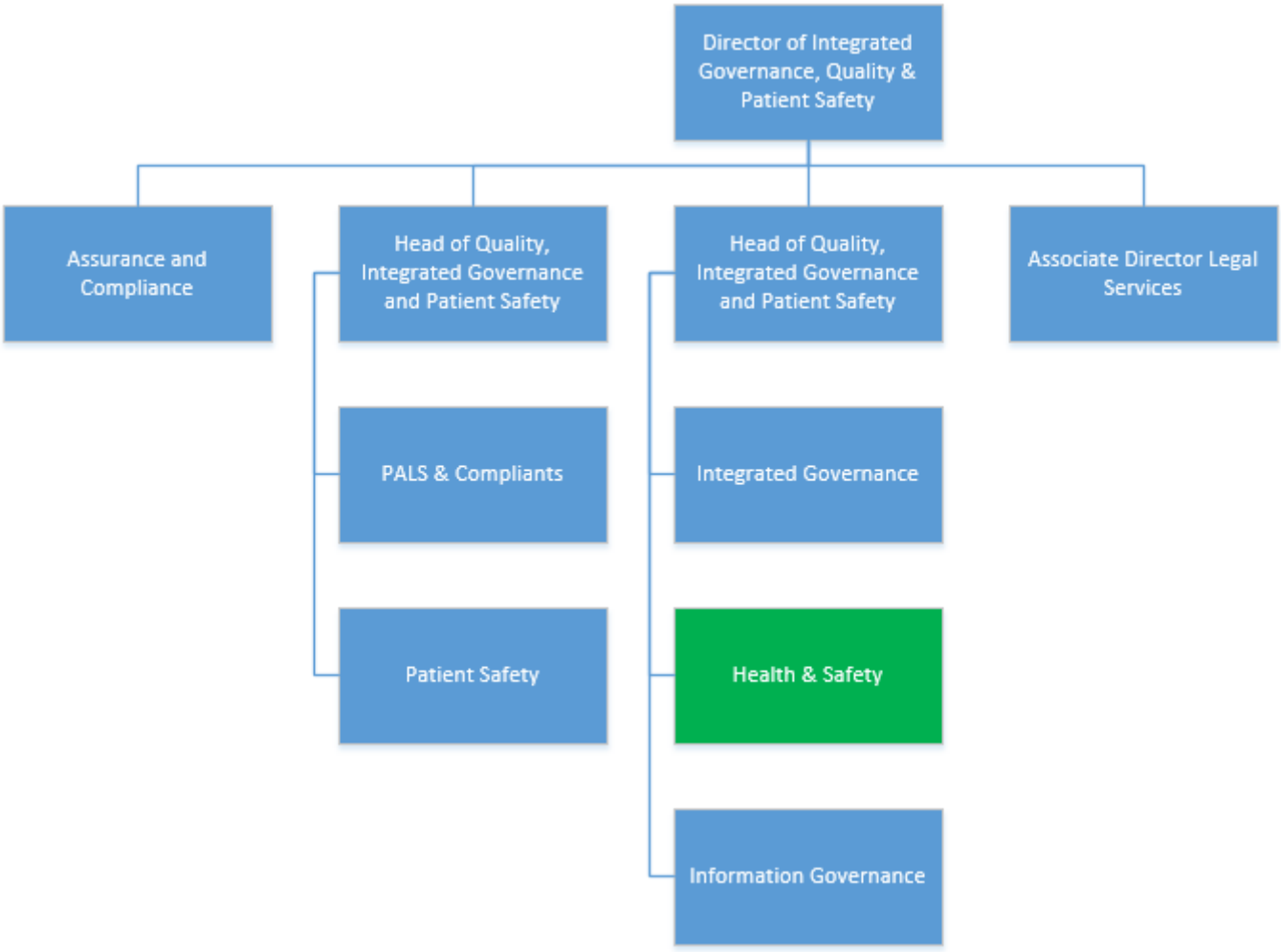
1. Violence & Aggression Group
2. Radiation Protection Group
3. Fire Safety Group
4. Water Safety Group
5. Occupational Health Group
6. Sharps Group

5.4 In addition to receiving reports from established sub-groups, the Health, Safety & Security Group also receives regular reports on topics including:

1. Estates & Facilities compliance (including waste management)
2. Employer liability and public liability claims
3. Wellbeing reports
4. Infection prevention & control

6 Competent Health & Safety Advice

6.1 The Health and Safety Team reports to the Head of Quality & Safety.



The Health and Safety Team consists of:

- Health & Safety Manager
- One Health and Safety Lead
- One Moving & Handling Lead
- Two Health and Safety Officers
- One Health & Safety Administrator

6.2 Regulation 7 of the Management of Health and Safety at Work Regulations 1999 requires organisations to have competent health and safety advice. The organisation has many health and safety risks and regulations that are managed across the organisation. These risks have are monitored through the Health, Safety & Security Group, or other appropriate monitoring arrangements.

6.3 The Health and Safety Team are responsible for advising and guiding the Trust to ensure that it is meeting, or working towards meeting, its legislative requirements. They also provide health and safety competent advice either verbally, via email or as part of an inspection/audit.

6.4 During this period 955 Datix incidents indicated as H&S factors were monitored by the H&S Team with H&S advice given in all incidents.

7 Policies

7.1 Policies and standard operating procedures (SOPs) that were consulted on and approved by the Health, Safety & Security Group include:

- Body Worn Camera Trial Policy
- Switchboard Emergency Bleep Standard Operating Procedure
- Lift 8 and 10 failure protocol- Reviewed (DOC347)
- Lone worker risk assessment – Reviewed (OTCS028)
- Ward Manual Handling Risk Assessment- Not Required (OTCS050)

7.2 The following policies and standard operating procedures (SOPs) were consulted on and incorporated in to version 1 of the Health & Safety Handbook, which was approved by the members of the Health, Safety & Security Group

- POLCS025; COSHH policy
- SOP0394; COSHH Procedure
- SOP0186; Risk Assessment Procedure
- SOP-MMH-DIR-001; Procedure for Dose Monitoring and Control of Staff Who Come into Contact with Ionising Radiation
- SOP0639; Display Screen Equipment (DSE)
- POLCS004; First Aid Policy
- POLCS005; Corporate Health & Safety Policy
- SOP0377; RIDDOR SOP
- POLCS008; Moving & Handling Policy
- SOP005, SOP0112 and SOP0113; Moving & Handling SOPs
- SOP0403; Security self-assessment SOP
- OTCS078; Security self-assessment
- POLCS032; Sanctions & Redress Policy
- Policy for Undertaking a Personal Search & Property

7.3 The following policies and standard operating procedures (SOPs) were consulted on and incorporated into version 1 of the Moving & Handling Handbook, which was approved by the members of the Health, Safety & Security Group:

- Moving & Handling Policy (POLSC008)
- Safe Moving & Handling Practice
- Moving & Handling Risk Assessments
- Equipment Procedure
- Moving & Handling of Bariatric Patient

8 Enforcement Notices and Improvement Plans

8.1 The Health & Safety Executive (HSE) is the regulatory body for Health & Safety legislation for all organisations across the UK.

8.2 The Trust received an improvement notice from the HSE on 23rd May 2022. The notice stated that the Trust was in material breach of Section 2(1) and 3(1) of the Health and Safety at Work Etc. Act 1974 (the Act) and Regulations 3(1) & 5(1) of the Management of Health and Safety at Work Regulations 1999 (the Management Regulations). The actions arising from the notice of contravention related to Security arrangements and Moving & Handling training and competency. The notice of contravention was closed by the HSE in March 2024, following receipt of final supplementary evidence

8.3 Following the notification it was agreed that the Trust should audit itself against the NHS Employers Workplace Health and Safety Standards. A separate action plan was created in line with the audit findings, referred to as the H&S Board Assurance Framework. At the time of reporting the action plan is currently 96% complete, 4% of actions overdue, and therefore requiring additional work to bring the action plan to a close.

9 Changes to Legislation

9.1 The Health & Safety team is responsible for communicating any relevant legislative changes to the Trust Board and staff via the approved governance routes.

9.2 The Health and Safety Executive (HSE) is committed to helping business and other stakeholders adapt to changes in occupational health and safety law and practice in line with Government policy on 'Common Commencement Dates' which are:

- 6th April (the start of the tax year); and
- 1 October.

9.3 The Health & Safety team continue to monitor upcoming legislative changes in order to ensure the Trust remains compliant. Any changes to legislation will be escalated via the Health & Safety governance route.

9.4 No legislative changes have come into effect in 2023/24 which will impact the Trust.

10 Incident Reporting

10.1 Health and Safety Incidents are reported via the incident management system; Datix. The graphs outline the health and safety incidents from April 2023 to March 2024

10.2 In 2023/24 there were 955 incidents indicated as H&S factors in this period, with only 43 near miss incidents. More work is required to increase reporting of near miss incidents as they are opportunities to prevent further H&S incidents and a key indicator of a positive health and safety culture.

Figure 1; Health & Safety Incidents by Month

10.3 Of the 18,435 notifications reported on Datix during the period of April 1st 2023 to March 31st 2024, only 955 related to health and safety (excluding Violence & Aggression). This equates to 5.18% of all incidents.

10.4 The Trust uses the Datix system to act as its digital 'accident book'. The accident book is an essential document for employers and employees, who are required by law to record and report details of specified work-related injuries and incidents. It enables organisations to comply with legal requirements under social security and health and safety legislation, including Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) requirements.

10.5 Historically, reporting of health and safety incidents via Datix has been poor, with a lack of awareness of the importance of reporting incidents, and anecdotal feedback from staff citing inadequate locations and time consuming processes as reasons for not reporting. The Patient Safety team has worked on improving the system by making it easier to log incidents, and creating additional categories to help identify incident types, including health and safety and potential RIDDOR incidents, more readily. In addition, daily data cleanses by the Health & Safety team is identifying incidents where there is a health and safety dimension – for instance, a staff member receiving an injury whilst preventing a patient fall would be missed if it was only considered as a 'patient fall' incident.

10.6 The Health & Safety Manager recently reviewed the Datix reporting process and has taken steps to incorporate a streamlined process for the reporting of Safety Incidents.

10.7 The following data provides a breakdown of the type and cause of health and safety related incidents that have been reported in 2023/24. The previous year's figures are included for comparison.

Figure 2; H&S Incidents by Type

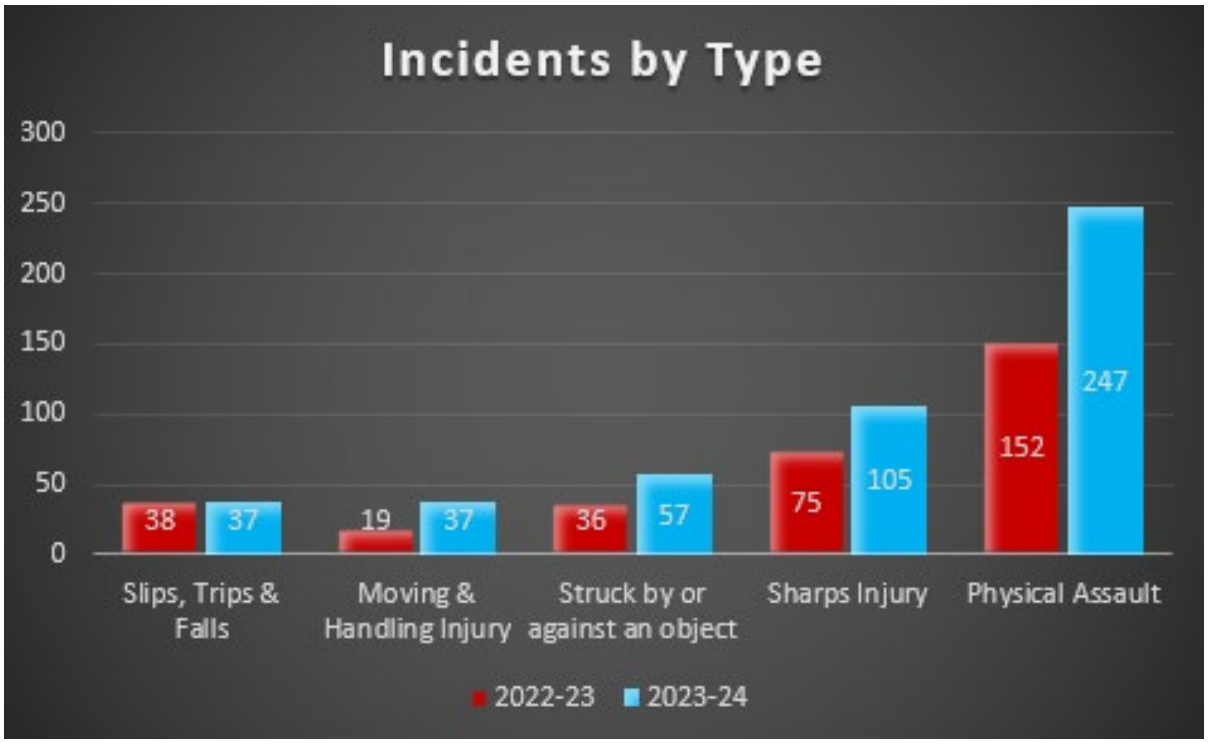
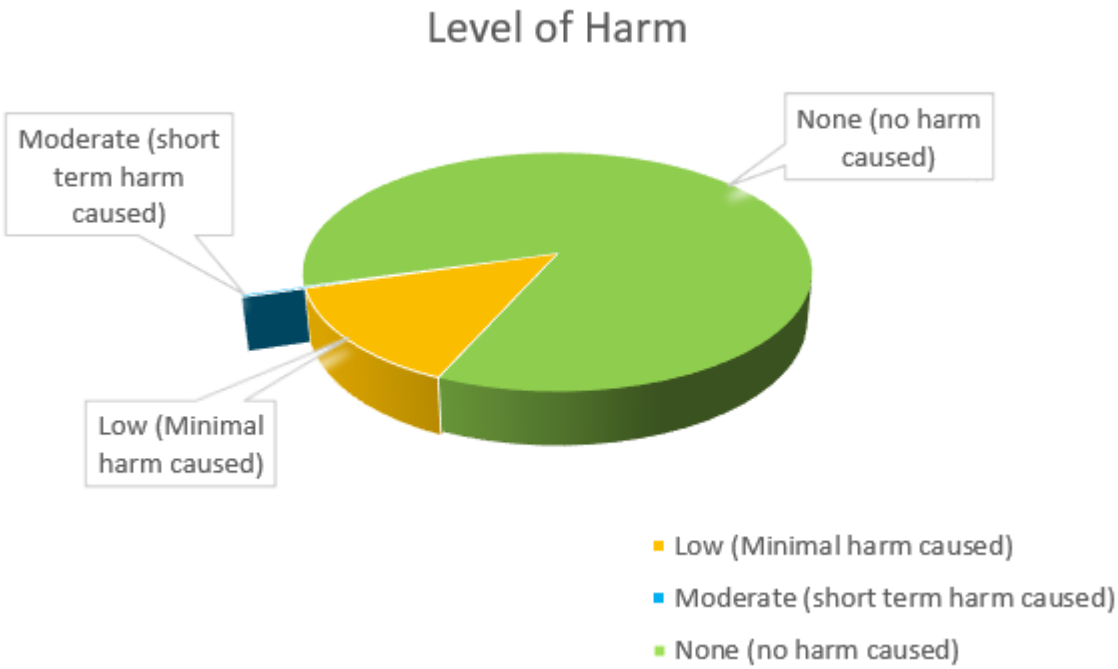


Figure 3; H&S Incidents by Harm Level



10.8 The top two sub categories of incidents have not changed since the previous annual report; they remain physical assaults (see section 14) and injury from sharps.

10.9 Managers investigate incidents, supported by specialists when required, and any trends are

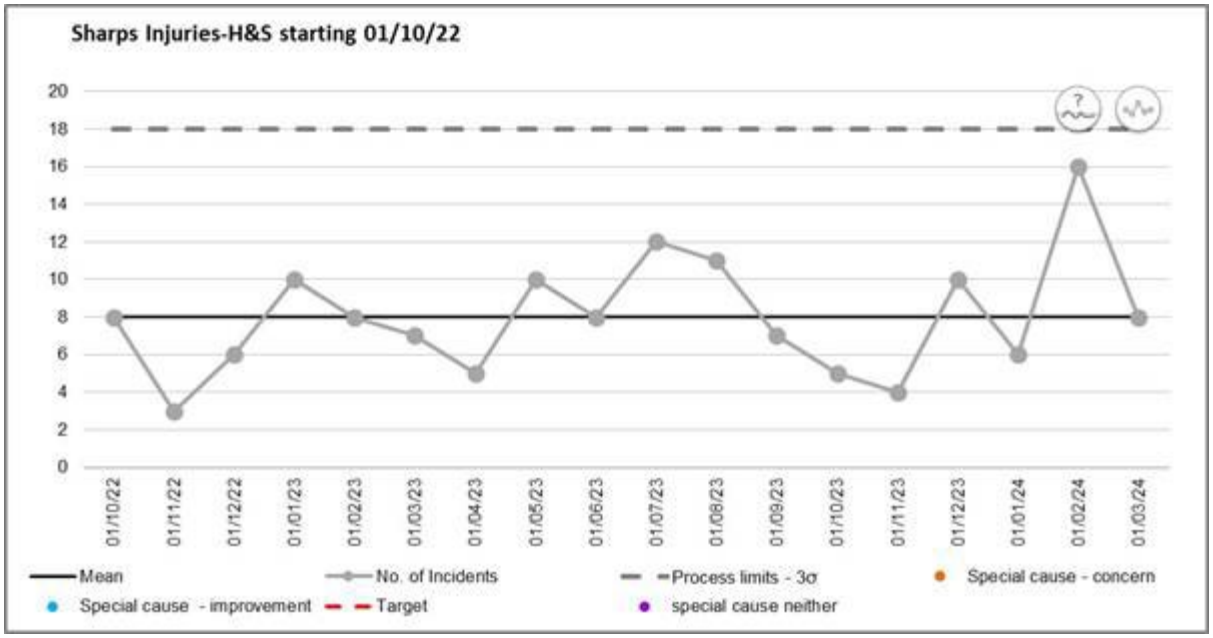
reported to the Health, Safety & Security Group. Any learning is incorporated into H&S audits, advice and training. Only 0.9% of incidents were moderate harm; 13.1% being low and 86% no harm.

11 Sharps Safety

11.1 Injuries caused by sharps devices continue to be one of the categories with the highest number of incidents in the year at 105 incidents.

11.2 Measures to avoid occupational exposure to blood borne viruses including prevention of sharps injuries must include; the safe handling and disposal of sharps. This includes the provision of medical devices that incorporate sharps protection where there are clear indications that they will provide safe systems of working for staff. This is a requirement of the 'Code of Practice on the prevention & control of infections' and 'Sharps Instruments in Healthcare Regulations 2013'.

Figure 4; Sharps injuries by month



11.3 Sharps and contamination injuries are a significant risk in healthcare settings, and the topic is a current area of interest for the HSE who have included it in their current hospital inspection programme.

11.4 The Health & Safety team have been working in collaboration with the Infection, Prevention & Control (IPC) team to review the number and types of sharps used across the Trust, with an

aim to both streamline the number of devices (circa 6000) used, whilst ensuring the Trust is compliant with the Health & Safety (Sharps Instruments in Healthcare) Regulations 2013. Departments have been asked to review their unsafe sharps and move to safer alternatives or present risk assessments to the Sharps Group for decision.

11.5 The move to using safer sharps, and ensuring risk assessments are in place for non-safe sharps, are part of the process of reducing the frequency of sharps injuries. However, training and supervision is of equal importance as the safer sharp alternatives, are only safer if used correctly, and staff follow the correct procedures when disposing of them.

11.6 A Sharps Group has formally been established, with the inaugural meeting held in February 2024. The purpose of this group will be to ensure there are robust governance arrangements in place for Sharps Management and providing assurance onto the Health, Safety & Security Group. There is now a greater analysis of data in order to inform where the H&S and IPC resources should be focused

12 Slips, Trips & Falls

12.1 Slips, trips and falls of staff of other users of the site (excluding patients) are the lowest occurring incident type, which is a move away from being the third most occurring incident type in 2022/23

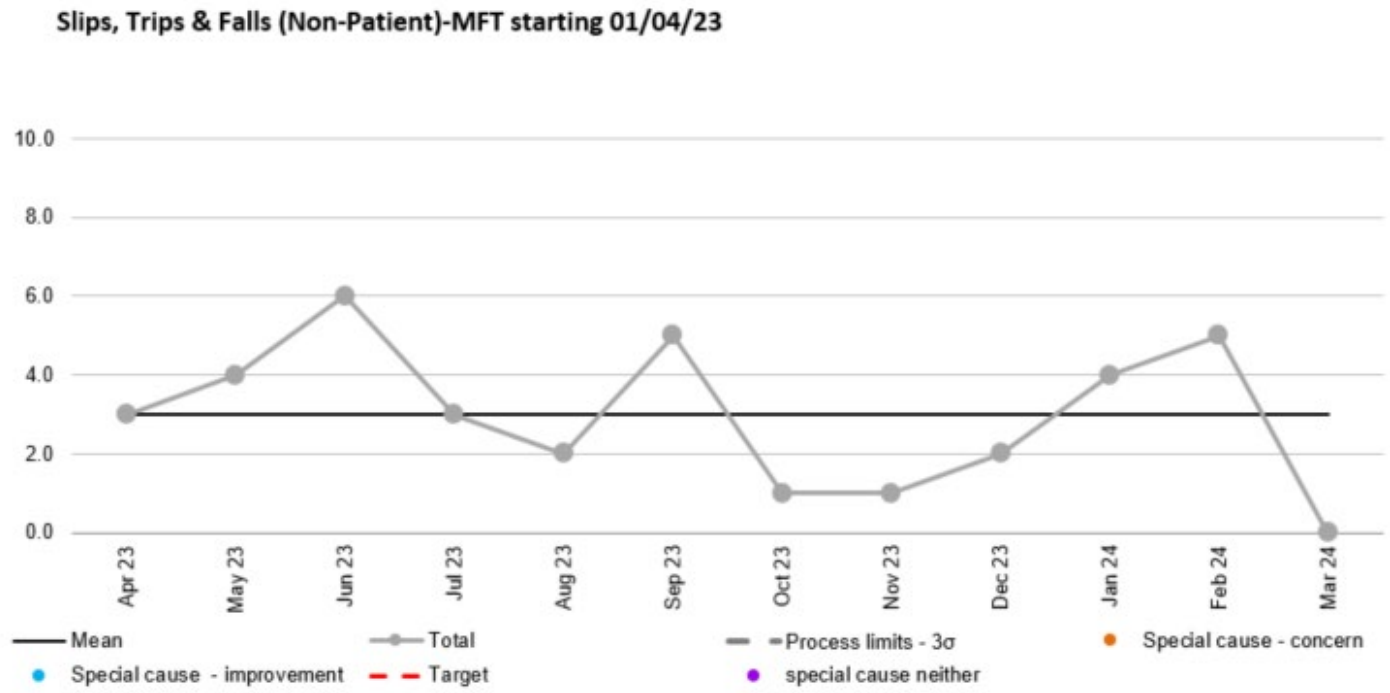
12.2 Slips trips and falls accounted for 10% of RIDDOR reports in 2023/24 due to the potential for fractures or prolonged absences from work.

12.3 An analysis of the 2023/24 incidents identified three primary causes of slips trips and falls:

1. Tripping over an object (50%) – this relates to the tidiness of workspaces and ward areas. Injuries occur from tripping over boxes, furniture and other obstructions in the working environment.
2. Falls from chairs (19%) – this relates primarily to chairs which move as people go to sit on them. This is attributed to incorrect castor specifications for the flooring. The use of computers on wheels in ward areas may be a factor in that more staff are working at computers in the wards as opposed to offices.
3. Slipping on wet/slippery surfaces (31%) – this includes both wet and dusty environments due to cleaning or maintenance work, as well as areas that become slippery due to inclement weather.

Figure 5; Slips, Trips & Falls by year

Figure 6; Slips, Trips & Falls by month



12.4 There have been improvements made across the site with flooring repairs and replacements being undertaken and resurfacing works. However, there is no formalised process for

undertaking routine risk assessments across the site so a standard operating procedure needs to be implemented to routinely review common areas of the site for potential hazards. Individual teams remain responsible for keeping their work area tidy and reporting faults to the Estates Hotline.

12.5 IPC and H&S audits flag work areas that are cluttered and pose trip hazards. The Health & Safety team have worked with the Procurement Department on ensuring that chair castors are specified for the type of flooring they will be used on, and H&S audits include checking existing chair castors. Each incident is reviewed by the H&S team to ensure the handler has undertaken remedial measures to prevent a recurrence.

13 Moving & Handling

13.1 Moving & Handling matters at MFT are overseen by the Health & Safety Team, Specifically by the Trusts Moving & Handling Lead.

13.2 The Moving & Handling function have a designated training room from which all training is delivered.

13.3 The Moving & Handling Lead is responsible for investigating all incidents that include a factor of manual handling, alongside providing advice and guidance on equipment provision.

13.4 Thirty seven (37) Moving and Handling incidents were reported in 2023-24, an increase of eighteen (18) from the previous year. Due to their severity, twelve (12) of the incidents met a requirement to be reported to the HSE under the RIDDOR regulations (see section 14 below).

Figure 7; Moving & Handling Incidents by Year

Figure 8; Moving & Handling Incidents by month

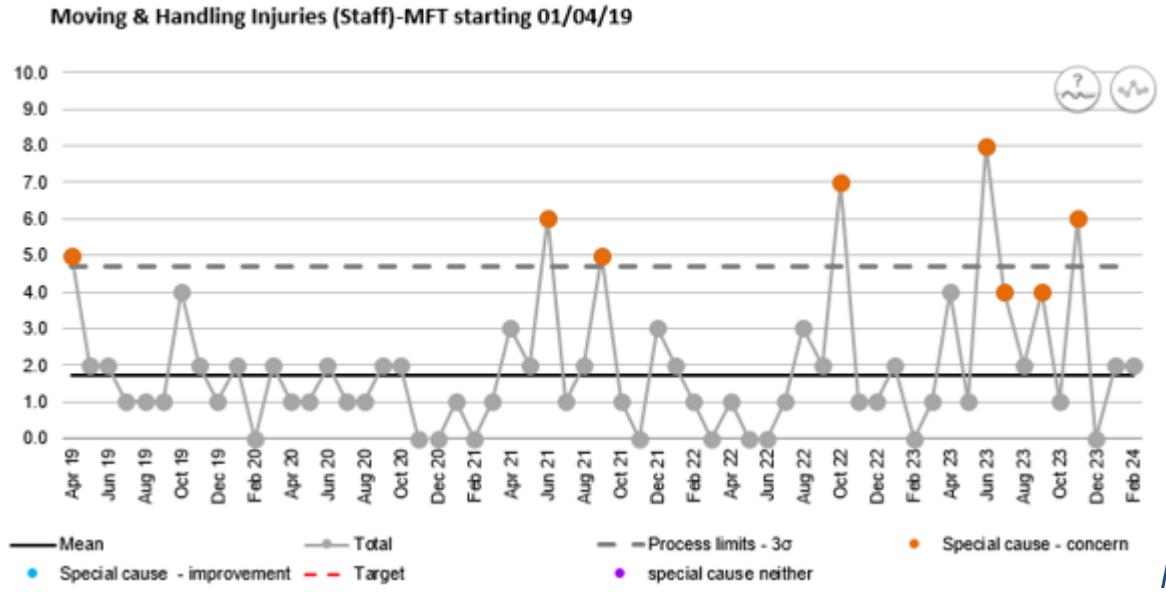


Figure 8;

13.5 Moving and handling is recognised as a significant risk within healthcare settings. The challenges for safely moving patients without risk of injury to staff relate to ensuring that the staff are trained in correct moving and handling techniques, and have access to appropriate

equipment for the task. Moving and handling risks also extend to non-patient moving and handling activities, as the hospital is reliant on the movement of significant quantities of waste, laundry, consumables and equipment in and around the site. The level of risk is reflected in the number of moving and handling related RIDDOR incidents reported by the Trust in 2023/24, putting moving and handling at the top, with 12 incidents.

13.6 Causes of injuries in 2023/24 vary and are seen across a range of activities, including moving inanimate loads around the building, assisting patients as the stand or walk and undertaking routine activities such as changing mattresses or moving beds around the hospital. Key to preventing moving and handling injuries is ensuring staff are fit to perform the task, that they have been trained and have the right equipment and follow the correct process. Training and observing staff in the workplace is also essential in ensuring good practice, as staff will not always follow their training within a busy work environment. A significant factor in the reporting of incidents is identification that the majority of RIDDOR incidents are related to self-certification following an incident, which leads to over the RIDDOR over 7 day injury trigger. The Safety team are currently undertaking audits including across departments to better understand emerging trends. M&H Key Worker training has also recommenced to bolster the availability of local M&H advice.

14 Security (Violence & Aggression)

14.1 During the year, the Security Management Specialist has carried out security risk assessments, violence and aggression risk assessments and made recommendations to clinical staff and Estates and Facilities Department where changes can be made to the environment and alterations to the premises.

The Security Management Specialist continues to attend multi-disciplinary meetings and advise multiple staff groups on Violence and Aggression, crime reduction and lone working.

14.2 There has been a total of two hundred and forty seven (247) physical assaults in 2023-24, an increase of ninety seven (97) from the previous year, still remaining one of the highest occurring incident categories reported via DATIX.

Figure 9; Moving & Handling Incidents by Year

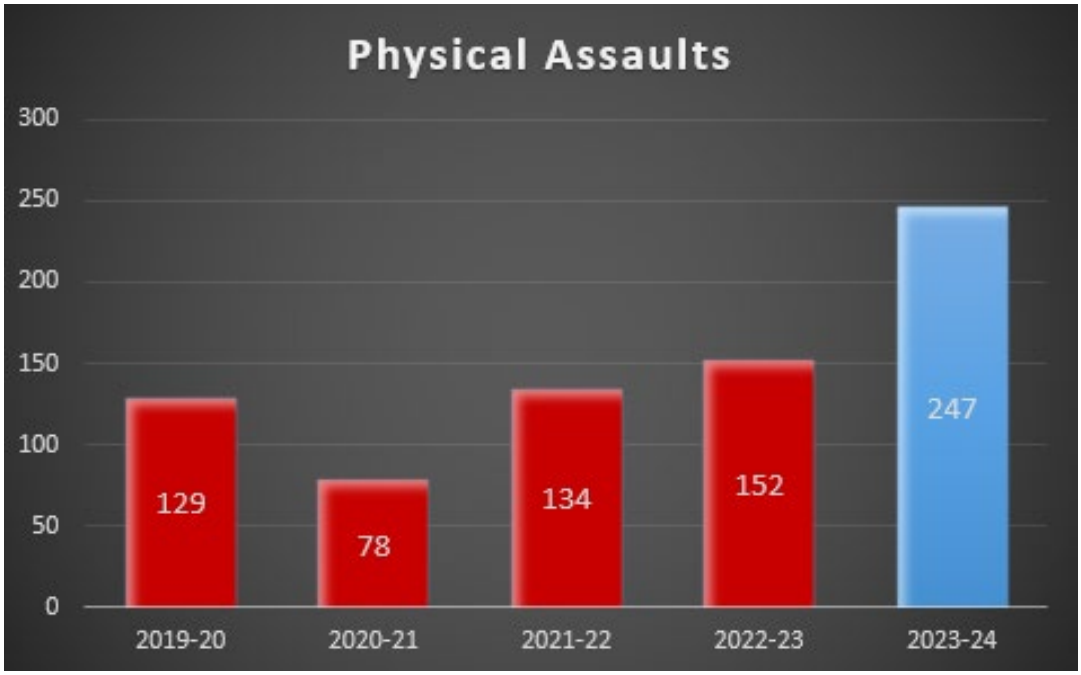
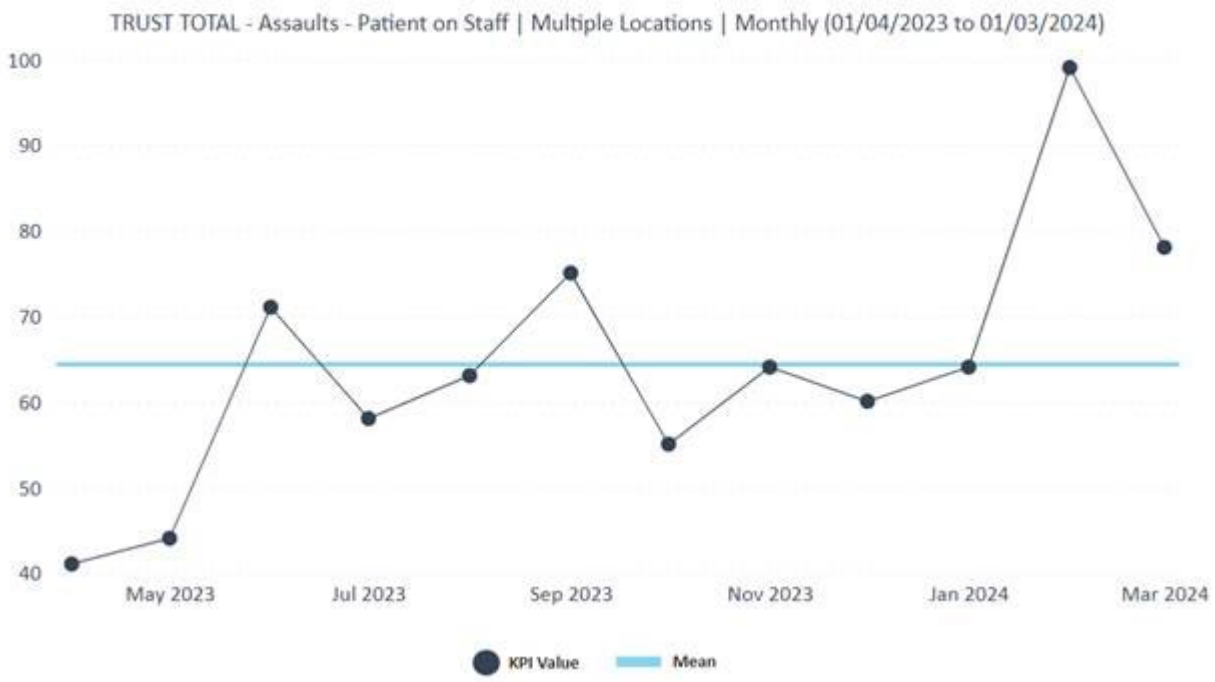


Figure 10; Total physical assaults by year SPC chart



14.3 Violence and aggression is an area of special interest to the HSE following their visit to the Trust in March 2022.

14.4 Physical assaults are the most reported incident type in 2023/24 with a 65% increase in comparison to the previous year. Physical assaults are one of the three main causes of RIDDOR reports.

14.5 The Violence, Aggression and Security Steering Group has been established to undertake a more in depth review of each incident to identify causative factors (clinical and non-clinical) in order to develop targeted controls to manage the risks in each area. The inaugural meeting is due to be held in April 2024

14.6 The Prevention and Management of Violence and Aggression (PMVA) training is available to all staff and the Security Manager is working with departments, such as the Emergency Department, to identify targeted strategies to manage violence and aggression, as well ensuring that the Sanctions and Redress Policy is applied to patients who physically or verbally assault staff. A priority of the Violence, Aggression and Security Steering Group will be to expand this Policy to a Violence and Aggression Reduction Strategy for 2024/25.

14.7 Following an assault, staff are advised to attend A&E for assessment and treatment. They are also encouraged to attend Occupational Health where support and further guidance is offered, and to report the assault to the Police. The Security Manager is there to support staff who are part of a criminal case, and he meets regularly with an allocated Inspector from Medway Police to discuss criminal activity at the hospital. At present no staff assaults from 2023/24 have resulted in a criminal prosecution, however five incidents have been passed to the Police with the outcome on prosecution still to be confirmed.

14.8 The Trust remains committed to the delivery of a secure environment for those who use or work in the Trust so that the highest possible standard of care can be delivered; to this end security remains a key priority within the development and delivery of health services. In response to the HSE's improvement notice the Trust has maintained the capacity of the in-house security team to sixteen substantive members of staff and is trialing the use of body cameras in clinical areas where violence and aggression are prevalent.

15 Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR)

15.1 Under RIDDOR, certain work place accidents, incidents, ill-health and certain near miss events must be recorded. Depending on the severity and nature of the injury, the Trust has a legal duty to report this data to the Health and Safety Executive.

15.2 Thirty-two (32) RIDDOR reportable incidents occurred within the Trust in 2023/24. This is an increase of ten (10) from last year, well above trusts of similar size and composition, which tend to report about a third of that number.

Figure 11; RIDDOR submissions by Year

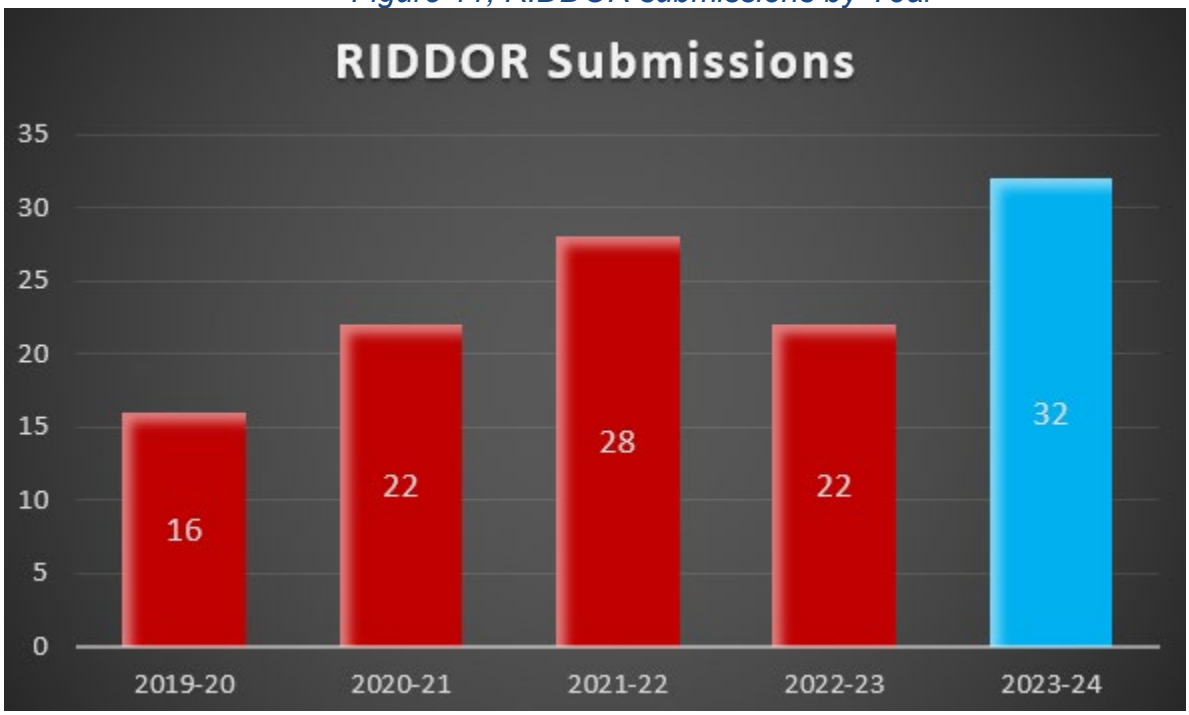
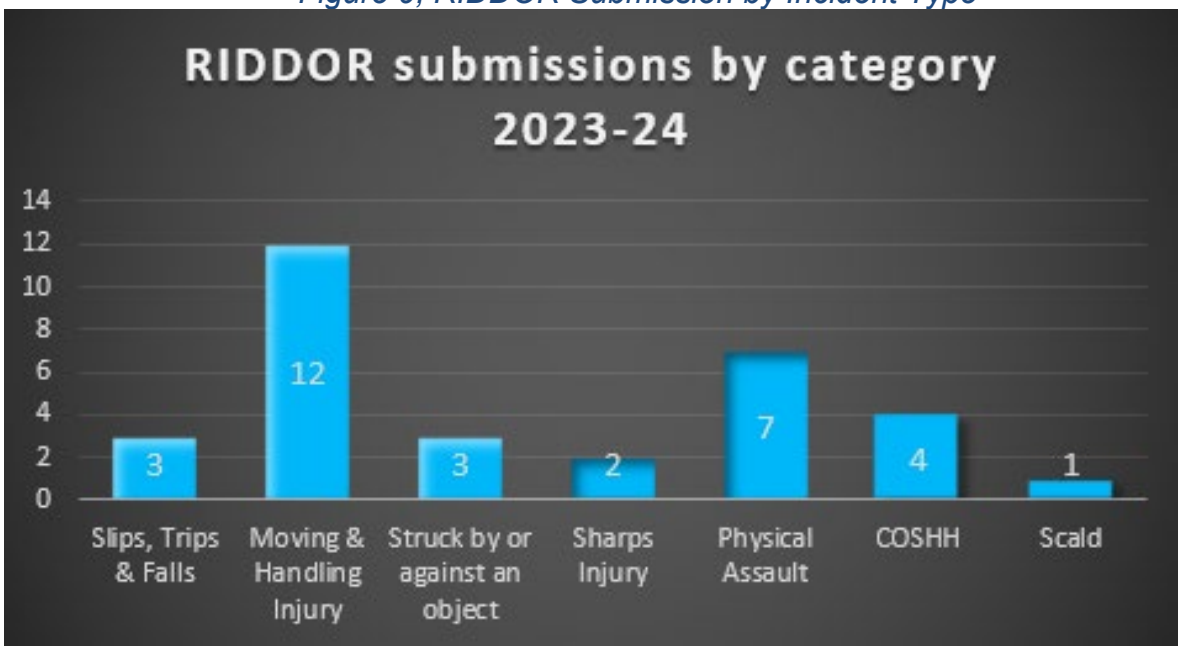


Figure 9; RIDDOR Submission by Incident Type



15.3 Under RIDDOR, certain work place accidents, incidents, ill-health and certain near miss events must be recorded. Depending on the severity and nature of the injury, the Trust has a legal duty to report this data to the Health and Safety Executive.

15.4 The Trust has historically performed poorly when reporting RIDDOR incidents within the regulatory timescales. This year saw a compliance rate of 70%, up from 68% for the financial

period 2022-23 which is similar to previous years. Late or non-reporting of incidents by staff and managers is the main cause as this prevents the H&S team from flagging potential RIDDOR incidents early and ensuring an investigation is undertaken before determining if an incident is reportable.

15.5 The introduction of a daily cleanse by the Health & Safety Team to detect potential qualifying incidents, and although RIDDOR reporting is covered within the statutory and mandatory health and safety training package, with the message being reinforced at induction sessions, in IPC and Occupational Health training sessions.

15.6 The top three areas for RIDDOR reportable injuries are moving and handling, physical assault, with COSHH coming third.

15.7 The Trust needs to improve its compliance with RIDDOR by ensuring staff and managers' report all incidents in a timely manner and flag those within Datix which may become RIDDOR reportable at the earliest opportunity. This will be achieved though staff training and awareness programs which are refreshed on an appropriate timescale.

15.8 All RIDDOR incidents reflect a level of harm that is impactful on the individual as well as the organisation. The Trust must set an ambitious target to reduce the number of these incidents to as low as is reasonably practicable and certainly within line with similar organisations which would mean only seven RIDDOR incidents or less per year.

15.9 The annual work plans need to focus on the high risk areas within the Trust and ensure there are sufficient resources in place to progress improvements quickly.

16 Training

16.1 Mandated Health & Safety training within the Trust currently consists of 2 levels of training:

1. **Health, Safety and Welfare**; completed at induction with a renewal period of 3 years. Training is available via a national e-learning package.

17.2 Mandated Moving & Handling training within the Trust currently consists of 3 levels of training:

1. **M&H Level 1 (theory);** completed at induction by all staff, renewal every 2 years, available as e-learning module of face to face
2. **M&H Level 2**, is a practical session for all clinicians and non-clinical roles where manual handling is required, such as portering. Renewal every 2 years, face to face only.
3. **M&H Level 3**, is a practical session for Doctors only with a renewal period of 3 years.

16.3 The compliance rate for individual departments is set at 85% across all statutory and mandatory subject areas by the Trusts organisational development team.

16.4 Compliance levels at the end of the year for Health, Safety & Welfare, and Moving and Handling Level 1 were above 90%.

16.5 A gap analysis against NBE standards was completed that re-mapped the training to meet NBE standards in relation to duration and ratio perspective. The Safety Team also introduced additional training materials such as Sara-Stedy, Hoist slings etc. A 2-year improvement plan was compiled and is being progressed with monthly monitoring via the M&H report within the HSSG meeting. Keyworker training for non clinical staff in high risk areas was introduced in response to HSE concerns with the commentary provided by the HSE on provision of the evidence was to include full legislative document titles.

16.6 Compliance levels for Moving and Handling Levels 2 and 3 were well below the target 85% score at the end of 2023/24 and this issue persists into the current financial year. Moving and Handling Training compliance is being severely impacted by the DNA rate with an average over the last quarter of 60%, a key factor being the release of personnel to attend training by their line managers. The DNA rate is being monitored via the Statutory and Mandatory Training Group meeting.

16.7 In addition to statutory and mandatory training, additional training is required to be undertaken by staff who use ladders as part of their daily job. The requirements for ladder safety training are set out by the Working at Height Policy.

- Level 1 Ladder Safety Training (E-learning module via ESR) – renewed every 3 years.
- Level 2 Ladder and Step-ladder User Training (1/2 day face to face session) – renewed every 5 years.

Level 2 training is only required to be undertaken by staff who undertake working at height for the purpose of activities such as maintenance (I.e. Estates staff). All other staff required to work at height, should complete Level 1 training. The compliance levels for Level 1 training and reported on monthly by the Workforce Team. Records of compliance for Level 2 training should be held by the individual department in which the individual works.

Table 1; Training Compliance

Training	2020/21	2021/22	2022/23	2023/24
Health & Safety & Welfare	90%	89%	89%	89%
Moving & Handling Level 1	90%	87%	87%	91%
Moving & Handling Level 2	83%	77%	77%	78%
Moving & Handling Level 3 (Doctors)	68	51%	51%	44%

16.8 Compliance rates continue to fall below the target figure of 85%, this is likely due to the fact. Without mandating key safety subjects, compliance is likely to remain low.

16.9 The Health & Safety Team also facilitates 1-day emergency first-aid training for departments who have identified via a risk assessment, that first aid provision is required. The nominal target for the Trust is currently being assessed, although this needs to be reviewed against the actual risk assessment for each area. There are currently (36) first-aiders, although registered nurses can also fulfil the role. The locations of the first-aiders will be dependent on the risk level of individual departments.

16.10 Other departmental-specific safety training such as confined space, radiation safety etc. is currently arranged and managed locally at departmental level, and as such, the Health & Safety team does not have a broad-picture of compliance across all aspects.

17 Audit

17.1 Auditing is a key function of the Health & Safety Team, and is supported by the Management of Health & Safety at Work Regulations 1999, HSG65 (Plan, Do, Check, Act) and is a core component of the Trusts Health & Safety Management Arrangements.

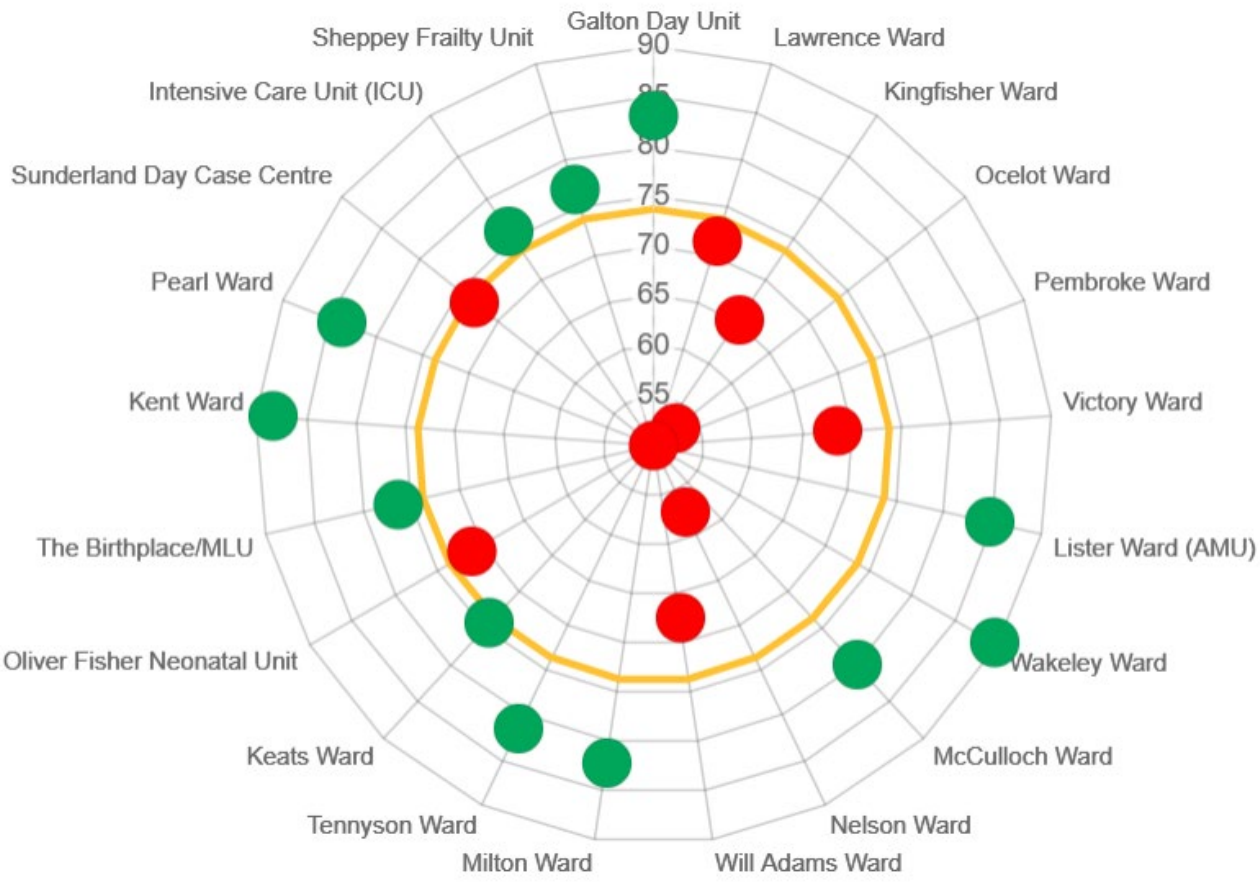
17.2 During the Covid pandemic, the Health & Safety audit programme was placed on hold. The audit programme was re-visited for 2023/24, with the intention to audit all Trust departments before year-end.

17.3 The order of audits was based on the risk-profile of each department, with departments being given a priority level of 1-4. 1 being highest priority and 4 being the lowest priority. E.g. Inpatient wards have been issued a level 1 priority.

17.4 Due to staffing levels within the Health & Safety team, the audit programme had to be revised to focus on the priority 1 areas only with the remaining areas to be reprogrammed once the

vacancies had been filled. 27% of audits were completed against plan, including 100% of priority 1 areas by the end of the 2023-24 financial year.

Figure 13; Priority 1 audits



17.5 The audits are now completed using Gthr (a data collection and analysis tool) to make the process more efficient.

17.6 In the meantime, departments are required to undertake local audits and inspections on a regular basis, on matters pertinent to health & safety, inclusive of:

- Window restrictor checks - conducted weekly
- COSHH (Control of substances hazardous to health) checks – completed weekly
- Workplace Inspections – Completed quarterly

These audits are currently completed by either the Health & Safety Keyworker or the departmental manager, with copies of audits shared via email, and data recorded in a spreadsheet.

17.7 To improve efficiency of completing the audits, and to enable data analytics, the suite of local audit tools have been integrated into Gthr and the results started to be compiled for analysis.

18 Risk Assessments

18.1 The Health & Safety Team support the completion of risk assessments as required. The management on control measures from such risk assessments sit under ownership of the departmental manager/s.

18.2 In addition, several risk assessment pro-formas with associated guidance notes are available for staff to complete as required, including:

1. General Risk Assessment
2. COSHH Risk Assessment
3. Display Screen Equipment Self-Assessment
4. First Aid Needs Assessment
5. Lone Worker Risk Assessment
6. New and Expectant Mothers Risk Assessment

18.3 From the priority 1 audits completed so far the lack of suitable and sufficient risk assessments is apparent and so the affected departments will be contacted to arrange a support visit where the incomplete assessments will be reviewed with the Safety Team

19 Conclusion

19.1 Improvements in health and safety are on-going across the Trust. The Health & Safety Team are working with the Trust's Clinical Divisions to increase compliance of local audits. Improvements in this area will show a greater level of legal compliance generally across the Trust.

19.2 Both the audit programmes and incident reporting are fundamental to the Trust being able to identify, analyse and address its high-risk areas. This relies on the involvement of all staff and managers and the Health & Safety Team are working Trust-wide to deliver on this. Reconfigurations made to Datix continues to improve the efficiency of reporting for staff and should also improve the follow up and investigation of incidents by managers.

20 Health & Safety Objectives 2024/25

The key objectives for the Health & Safety team for 2024/25 are set out below.

20.1 To successfully deliver the Stage 1 Moving & Handling training improvement plan. This consists of providing capacity to address the backlog of staff overdue for Moving & Handling training (circa 1000) and the focus of training being on the below areas:

- Induction (Clinical & Non-Clinical)

- Keyworker Induction (Clinical & Non-Clinical)
- Keyworker refresher (Clinical)
- Manager Awareness Training

20.2 To complete all actions from the National Back Exchange Gap Analysis that align to the Stage 1 Moving & Handling training improvement plan, consisting of:

- Completion of a risk assessment for training facilities and equipment.
- Create a means to provide structured feedback to managers where concerns relating to staff training are highlighted.
- To monitor outputs from M&H keyworker audits, and take action where needed.

20.3 To establish and roll-out a Health & Safety training programme for all persons who have managerial responsibilities across the Trust. This will include training on risk assessing, in order to ensure departments have the competency to become self-sufficient in this activity, in line with the Trusts Health & Safety Policy.

20.4 To expand the use of digital technology, to enable the Health & Safety team to better respond to queries, including space utilisation and display screen equipment (DSE).

20.5 To work with clinical colleagues to develop and distribute a suite of risk assessments for all in-patient wards and their activities.

20.6 To re-audit against the Workplace Health & Safety Standards Audit on a monthly rolling programme, with all audit sections being complete by March-2025. Actions arising from audits to be set and monitored by the Health, Safety & Security Group (HSSG).

20.7 To complete departmental audits against priority areas rated 2, 3 and 4, following the successful completion of Priority 1 audits in 2023/24.

20.8 To review and redesign the Trust's audit tools where required and to undertake audits for specific high-risk areas, including:

- Waste & Transport
- Catering
- Procurement
- Portering
- Housekeeping
- Medical Records
- Laundry

Trust Risk Register Report

Louise Furlong; Head of Quality & Safety

July 2024

Executive Summary

	Assurance
Risk Management	

The Trust Risk Register has 237 approved risks in total
25 risks are scoring 15 and above.

25 new risks added
16 risks are awaiting review, and
43 risks awaiting approval.

22 risks have been closed down
16 risks have had the score reduced since their last review,
5 risks have had the score increased since their last review, and
9 risks have been rejected.

All Executive Members have been invited to review each of their risk profiles on a monthly basis.

Full Assurance	Partial Assurance	Limited Assurance

SIOR - Risk Management

NHS Medway NHS Foundation Trust

Successful Deliverables

- 22 risks have been closed in June
- 86% of risks were reviewed within their required timeframe in June (Down from 92% in May)
- 96% of risks scoring 15+ have been reviewed within the required timeframe in June (Down from 100% in May)
- Risks are now a standing agenda item for all groups and committees
- 47% of risks now have actions assigned to address the gaps in controls (Up from 29% in May)

Risks Closed in June

Risk ID: 1083
Risk Title: Patient Experience and Care Pathways: Failure to improve patient experience and care pathways, lack of adequate EPR
Rationale for closure: Risk closed as consolidated under a new risk 2068: Limitations of EPR/EPMA System Functionality Impacting Patient Safety.

Risk ID: 1332
Risk Title: Inability to recruit substantive microbiologists could mean delays in identifying infections and clinical reviews of patients
Rationale for closure: Risk not review for 8months, no engagement received from risk owners despite frequent chasing

Risk ID: 1414
Risk Title: Late RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) Submissions
Rationale for closure: Risk reviewed and target of 3 months 100% compliance achieved as of 1st June 2024.

Risk ID: 1488
Risk Title: POCT -Incorrect capillary blood glucose ranges on EPR
Rationale for closure: Risk closed as consolidated under a new risk 2068: Limitations of EPR/EPMA System Functionality Impacting Patient Safety.

Risk ID: 1539
Risk Title: PoCT-Blood Gas results not recorded electronically in EPR
Rationale for closure: Risk closed as consolidated under a new risk 2068: Limitations of EPR/EPMA System Functionality Impacting Patient Safety.

Risk ID: 1552
Risk Title: Non-compliance with Regulations 5, 6 and 12 of the Working at Height Regulations 2005
Rationale for closure: White paper submitted to HSSG ref forward provision of access equipment training by Safety Team (No impact on ladder training provided by Estates) was approved at June 5th HSSG. Training presentation has been compiled and is currently with E-learning team, prior to being uploaded to ESR as an optional training package and as such is considered business as usual.

Risk ID: 1568
Risk Title: ED EPR allows users to admit more than one patient into a bed location causing disruption to workflows and patient safety
Rationale for closure: Risk closed as consolidated under a new risk 2068: Limitations of EPR/EPMA System Functionality Impacting Patient Safety.

Risk ID: 1574
Risk Title: Admit Via process in Sunrise EPR
Rationale for closure: Risk closed as consolidated under a new risk 2068: Limitations of EPR/EPMA System Functionality Impacting Patient Safety.

Risk ID: 1644
Risk Title: Aging Diathermy Equipment
Rationale for closure: New machines delivered therefore risk closed

Risk ID: 1659
Risk Title: Lack of dose range limits when prescribing on EPMA
Rationale for closure: Risk closed as consolidated under a new risk 2068: Limitations of EPR/EPMA System Functionality Impacting Patient Safety.

Risks Closed in June

Risk ID: 1675
Risk Title: Lack of system integration between Medicus ICU/Outreach Team and Sunrise EPR
Rationale for closure: Risk closed as consolidated under a new risk 2067: Deployment and Interfacing of EPR/EPMA System Impacting Patient Safety

Risk ID: 1728
Risk Title: Quoracy of Clinical Effectiveness and Outcomes Group
Rationale for closure: 11-06-2024 - CEOG meeting agreed to reduce the score to 3x 2 and close the risk. The meeting has been very well attended for the last 4 meetings and it remains unlikely that it will not to be quorate in the future.

Risk ID: 1742
Risk Title: There is a risk that staff are not alerted to children on a child protection plan as not all staff check on the CP-IS system
Rationale for closure: 21.6.24 Agreed closure a CYP care group, embedded into practice

Risk ID: 1843
Risk Title: Migration to EPR - Paediatric & Maternity Wards not yet completed which may impact contemporaneous records and patient safety
Rationale for closure: Risk closed as consolidated under a new risk 2067: Deployment and Interfacing of EPR/EPMA System Impacting Patient Safety

Risk ID: 1881
Risk Title: Extramed Decommissioning
Rationale for closure: Risk discussed at IGG on 03/06 and Director of IT assured risk closed as no issues remain following decommissioning.

Risk ID: 2061
Risk Title: Lack of UKAS Accreditation to ISO15189
Rationale for closure: Discussed at Care Group Board, Waiver now received and risk no longer apparent. Closed accordingly

Risk ID: 1887
Risk Title: Ending of work contract for NSS Pathway will impact patient experience, reputation and cancer performance
Rationale for closure: Secondment renewed until 31.3.2025

Risk ID: 1890
Risk Title: Trust non-compliant with the regulatory requirement relating to first-aid provision, which may result in enforcement action
Rationale for closure: The paper presented at the June 5th HSSG was approved and budget for first aid training has been confirmed. Procurement of services are progressing, as such the risk is considered business as usual.

Risk ID: 1917
Risk Title: Workforce review required for Rheumatology service
Rationale for closure: Risk discussed at DGB, agreed to be linked and closed linked Risk 1679- NEIAA & 1365- NICE recommended timeframe

Risk ID: 1933
Risk Title: The Trust may breach the submission date for the Data Security protection Toolkit
Rationale for closure: DSPT submission made ahead of timeframe - risk closed

Risk ID: 1955
Risk Title: EPMA: Order Reconciliation Manager does not transfer between ED to in-patient
Rationale for closure: Risk closed as consolidated under a new risk 2068: Limitations of EPR/EPMA System Functionality Impacting Patient Safety.

Risk ID: 1980
Risk Title: Risk of patient cancellations due to obsolete orthopaedic power tools
Rationale for closure: New power tools available for use

Risks Rejected in June

9 Risks were rejected in June

The number of rejected risks broken down by category are as below**:**

Risk Already Resolved - 0

Incorrect Form Completed – 8

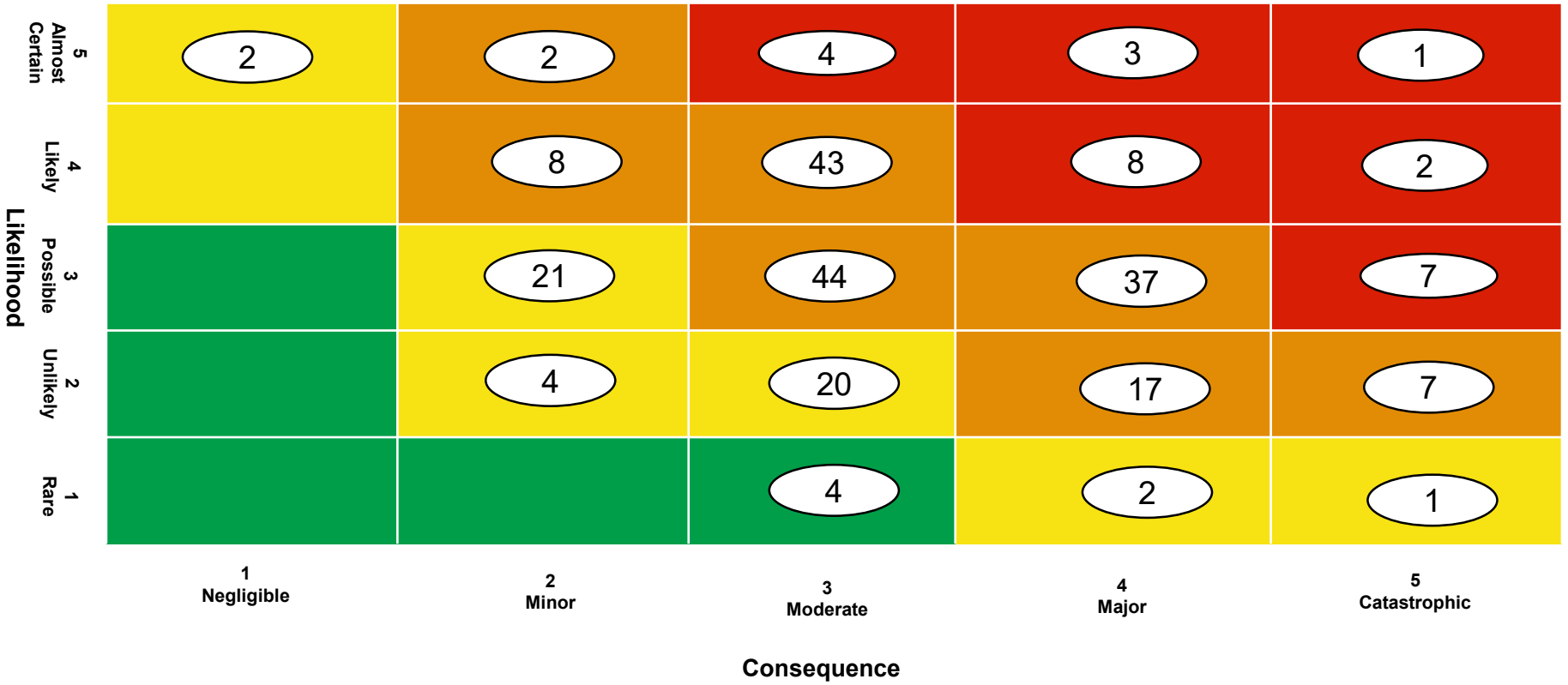
Duplication – 1

No Reason Given - 0

All risk originators were contacted to advise of the reasons for rejection, and where applicable asked for incidents to be raised instead.

Trust Risk Register – Heat Map

The heat map summaries the total number of risks assigned to each score.



Risks scoring 25

2060 - Capital allocation vs requirements

Risks scoring 20

2052 - If the trust does not deliver its 24/25 efficiency programme then the financial performance vs. control total could be at risk.

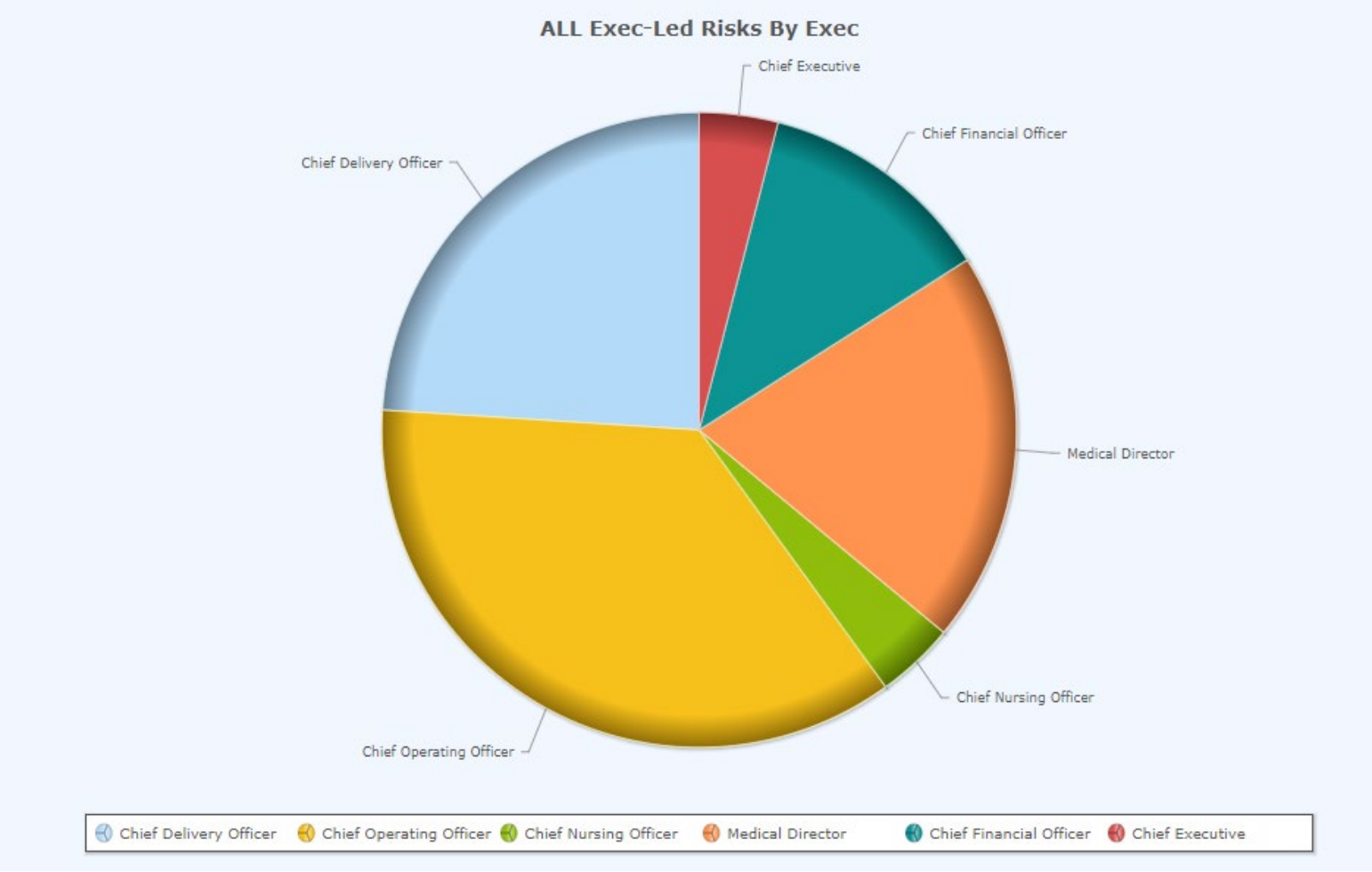
2005 - Various environmental issues affecting Nelson ward which may impact patient safety

1711 - Trust may be in breach of Article 5 of GDPR as a result of breaching retention, archiving and disposal of leavers information.

1502 - Non-Compliance to SAR & FOI Timeframes which gives rise to potential enforcement action and penalties

1133 - Insufficient Midwifery Staffing impacting the ability to provide patient care.

‘Extreme’ Risks by Executive



25 Risks scoring 15+

CDO – 6 (24%)

CFO – 3 (12%)

CMO – 5 (20%)

CNO – 1 (4%)

COO – 9 (36%)

CPO – 0 (0%)

CEO – 1 (4%)

NHS
Medway
NHS Foundation Trust

CDO - Extreme Risk Profile

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1025	07/04/22	31/03/25	Euroking maternity system not fit for purpose, impacting patient safety data quality, stat analysis, CNST & clinical info	A number of issues have been identified with Euroking maternity system, inclusive of: - Back-copying of answers and - Duplication of records caused by failed data migration (Sep 2020) These issues have resulted in no assurance of reporting output and may result in issues relating to patient safety, data quality, statistical analysis, CNST and clinical information. The impact may be financial implication by way of the ICO or harm to patients as a result of incorrect patient information being available.	- Manual data adjustments made to ensure MSDS is uploaded and local data reported. - Local data reconciliation being done to expose gaps occurring together with close working relationships between BI and Maternity. - Manual review and individual case file analysis underway - Gone into capital planning for 24/25. Sited on risk through digital data and technology group.	MNSCAB CGMB DMB IGG RCASC Euroking to be standing agenda item at IGG meetings as agreed with DPO from October 2023 onwards until issue resolved	- System supplier not acting on need. - Lack of funding to procure new system. - No reconciliation between System, System Reporting solution & automated Data Output. - EuroKing supplier will not provide mapping for fields. -National risk identified by Another EuroKing Trust -Some legal records are overwritten or completed when none was there. - Uncertainty of where liability arises should euroking be cause or causative factor of any incident/harm etc. - Depending on the provisions of the Trust's contract with Magentus Software (the company that supplies this system), liability for the technical issues might sit with them, However, the Trust in any event would be liable for the issues caused through the actions of the Trust employees using the system - e.g. copy-pasting, failing to check that the correct patient's record has been accessed.		9	15 (5x3)	3 (1x3)	—	Trude McLaren

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Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1408	30/08/2022	31/08/2024	Emergency Bleep/Pager system reliability	Emergency pager/Bleep system is unreliable and has failed on multiple occasions in the 6months leading up to risk being raised. Emergency requests for critical clinical staff support teams has to reverted to the use of radios. The implementation of this plan is a manual distribution task.	Radio's used as back up option to replace the bleeps in the event of failure. Funding secured for Everbridge system, to go live Summer 24. Testing undertaken by existing supplier. Tightening up of process for twice daily test calls.	Pager system maintenance contractor to assess system and complete health check and carry out required replacement of components to improve reliability.	No sufficient number of radios to circulate in event of bleep failure. Existing telecomms contract expires in approx. 18months, wider review of system to take place in anticipation of this.		4	15 (5x3)	5 (1x5)	—	Adrian Billington
2052	26/04/2024	31/03/2025	If the trust does not deliver its 24/25 efficiency programme then the financial performance vs. control total could be at risk.	The efficiencies target for 2024/25 is £21.6m / 5% of income. The Trust has not identified the full value of efficiencies at the start of the financial year. If the trust does not deliver its efficiency programme then the financial performance against control total could be at risk. (NB - there is a statutory duty to breakeven.) Linked to BAF risk 5b	• Scrutiny and challenges at the Efficiencies Delivery Group. • Fortnightly check and challenge sessions with divisions. • Financial Improvement Director and PMO in place. • Supported by / participants of the system productivity and efficiency group.	• Reporting to Efficiency Delivery Group and the Finance, Performance and Planning Committee (identified vs target, delivered vs budget [in-month and YTD]). • External audit value for money procedures. • Internal audit procedures on a cyclical basis. • SOF reporting / meetings with NHSE, including leveraging knowledge and best practice from Intensive Support Team. • Model Health System and other benchmarking.	• Financial culture and awareness. • Capacity and use of benchmarking. • Efficiencies identified at start of financial year equate to circa £12m, however the risk assessed position of each of these schemes equates to only £4m		9	20 (4x5)	10 (2x10)	▼	Linda Longley

N.B. Full details of all risks are available on the Trust Risk Register.

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Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1645	04/09/2023	31/08/2024	Unsupported Server Operating Systems	The Trust is running outdated and unsupported operating systems on a number of servers that host clinical and administrative systems.. The Trust had up until January 2023 purchased extended support arrangements (ESU) from Microsoft, however the extended support period is no longer offered for further renewal. This means that Microsoft is no longer providing security updates or technical support for this operating system, which leaves the organization's servers vulnerable to security threats and software vulnerabilities. There is a small number of Servers running Server 2003. Due to the age of these servers and the lack of an active support arrangement. These servers are at increased risk of a cyber attack due to their increased vulnerability	- The Trust has invested in licensing and data centre hardware to enable the mitigation of these risks. - The ITPMO is actively running a project to review server operating systems and work associated with this mitigation. - Implement Security Measures such as firewall restrictions, intrusion detection and prevention systems, and utilise existing antivirus software to reduce the risk of a security breach. - Regular Vulnerability Scanning to identify any security vulnerabilities and to take appropriate remedial action. - Limit Access to these servers to limited authorized personnel only. -Capital Allocation 23/24, project: 21/22-159 Cyber Security - Server supporting clinical systems have been prioritised and upgraded. - Aiming to have all upgrades complete within year.	The ITPMO will document the associated remediation plan and provide a schedule of works. Highlight reports and compliance to this plan will be provided at Project and Digital Board. Although this has not been requested yet. The Trust may need to report on this progress to NHSE in a similar way to how PC/Laptop OS migrations were reported.	Until the remediation works are completed, the Trust is at increased risk of: Cyber Security Risks: Since the operating system is no longer receiving security updates, any new security vulnerabilities discovered by hackers or cybercriminals will not be patched by Microsoft, leaving the organization's servers at risk of cyber attacks. Compliance Issues: The organization is in breach of compliance requirements of the DSPT and Cyber Essentials until at least 90% f servers are on supported operating systems. Business Disruption: Any security breaches or vulnerabilities discovered could result in business disruption and potential loss of data.		9	16 (4x4)	4 (2x2)	–	Craig Allen

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1880	21/12/23		Lack of digital clinical safety officers and digital clinical risk expertise to support Digital and EPR deployments	There is only 1 nominated Clinical Safety Officer for the trust. There are a number of high priority digital and EPR deployments which require risk review and over sight by a clinical safety office for each project. The impact is that DCB0160 are being submitted without sufficient evidence, risk analysis or time resource to review and support a safe an secure healthcare system deployment, upgrade or decommission. Resulting in delays in system deployment or unsafe deployments activities which may result in unknow harm to patients without full risk review and analysis of the impact of digital clinical change. Lack of standardise operating procedures and governance in place to over see the range of deployments.	1 Clinical Safety Officer 2 P.A. a week, CNIO, CCIO and EPMA Pharmacist are clinical safety officer trained with role experience. Digital midwife trained as CSO with limited experience supports hazard log reviews with the CSO team. Quality Manager non clinical, supports the CSO activity and the hazard log reviews	Clinical Safety Officer EPR meetings held 2 weekly, Clinical Safety Group meetings to review live and PMO risk DCB0160 activity. EPR workstream meeting. Clinical safety reviews are part of the project management activity. Team now using the NHSE digital clinical safety templates and associated documentation.	Lack of resource to complete the number of clinical safety case reports and associated governance activity required to meet the NHS digital clinical safety standards. Increase in number of clinical safety activity timeline against financial and clinical safety priorities. Clinical safety activity is very resource hungry, with competing deadlines for resource. The process is not stream lined with differing processes for PMO and EPR. CCIO and CSO The follow up activity required by the CSO post system deployment, upgrade, decommissioning is carried out by CNIO/ CCIO or Project managers which may not always be appropriate when transferring clinical risk to operational owners. ,	1. Authority to process SOP 2. Agree asset owner and system specific security policy 3. CSO report requirements for programme milestones	4	16 (4x4)	4 (1x4)	–	Kerry O'Reilly

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
2068	31/05/2024		Limitations of EPR/EPMA System Functionality potentially impacting Patient Safety	Limitations of the EPR and EPMA systems impacting patient safety, quality of care, patient experience and staff efficiencies.	- IT resource audit carried out. - ART audit monitoring. - Corporate Project raised for deteriorating patients. - ED Staff trained how to discharge the patient from ED to the inpatient ward. - Dr and Pharmacy Staff have been trained to identify and correct issue/re-prescribe. - Pharmacy check daily medication errors - ED staff are checking on duplications of patient allocations. -- POCT Database correctly records results - EPMA Incorrect scheduling of as required frequency - report available for late administration. - Prescribers are trained to know that the EPMA/EPR clinical decision support tool will only alert for interactions between medications and allergies/intolerances. - For certain medications such as paracetamol the maximum dose limit within 24 hours is stated in the medications administration information which displays at the point of prescribing, - Working with the vendor to update the system to support	- Digital Data and Technology Group - EPR Clinical Implementation Group is a route for staff to raise problems if they are encountering difficulties. - EPMA Huddle - IT Service Desk Reporting - Incident reporting. - Pharmacy Governance Group for EPMA related incidents. - There is constant training review. Weekly meetings in place to receive updates from the vendor on updating the EPMA software to support dose range limits.	- Delayed Recording of Observations on EPR. - Sunrise NEWS. - DTA link from Sunrise EPR to PAS not set correctly to allow the 'admit via' pop up to display - The Emergency Department EPR allows users to admit more than one patient at a time into a bed location - POCT Blood Gas results not recorded electronically on EPR. - POCT Incorrect capillary blood glucose ranges on EPR therefore, results being entered manually - EPMA Incorrect scheduling of 'as required' frequency. - EPMA Lack of dose range limits when prescribing. - EPMA Order reconciliation manager does not transfer between ED to inpatient. - Patients admitted to ED corridors will be discharged without an inpatient discharge summary - ED require discharge tracking board view on Sunsirse EPR to manage	1. Solution for EPR bed allocation 2. Review lack of dose range limits when prescribing on EPMA	4	16 (4x4)	4 (1x4)	—	Kerry O'Reilly

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CFO - Extreme Risk Profile

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1363	21/02/2023	01/04/2024	End of Life and support of Philips FD20	Due to the age of the equipment. December 2022 Philips have issued end of support this means that no other service activities, paid repair or help desk support will be permitted. The Impact will be no Interventional Radiology Service including the out of hours on call service. This would mean all patients requiring an intervention would either have to be transferred to another hospital or have a more invasive surgical procedure depending on clinical assessment.	- Annual preventative maintenance are still being completed and medical physics are still completing annual QA. - Going forwards Phillips have stated they may not be able to fix any issues as there will now be difficulty sourcing parts and expertise. - On list of high priority schemes for 23-24 as there is slippage in capital list - Business case going to December finance committee.	Machine is operating within required limits of radiation and although image quality is deteriorating this is still on monitoring only.	- The only option is replacement and this requires funding. - Need confirmation as to timeframes for completion - delivery will be dependant on procurement - Timescales will fall early 2024/25		4	16 (4x4)	8 (2x4)	—	Lorraine Beccon shall

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
2058	25/04/2024	31/03/2025	Unchecked staff growth	The Trust has seen growth in worked WTEs in the 12 months to March 2024 of c9%. Continued growth without funding/additional income through tariff - particularly where this is unplanned or without appropriate oversight and scrutiny - will push the Trust into larger deficits.	- Vacancy control panel - Investment governance process - Month end budget holder review - Safer staffing reviews - Business planning triangulation, incl. headroom in budgets - Rostering controls - Weekly check/challenge	- FPPC monthly reporting - NHSE productivity metrics data	- Timely scrutiny of temp staffing requests - Habitual use of temp staffing / understanding of coverage already provided in budgets		9	15 (3X5)	5 (1X5)	—	Dominika Kimber
2060	25/04/2024	31/03/2025	Capital allocation vs requirements	The Trust receives a capital allocation/limit from the ICS, which in turn receives its limit from NHSE. Our actual allocation is only approximately two thirds of this value at a little under £13m. (Any third party funding/PDC that can be secured allows us to spend over and above that sum.) Given the estates survey in early 2024, together with the 5-year capital programme request list and 2024/25 capital commitments, this sum is significantly below our needs. This could put patient and staff safety at risk.	- 5-year capital programme list - Investment governance policy and templates, including prioritisation matrix - Estates Strategy - Medical devices replacement programme - Applications to access additional funding	- Reporting to FPP	- Availability of funding - Estates Strategy under development	1. Estates Strategy 2. Capital Funding	9	25 (5x5)	10 (2x5)	—	Paul Kimber

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CMO - Extreme Risk Profile

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1502	04/04/2022	26/06/2024	Non-Compliance to SAR & FOI Timeframes which gives rise to potential enforcement action and penalties	The Trust is currently non-compliant with the statutory timeframes due to significant backlogs for SARS & FOI with a risk of enforcement action and penalties	- Business Case approved by ICB and requires recruitment to positions - 4 posts on fixed term contracts (8months) - Assigned 1 individual to admin role daily to deal with phone calls and emails in order to minimise disruption to workload - Processes constantly monitored in order to make improvements at earliest opportunity. - Addition of twice weekly meeting where issues are raised internally - Proposal to temporarily reduce disclosure rules put forwards to address backlog - Associate Director of Legal and Integrated Governance Manager to investigate actual SARs and FOI position ahead of next IGG on 5th February 2024 - IGM reviewed (07032024) 92 SARs of which 15 were not added to the SARs database. Raised with IGL, member of SARs team going through email inbox and adding SARs onto database (this will likely raise our non-compliance stats as ALL SARs will now be recorded)	- Weekly reports to Director of Integrated Governance, Patient Safety & Quality - Reports onwards to CMO/Caldicott Guardian - Information Governance Meetings, onward Assurance & Escalation report to RCAG	- Lack of funding for the additional positions - fixed term positions likely to end soon - Requests for email information requires liaison with NHS Digital and adds to backlog - IG Meetings not routinely held. - Trust written to by ICO in regards to case not dealt with in a timely manner - Backlog circa 900 for SARS with approx. 800 breached - Backlog circa 110 for FOIs with approx. 70 breached - Actual SARS and FOI position unknown as tools available to Trust to extend timeframes may not have been utilised.	1. All SARs team to undertake ICO approved training 2. Benchmarking of resource vs demand 3. Streamlining of database – adding cases 4. Process standardisation – templates 5. Request access to SSO for IG team 6. Streamline of database – reports 7. Review access requests pre 1st April 2024 8. Review access requests post 1st April 2024	9	20 (5x4)	8 (2x4)	–	April Howard

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1725	29/09/23		The ongoing and continuous increase in antimicrobial consumption	At MFT Access category (first line antibiotics) shows a downtrend while Watch category (second line broader spectrum antibiotics) shows an uptrend overall. These are negative developments considering that Standard Contract for 2023-24 as aligned to the UK AMR National Action Plan is to reduce consumption of Watch and Reserve antibiotics in hospitals by 10% from a 2017 baseline. An increased use of antimicrobials have an implication for increased cost, antimicrobial resistance and increased rates of C.difficiles and invasive fungal infection	- EPMA - Antimicrobial ward round - AMSG - Report to IPCSAG and QPSSC - Consumption report - ward clinical pharmacists have capability to review antimicrobial prescribing where there is cover - junior doctor training	- Reports presented to AMSG, IPCC - Antimicrobial point prevalence audit twelve monthly - Antimicrobial CQUIN	- Lack of audits due to start in July 23 - Lack of antimicrobial pharmacist time - Antimicrobial pharmacist on sabbatical from Oct 23 to Jan 24 - Prescribing practice - Reduced microbiology consultant input due to capacity issues on a 10 PA job plan - lack of clinical pharmacist time on wards due to staffing shortages - lack of ownership across MDT for antimicrobial stewardship		4	16 (4x4)	4 (1x4)	—	Vasile Laza-Stanca

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1285	07/04/2022	01/03/2026	Lack of adequate critical care consultants to manage the critical care unit	There is a risk that lack of adequate critical care consultant could lead to patients safety and experience concerns, including the closure of some critical care beds. Increased patient morbidity and mortality as a result of over-stretched critical care consultants Poor morale amongst the consultant workforce leading to increased sick leave and consultants leaving, thereby exacerbating the situation	• An approach of reduction of critical care beds based on staff availability • There are critical care consultants: albeit not enough • One post recruited to (2023) • Regular short-term locum • Many weekends are covered and 1 consultant has been recruited.	• Planned Divisional Governance Meeting • Business Planning - Operational risk owner to provide • Chief Medical Officer Team meeting	• Staff morale is very low, needing an incentive for current workforce and advertisement agreement to enable competitive recruitment • National shortage of critical care consultants • Next potential recruitment February 2025 • Lost 3 posts to neighbouring Trusts in last 12months • A3 exercise required to explore lack of applications • Currently there are two slots available with 1 consultant WFH and 1 vacancy	1. JD review	9	16 (4x4)	4 (1x4)	—	Rachel Krol

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1711	29/09/2023	31/03/2025	Trust may be in breach of Article 5 of GDPR as a result of breaching retention, archiving and disposal of leavers information.	The Trust processes around retention, archiving and disposal of personal information relating to members of staff who have left the Trust is not clear, and as such the Trust may be in breach of their regulatory duties - this may lead to financial and reputational damage to the Trust. This will relate to locally recorded personal information and local personal files, as well as official HR records (occupational health, payroll, employee relations, training records etc.)This is also relevant to SARs.	- Records held directly by HR are stored in electronic files	- information Governance Group - risk and compliance assurance sub-committee	- No retention, archiving of files - Very variable across Trust	1. Initial discussion with HR, OD and ER on data flows re staff info 2. Review of records management policy 3. HR to update their information asset and flow registers 4. Training and communication to staff on responsibilities of staff data retention, archiving and destruction	9	20 (5x4)	4 (1x4)	–	April Howard

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1699	29/09/23	31/05/2024	Failure to Provide Agreed Level of Imaging Cover To Theatres Due to Poor Quality Imaging Equipment	Imaging unable to fulfil an agreement with Theatres to provide 4 Radiographers and Image Intensifiers (II) each day Monday to Friday due to equipment availability and quality. Three of the intensifiers are over 10 years old and require urgent replacement.	1. Staff are trained to optimise image quality 2. Weekly attendance at the planning meeting to allow best use of the limited resources and allocation of machines is completed based on the one that would work best for the case in question. 3. Ongoing staff training is in place and the nature of the issue is known to the surgeons and the Radiographers. 4. PID drafted, equipment bid submitted	- Planning Meetings	1. Staff can only optimise image quality within limitations of machine 2. The only way this risk will be mitigated is to purchase additional equipment to replace that which is no longer usable. 3. Image quality of existing equipment poor 4. Equipment aging and been advised to take some out of use 5. Awaiting outcome of equipment bid 6. Awaiting confirmation as to capital slippage for 23/24 before submission of PID		4	15 (5x3)	3 (1x3)	—	Lorraine Beccon shall

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CNO - Extreme Risk Profile

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1133	07/04/22	31/03/25	Insufficient Midwifery Staffing impacting the ability to provide patient care.	Insufficient midwifery workforce to meet demand. • Inability to provide 1:1 care in labour. • Avoidable delays in the IOL pathway. • Poor patient experience. • Potential for adverse clinical outcome. • Poor staff morale and burnout. • Inability to implement continuity of carer in line with national directive.	• Enhanced Bank Rates: encourage staff • Weekly workforce meeting with senior sisters • Rolling recruitment to fill vacancies • Vacancy increased to 21.12 and maternity leave 11.72 • Mitigate risk by movement of staff across the unit based on acuity and capacity. • Senior Sisters, specialist midwives and matrons working clinically to support ward staff • Regular HOM Briefing to staff and Board Level Safety Champions walk around to support staff. • Support staff for retention • Workforce improvement plan • Working closely with CCCU to determine next steps for 3rd year students • LMNS (Local Maternity Network System) • ICB Maternity Lead	CGB MNSCAB DMB RISK MEETING	• Staff retention and international recruitment options • 2nd and 3rd year students will attend Surrey University and qualify in 2025		4	20 (4x5)	4 (1x4)	▲	Kate Harris

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COO - Extreme Risk Profile

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1979	01/05/2024	31/07/2024	Risk of patient harm caused by Metavision failure due to unsupported IT systems	Metavision is a full electronic patient record which includes prescriptions and is used in critical care. The existing Metavision version faces challenges with reported bugs and compatibility issues with the current IT systems in the Trust and therefore requires urgent upgrade to Metavision 6. Without this upgrade there is a risk of patient harm caused by system failure and lack of patient records available to make informed care decisions. The backup Electronic Data Archive (EDA) system serves as a contingency, ensuring uninterrupted access to critical patient data in the event of system or network downtime. The EDA has not worked since 17/01/24	- - Revert to BCP and use paper records if live system fails - - in case of failure of back up system, Print summary of care from MetaVision to be placed at patient bedside - - Written paper drug charts – to be updated when changes are made on MetaVision and reviewed/compared with MV on the ward rounds - - Ward clerks will print MV patient prescription after the daily ward round - - Nurses will print MV patient prescription at the end of each shift	- daily huddles - weekly and monthly governance meetings - weekly review of risk	- Upgrade to Metavision urgently required - 2nd EDA backup required in case of failure of 1st		4	20 (4x5)	5 (1x5)	–	Sharon Kaur

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
2055	25/04/2024	31/03/2025	ERF / elective activity plans	The Trust must deliver ambitious activity plans in 24/25 - over and above that delivered in 23/24 - in order to meet its planned deficit of £29m.	- Activity performance monitoring	- Reporting to FPPC			9	20 (5x4)	9 (3x3)	—	Paul Kimber
1901	04/01/2024		Access Control	Access Control uses a system of cards and readers to unlock doors. Access Control management is weak allowing access by staff to areas where they are not authorised, and may prevent staff accessing areas they need to during an emergency. Contractors and other visitors given access using Access Control along with staff who leave are not removed from the system and may still have access.	- Mortuary and Pharmacy areas access restricted to an agreed list of staff. - Most hospital staff currently are unaware of their Access Levels.	Reports issued to mortuary of entry and entitlement to check access entitlement.	Access control is not managed according to the principles of the Access Control Paper Aug 2023. Staff can find they have access to areas where they are not permitted. There is no overarching policy or SOPs. Access can be granted in one of five different locations with no control and no audit process. Staff and contractors who no longer work in the Trust still have working access control tokens. There are many more tokens registered on the system that there are staff. Recent bid to provide staff and software to manage the system was declined meaning that the Trust cannot perform a lockdown and may not be able to monitor and prevent access to sensitive areas such as mortuary and pharmacy.		4	16 (4x4)	4(1x4)	—	Neil Adams

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1053	07/03/23	15/08/2025	Risk of inability to provide adequate plain film service due to ageing equipment and increased downtime.	Due to their age, the CR readers used in General Imaging to process x-rays are unreliable and very prone to breaking down. The age of the equipment also means sourcing parts for the machines is becoming increasingly difficult. There is a risk that these concerns could lead to potential delays in care delivery, damage to Trust reputation and patient safety concerns through potential wrong information being given to patients or test result being wrong	• Capacity going through the machine is regularly monitored and managed • Limited GP walk-in service • Inpatient x-ray room utilised to facilitate A&E patients and potentially some GP bookings • Sittingbourne and Sheppey hospitals can be utilised	• Imaging governance meeting • Diagnostic and Clinical support services governance meeting • Divisional governance Board	No CR reader has not been sourced	1. Await sourcing of CR reader	4	15 (3x5)	5 (1x5)	—	Lorraine Beccon shall
1864	10/01/2024	28/11/2025	Maternity Information System coming to end of contract; need alternative system	Euroking contract end date is 03 December 2025. Need to begin exploring options for alternative system as Euroking does not meet service needs.	Discussions with LMNS and Trust IT Directors re sourcing alternative system. Scoping to be reviewed.	Labour ward forum Care Group Governance Board Divisional Board MNSCAB			9	15 (5x3)	4 (2x2)	—	Sam Chapman

NHS Medway NHS Foundation Trust

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1839	05/12/23		High Radiation Doses at Sittingbourne Hospital	As a result of Medical Physics reviewing dose data to establish Diagnostic Reference levels (DRL's), it has been highlighted that patients are receiving higher doses of radiation when having x-rays at Sittingbourne Hospital. This is compared to National DRL's (for CR equipment) and compared to digital (DR) equipment.	Radiation Protection Supervisor is collecting DRL information and exposure indexes for the most routinely performed x-rays. This will help establish the relationship between dose and the diagnostic quality of radiographs.	Radiation physics are aware and currently investigating. The equipment is still producing diagnostic images, although these are over the recommended National DRL's and higher exposure factors are needed to produce the diagnostic images. Staff are aware and using the ALARP (As Low As Reasonable Practicable) principle to optimise doses as much as possible.	Until this equipment is replaced we cannot easily reduce the dose to patients, and therefore cannot reduce the risk score. CR equipment is gradually becoming obsolete which means finding parts and optimisation of equipment is difficult. The CR reader is on end of life.	1. Replace Equipment 2. PID to be written	4	15 (5x3)	3 (1x3)	—	Sarah Lee
1293	07/04/22	31/03/25	SAU being bedded/having patients with a DTA and no bed to transfer to	Closure of the SAU may lead to: 1. Patients stay in ED for long period of time 2. As patients are speciality patients they are often placed in the corridor to wait to be seen by the surgical teams, risk of patient deterioration 3. This causes additional pressure to ED and capacity in ED. 4. Delayed treatment 5. Staff welfare/wellbeing/morale 6. Patient feedback/FFT	- The aim is to get the 2 assessment rooms open as soon as possible so that waiting room suitable patients can go to SAU. - Any returners i.e. for scans etc. are still seen in SAU whilst closed - Relocation of staff as required in order to support - FFT surveys/ monitor outputs - Not recent closures/ unit continues to function	- Divisional Risk Review Group - Care Group Board - Divisional Governance Board - PSG - QPSSC	- SAU needs to be ring fenced so it can continue to function - Staff availability in order to support - Medical outliers even when Trust is not in business continuity		4	15 (5x3)	3 (1x3)	—	Joss Hargan

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
1656	11/05/2023		Fire Safety	A fire on site could lead to: - Loss of life - Injury or harm to people, including patients, staff and visitors etc. - Loss or damage to buildings, infrastructure and equipment - Reputational damage - Impact on patient services/care - Financial impact Fire Safety is multi-faceted and as such, the risk score is impacted by - Detection - Compartmentation - Suppression - Emergency Lighting - Training - Management - Housekeeping (Site safety).	- Mandated annual fire safety training for all Staff -Optional annual fire warden training available - In-house fire response service provided to attend all detector and call-point activations on a 24/7 basis - Departmental FRAs - Annual inspection of all fire doors on site - Repair or replacement of fire doors as required - Fire safety team involved in planning stages of all capital projects - Weekly fire alarm tests - 5-day week presence from fire alarm engineers - New fire alarm being systematically installed - Fire damper inspections undertaken in March 2023 - All cladding replaced on-site post-Grenfell. - Walkarounds undertaken by fire safety team to check controls - Capital allocation for 2023/24.	- Competent person appointed for Fire - Monthly Fire Safety Group - Monthly Health, Safety & Security Group - Appointed Authorised Engineer (AE) for Fire - Annual Audit by AE - Annual Audit by Kent Fire and Rescue Service (KFRS) - Roles and Responsibilities of designated individuals recorded within the Corporate Fire Safety Policy	- Management: No methodology of dealing with smokers. - No consequence to rule-breakers. - ED Misting system cannot be commissioned whilst occupied and therefore will not function. - no smoking cessation group established.	1. Lightning Conductor 2. Smoking on site 3. Emergency Lighting 4. Fire Dampers	8	15 (3x5)	5 (1x5)	–	Neil McElduff

Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
2005	28/03/2024	18/04/2024	Various environmental issues affecting Nelson ward which may impact patient safety	Following a PLACE review of the Nelson ward environment there have been a number of issues that have been identified for urgent attention. Please see below the list of issues: 1. The fire doors need replacement due to damage 2. Areas of damp noted to the flooring in Bay 3 with no known source. 3. Mould was found in both side rooms and on the behind the nurses station. 4. Mould found in bathroom and store cupboard 5. There is regular reports of drain blocks which result in closure of toilets until the issue can be resolved. 6. Due to works carried out for the side rooms, this as resulted in closure of both side rooms. The ward is a Gastro ward with no side room capacity	- Areas where mould has been found have been stripped out and are not accessible to patients. Reactive maintenance remains ins place however, only demolition and rebuild would be the sensible course. Ruby ward will provide alternative accommodation for this patient cohort.	Comment from Senior Fire Safety Advisor on 25/03/2024 - Given that fire-doors were part of the recent refit, it is more likely that they require attention rather than replacement. However, further details are required.	Ruby ward refurbishment will provide alternative accommodation and COO in receipt of paper proposing closure.	1. Close Nelson Ward	8	15 (5x3)	3 (1x3)	–	Paul Norman Brown

NHS
Medway
NHS Foundation Trust

CEO - Extreme Risk Profile

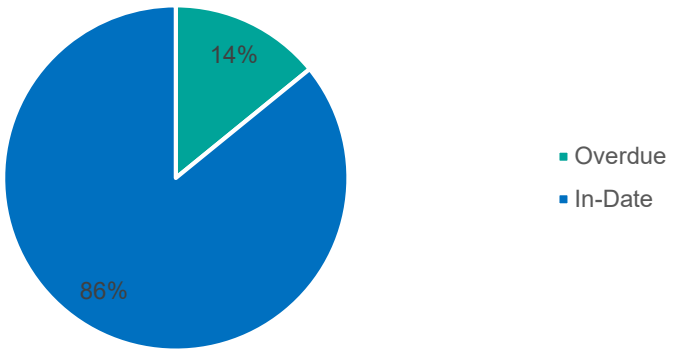
Risk ID	Date Approved	Proposed for Closure	Risk Title	Risk Description	Controls	Assurances	Gaps in Controls	Actions	Trigger Level	Current Score	Target Score	In Month Change	Owner
2056	25/04/2024	31/03/2025	ICB alignment of clinical income	The Trust has set a 24/25 plan that assumes income from commissioners that the commissioners themselves have not included in their opening contract offers. There is consequently a risk that the Trust does not met its income target and could jeopardise delivery of its planned deficit.	- - Business planning triangulation - - ICB working group to review allocations - - ICB "difficult decisions" committee - - Reporting of unfunded services - - Month end financial performance management	- FPPC reporting	- Commissioners discretion over certain items in respect of payment	1. ICB Contract negotiation	9	16 (4x4)	9 (3x3)	–	Paul Kimber

Approved Risks

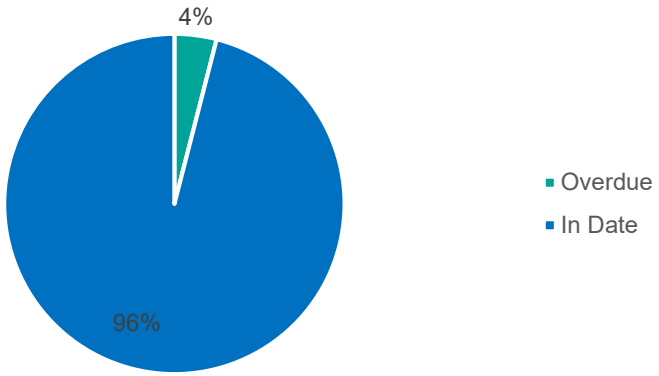
Of the 237 approved risks;
- 39 have breached their review date

Of the 25 ‘extreme risks’;
- 1 has breached their review date

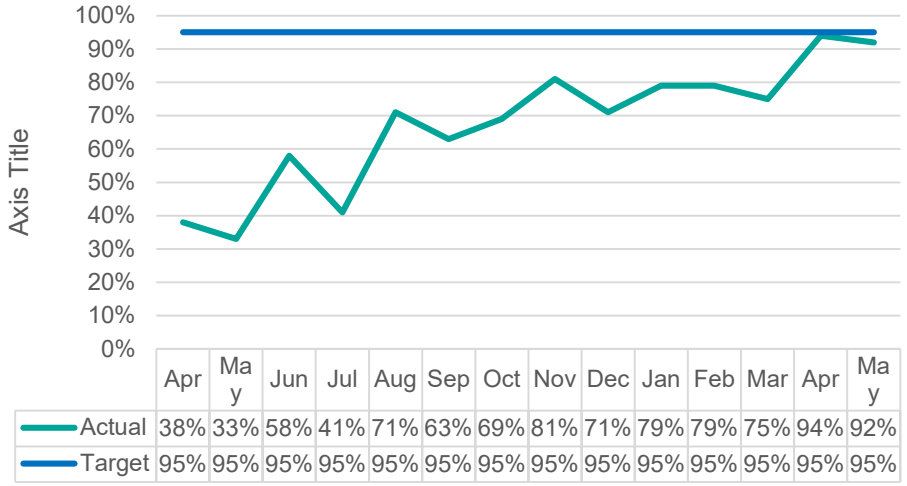
Risks by Review Status



'Extreme' Risks by Review Status



Review Rate by Month



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Actual	38%	33%	58%	41%	71%	63%	69%	81%	71%	79%	79%	75%	94%	92%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Surgical Services– Deep Dive

The Surgical Services Risk Register has 4 approved risks in total, 1 of which is 'extreme'

1293 - SAU being bedded/having patients with a DTA and no bed to transfer to (Score 5x3 =15)

1474 - ENT PTL and Waiting Times (Score 4x3 = 12)

1462 - ENT PTL and Waiting Times Information – DVH (Score 4x3 = 12)

1 new risks added, of which
1 risks are awaiting review, and
0 risks awaiting approval.

0 risks have been closed down in June

100% of risks have been reviewed within their required timeframes

Oldest risk: 20th October 2021 (*Risk ID: 1293*)

Action Required

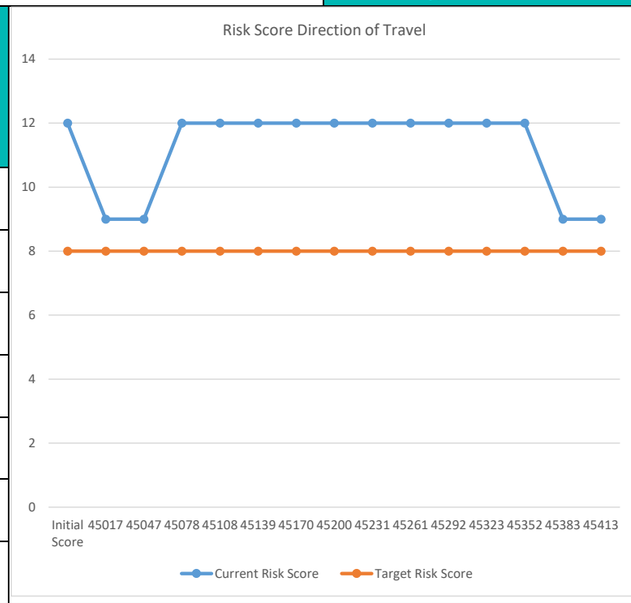
Ref	Action	Owner	Date	Status
01	95% of approved risks to have been reviewed within timeframe	Risk Owners with oversight by IGT	31 July 23	Overdue. Review rate currently at 86%
02	Review of process for new risks to ensure they are approved in a timely way with 95% approved within 1 month of being raised	IGT	31 July 23	Process complete. 95% target not yet achieved
03	100% of approved risks are fully completed	Risk Owners with oversight by IGT	31 July 23	Complete
04	Quarterly reporting against Risk Management KPIs	IGT	31 July 23	Complete
05	Consolidate all EPR and EPMA Risks into 2 singular risks as agreed with MD and CNO. These 2 new risks should focus on functionality of the system and staff not following processes/using workarounds	Kerry O'Reilly with support from IGT	31 July 23	Complete
06	Assign every risk to the 'group or committee' responsible for onward monitoring	IGT	31 July 23	Complete
07	Work with divisions to 'cascade' information relating to the difference between incidents and risk	IGT	31 Oct 23	Complete

PATIENT BOARD ASSURANCE FRAMEWORK

Risk ID:	1a
Executive Owner	Chief Nursing Officer
Operational Owner	Nicola Lewis, Associate Director of Patient Experience
Primary Risk Grouping	Patient
CQC Domain	Responsive

Objective:	Providing outstanding, compassionate care for our patients and their families, every time.
Principal Risk Name & Description	Low uptake as a result of patient feedback fatigue due to patients not being able to see the improvement being made from completing a survey makes.
Relevant Group/Committee	Quality Assurance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	4	**12**	N
Risk Score at Last Review	3	3	**9**	▼
Current Risk Score	3	3	**9**	▼
Target Risk Score	2	4	**8**	—
Trust Risk Appetite	Appetite: Low Range: 5-8 Score (trigger level): 8			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Average**	**Comments:**
Total FFT Response Rate	45.0%	12.4%	12.6%	14.6%	13.9%	16.2%	15.2%	14.2%	
Inpatients FFT Response Rate	45.0%	42.2%	34.9%	40.3%	44.7%	53.4%	47.3%	43.8%	
Emergency Care FFT Response Rate	45.0%	7.2%	8.0%	9.7%	7.5%	10.0%	8.8%	8.5%	
Outpatient FFT Response Rate	45.0%	8.0%	9.0%	10.1%	9.2%	9.9%	9.8%	9.3%	
Maternity FFT Response Rate	45.0%	14.4%	30.7%	38.7%	30.4%	49.5%	47.6%	35.2%	

Context Summary
(Patient First problem statement, current situation)

FFT is a quick and simple way for our patients and other people who use our services to give us feedback, which would enable us to identify what is working well and where there are areas for improvement in any aspect of the patient experience. This is a national requirement set by NHS England whereby patients can express their opinion at all touch points of their journey.
Currently at Medway NHS Foundation Trust, only 9.9% of our patients and people who use our services provide us with FFT feedback which is behind target of 50% and only 87.9% of respondents would recommend us to their friends or family which is behind target of 95%.
The recent annual Care Quality Commission (CQC) Adult Inpatient Survey 2022 provided us with a baseline of how our patients feel about the quality of care and services we provide. This information doesn't enable us to be proactive in identifying examples of good practice, immediate issues requiring improvement or themes that are emerging.
Our patients, their families and carers have told us through many engagement routes, including the Care Quality Commission (CQC) Adult Inpatient Survey 2022, what is important to them. We are currently not capturing enough timely information around:
The different stages of the patients' journey, for example, from admission to discharge, every time they interact with our services, after leaving ED if not admitted.
Text messages are sent to patients after they have left our services and during inpatient admission.

Rationale for Current Score

This is the local target for the FFT response rate as part of the patient first breakthrough objective and the patient experience strategy. The risk score was raised in June as the response rate scores for ED and OPD reamin low and maternity response rate dropped in comparison to the months previously. There is little likelyhood that covid will have an impact on FFT response rate in the near future

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Quality Improvement Projects have been commenced based on patient feedback Engaging with patients to understand why they do not complete the FFT survey Change of SMS text provider Widened scope of text distribution Increasing use of electronic devices Paper surveys have been discontinued Posters and QR codes disseminated	Increased uptake in FFT responses in all areas Improvement in recommend rate and overall experience of care Improved response for completed surveys versus opened and incomplete surveys via text Improvement in recommend rate and overall experience of care CQC surveys / data Patient Experience Group

Gaps in Controls	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)

(What additional controls and assurances should we seek?)	Action	Due Date	Action RAG	Action Lead	Progress Notes / Action Completion Date
Errors in data with the FFT questionnaire on GATHER	To review all areas line by line to ensure accuracy when patients are completing the survey on gather	30/04/2024	Off Track	Malou Bengtsson-Wheeler	16/04/24 S&A areas completed. Other divisions will be completed by the end of April. **Delays with mapping the data. DDoN's have been asked to return this information by the 17th May, complete** - to close this action
Closure of feedback loop from patient feedback from FFT to patients/carers/staff and visitors	1a Regular updates regarding improvements made based on patient feedback on Trust website, social media and patient information. 1b Comms and patient exp team to create SOP for quarterly updates on the website.	31/03/2024	Complete	Nicola Lewis, Associate Director of Patient Experience	15/01/2024 Information is being passed onto patients via social media however, the Patient information group to commence January 2024. Comms will update when the new website is launched in late March 2024. the due date to change in line with the launch of the new website. Update 16/04/24 - new website has been launched and feedback is being shared to close the communication loop. propose to close this action.
Low response feedback rate in ED in OPD areas	2 Targeted focus with improvement initiatives in OPD in ED such as, an FFT champion each shift, FFT infomration placement for patients to understand why it is important to complete the feedback survey	30/09/2023	Complete	Nicola Lewis, Associate Director of Patient Experience	OPD Staff are engaging clinical teams in each clinic to provide a reminder to each patient to provide feedback if they get a text in OPD. action reviewed and split into 2 new actions for tracking and assurance. This action to be closed. **Action closed January 2024**
Some wards still utilising paper surveys	3 Business case to be written to Lease patient experience IPADS. This work is being carried out with the estates and facilities team to include digital meal ordering. Tablets to be fixed and returned to the wards for FFT use.	31/07/2023	On Track/Not Yet Due	Nicola Lewis, Associate Director of Patient Experience	Proposal is awaiting input from the director of IT and Estates and facilities team. The aim for this to be ready is w/c 02/10/2023. 16/10/23 update was received from DoIT which have been reflected in the BC. Further discussion is required with EH prior to submission. 09/11/23 an audit to account for all tablets in clinical areas was completed in October. scoping to be completed by the transformation team / CNO / COO to agree next steps. 15.01.24 update - PMO are supporting this action with the aim to close by the end of February. update 07/03/24 - action to be extended and proposal for closure is early MAy 2024. update 16/04/24 - Tablets are with the IT team, proposal paused for purchasing or leasing IPADS until the Tablets are fixed. to review this action in May 2024 **update May 24 - 2 tablets have been fixed they are being trialled on OPD and ICU.**
Low response FFT rate in ED	A3 has commenced in AEM, led by the HoN and Matrons	30/07/2024	Complete	Kathy Ward (HoN) and Kate Holmes (DDoN)	A3 countermeasures devleoped with the team. ADPE supporting. This action due date has been extended as the project will be long term. April 2024 - an improvement focus will commence in the ED during 'quality week' to support ED staff to work through challenges and identify countermeasure solutions in the last week of May. this work is being supported by the CNO team and integrated governance team with interventions from the CNS teams throughout the week. Recommend rate reduced to 85%. **complete - to close this action.**
Low FFT response rate in OPD areas	• Engaging all clinicians in OPD to engage with FFT and remind patients to scan the QR code. • Review and refresh all FFT merchandise in OPD areas. • ADPE to attend the OPD patient experience meeting to promote the use of FFT. • New divisional structure commenced in late 2023, areas in OPD to be updated on Gather and refresh of the system to commence in the next reporting period		Complete	Chris O'Connell (Matron) Laura Potter (DDoN / AHP Acting)	actions are complete. A marginal rise in FFT reposne has been noted. **16/04/24 propose the action to be closed**

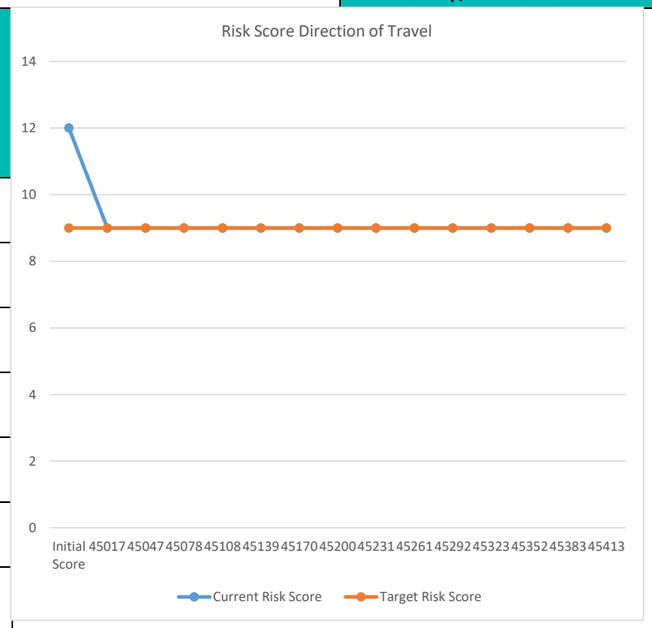
Poor response rate and uptake from text messages sent to patients		4 To review the reasonable adjustments requried for patients who may not be able to afford data / Wifi to connect to the survey. To provide adjustments for patients who may have dyslexia. To request assistance from the comms team to engage with patients who receive a text following an appointment or admission but do not provide their feedback to identify themes and trends.	15/12/2023	Complete	Nicola Lewis, Associate Director of Patient Experience	this action has been reviewed with the action to understand national themes and trends for low reposne rates and reasons for not engaging. **To be considered for closure please**
Trust Risk Register Aligned to Board Assurance Framework	Ref:		Current Risk Score:			
	Ref:		Current Risk Score:			
	Ref:		Current Risk Score:			
	Ref:		Current Risk Score:			
	Ref:		Current Risk Score:			
Additional Comments (Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)						
Date of Last Review:	14 June 2024					
Date of Next Review:	14 July 2024					

PATIENT BOARD ASSURANCE FRAMEWORK

Risk ID:	1b
Executive Owner	Chief Nursing Officer
Operational Owner	Nicola Lewis, Associate Director of Patient Experience
Primary Risk Grouping	Patient
CQC Domain	Responsive

Objective:	Providing outstanding, compassionate care for our patients and their families, every time.
Principal Risk Name & Description	Potential lack of patient feedback standardisation approach could result in development of multiple approach to feedback questions and data collection which could lead to data variation which cannot be used for benchmarking across the Trust
Relevant Group/Committee	Quality Assurance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	3	**12**	N
Risk Score at Last Review	3	3	**9**	—
Current Risk Score	3	3	**9**	—
Target Risk Score	3	3	**9**	—
Trust Risk Appetite	Appetite: Low Range: 5-8 Score (trigger level): 8			
Assurance Strength	High			
Adequacy of Controls	Adequate			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Average**	**Comments:**
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Inpatients FFT Response Rate	45.0%	42.2%	34.9%	40.3%	44.7%	53.4%	47.3%	43.8%	
Emergency Care FFT Response Rate	45.0%	7.2%	8.0%	9.7%	7.5%	10.0%	8.8%	8.5%	
Outpatient FFT Response Rate	45.0%	8.0%	9.0%	10.1%	9.2%	9.9%	9.8%	9.3%	
Maternity FFT Response Rate	45.0%	14.4%	30.7%	38.7%	30.4%	49.5%	47.6%	35.2%	

Context Summary
(Patient First problem statement, current situation)

FFT is a quick and simple way for our patients and other people who use our services to give us feedback, which would enable us to identify what is working well and where there are areas for improvement in any aspect of the patient experience. This is a national requirement set by NHS England whereby patients can express their opinion at all touch points of their journey.
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The recent annual Care Quality Commission (CQC) Adult Inpatient Survey 2022 provided us with a baseline of how our patients feel about the quality of care and services we provide. This information doesn't enable us to be proactive in identifying examples of good practice, immediate issues requiring improvement or themes that are emerging.
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The different stages of the patients' journey, for example, from admission to discharge, every time they interact with our services, after leaving ED if not admitted.
Text messages are sent to patients after they have left our services and during inpatient admission.

Rationale for Current Score

actions complete - to close this risk please

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Original surveys approved by Senior teams based on NHSE guidance All survey requests to be approved via the Executive Team All survey changes actioned by Gather Team	Gather system and FFT feedback to benchmark the responses in each

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**

1. An increase in requests for new or changes to the FFT surveys have been received from different clincal areas	1. Full review of all FFT surveys to take place and cross reference the relevance against all clinical areas	31/07/2023	Complete	Nicola Lewis, Associate Director of Patient Experience	All surveys have been reviewed and updated. This action is complete and awaiting approval with Execs. . 15/01/24 all reviews for surveys are complete and published on Gather. Action to be closed update 14/06/24 - questoins on the surveys reduced to 3 only plus free text boxes. **TO BE CLOSED**
2. action targets for response rate removed but added as a watch metric. **propose to close this risk**		30/06/2024	Complete	Nicola Lewis, Associate Director of Patient Experience	to close

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

Risk submitted to QAC for proposal of closure October 2023. Target score reached

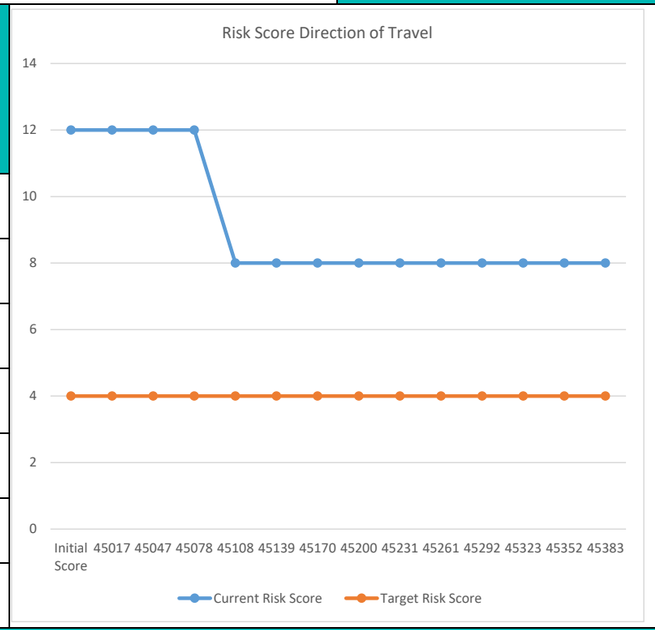
Date of Last Review:	14 June 2024
Date of Next Review:	14 July 2024

PATIENT BOARD ASSURANCE FRAMEWORK

Risk ID:	1c
Executive Owner	Chief Nursing Officer
Operational Owner	Nicola Lewis, Associate Director of Patient Experience
Primary Risk Grouping	Patient
CQC Domain	Responsive

Objective:	Providing outstanding, compassionate care for our patients and their families, every time.
Principal Risk Name & Description	Potential lack of delivery across other True North Domains could lead to patients not recommending our services as a place to receive care
Relevant Group/Committee	Quality Assurance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	4	**12**	N
Risk Score at Last Review	2	4	**8**	—
Current Risk Score	2	4	**8**	—
Target Risk Score	1	4	**4**	—
Trust Risk Appetite	Appetite: Low Range: 5-8 Score (trigger level): 8			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Average**	**Comments:**
Total FFT Recommended Rate	95.0%	88.7%	87.7%	89.4%	89.5%	90.4%	89.7%	89.2%	
Inpatients FFT Recommended Rate	95.0%	93.3%	92.3%	94.2%	93.1%	93.2%	92.6%	93.1%	
Emergency Care FFT Recommended Rate	95.0%	69.2%	64.7%	68.9%	71.6%	77.1%	70.2%	70.3%	
Outpatient FFT Recommended Rate	95.0%	91.9%	91.5%	91.9%	91.5%	91.3%	92.7%	91.8%	
Maternity FFT Recommended Rate	95.0%	82.7%	88.5%	85.8%	88.8%	99.4%	96.5%	90.3%	

Context Summary
(Patient First problem statement, current situation)

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Our patients, their families and carers have told us through many engagement routes, including the Care Quality Commission (CQC) Adult Inpatient Survey 2022, what is important to them. We are currently not capturing enough timely information around:
The different stages of the patients' journey, for example, from admission to discharge, every time they interact with our services, after leaving ED if not admitted.
Text messages are sent to patients after they have left our services and during inpatient admission.

Rationale for Current Score

National target and evidence of exemplary care. Risk score has reduced as the recommend rate has increased consistently within inpatient areas.
Risk rating has increased as actions are overdue and FFT recommend rate has not improved in OPD and ED, which decreases the overall receommend rate in the organisation.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Developing specifc improvements based on feedback themes and trends from patients	All actions are monitored via driver huddles, catch ball and SDR Patient Experience Group

Gaps in Controls
(What additional controls and assurances should we seek?)

Mitigating Actions to Address Gaps
(What more should we do to address the gaps?)

Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**

Errors in data with the FFT questionnaire on GATHER	To review all areas line by line to ensure accuracy when patients are completing the survey on gather	30/04/2024	**Complete**	Malou Bengtsson-Wheeler	S&A division complete. **Awaiting an update from the 3 remaining divisions by 17th May. Update 14/06/24 - complete**
Low recommend and response rate in ED	To consider standing up a quality event which engages all the clinical quality teams to support patient care in ED - a break the cycle week. This is awaiting a final approval with the senior teams	01/06/2024	Complete	Nikki Lewis / Wayne Blowers / Steph Gorman	a week to support the quality of care will commence in late April. Plans to support this are underway. **This is planned for W/C 20th May. Thefore the action due date has been updated.**
Operational flow and processes in maternity have caused a reduction in recommend rate over the last 2 months.	Maternity teams to implement a deep dive / A3 into the issues surrounding induction of Labour	31/07/2024	On Track/Not Yet Due	Alison Herron, Director of Midwifery / Kate Harris, Head of Midwifery	This project will be running for 1 year
Noise at Night	A full evalutation of the noise at night project to be completed	31/08/2023	Overdue	Divisional Directors of Nursing	15/01/2024 awaiting the evaluation report from DDoNs. 16/04/24 - no further update
Staff attitude has been a theme from patient feedback, PALS and Complaints in maternity areas	A3 deep dive into issues surrounding staff attitude, with intentional rounding from senior staff out of hours	31/08/2023	Complete	Kate Harris, Head of Midwifery	Maternity A3 and action are complete 15/09/2023. action to be closed
Staff attitude has been a theme from patient feedback in inpatient areas	A3 deep dive discussions have commenced with further detail around actions and improvements will be collated with the CNO and team	30/11/2023	Complete	Nicola Lewis, Associate Director of Patient Experience	the A3 for staff attitude to be shared at the PE Group / QPSSc and QAC. **To be closed**
Staff attitude and concerns at night have been raised from patient on inpatient areas	A rota for senior staff support and visibility has been developed with the CNO. The approach to be approved at the next CNO meeting	30/09/2023	Complete	Nicola Lewis, Associate Director of Patient Experience	**to be closed**
Low recommend rate in OPD and ED	Clinicans in OPD to offer a reminder to patients complete the survey following their consultation. Actions are being collated in care group huddles to improve the FFT recommend rate, these are escalated	30/11/2023	Complete	Outpatients / ED Team	to separate this into 2 separate actions.**to close this action.**
Low recommend Rate in ED	to meet with the ED teams and join their huddles. Restart A3	01/01/2024	Complete	Kathy Ward (HoN) Kate Holmes (DDoN)	Complete. **Action to be closed**
Low recommend rate in OPD	• Engaging all clinicians in OPD to engage with FFT and remind patients to scan the QR code. • Review and refresh all FFT merchandise in OPD areas.	15/02/2024	Complete	Chris O'Connell (Matron) Laura Potter (DDoN/AHP interim)	**complete - to be closed**

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

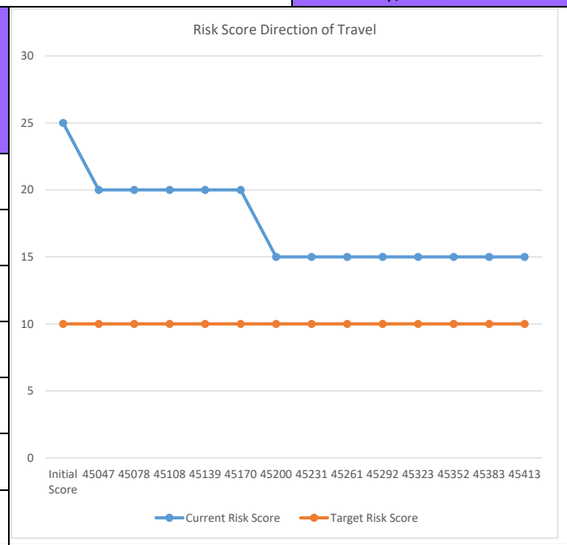
Risk rating has increased as actions are overdue and FFT recommend rate has not improved in OPD and ED, which decreases the overall receommend rate in the organisation

Date of Last Review:	15 May 2024
Date of Next Review:	14 June 2024

QUALITY BOARD ASSURANCE FRAMEWORK

Risk ID:	2a	**Objective:**	Excellent outcomes ensuring no patient comes to harm and no patient dies who should not have
Executive Owner	Chief Medical Officer		
Operational Owner	James Alegbeleye, Medical Director for Quality and Safety	**Principal Risk Name & Description**	Lack of timely escalation and treatment of deteriorating patients
Primary Risk Grouping	Quality		
CQC Domain	Safe	**Relevant Group/Committee**	Quality Assurance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	5	5	**25**	N
Risk Score at Last Review	3	5	**15**	—
Current Risk Score	3	5	**15**	—
Target Risk Score	2	5	**10**	—
Trust Risk Appetite	Appetite: Very Low Range: 1-4 Score (trigger level): 4			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Average**	**Comments:**
Avoidable 2222 Calls - Total	16	2	4	2	0	3	3	2	
Avoidable 2222 Calls - Cardiac Arrest	1	2	1	0	0	1	2	1	
Avoidable 2222 Calls - Peri-Arrest	3	0	3	2	0	1	1	1	
ALS/BLS Training Compliance	85.0%	81.2%	81.0%	81.0%				81.1%	

Context Summary
(Patient First problem statement, current situation)

We have patients in the hospital who die unnecessarily and the data tells us that this is more likely at the weekend than during the week. From analysis we have identified that possible delay or failure to monitor or escalate is one of the biggest causes of “death” harm incidents behind implementation of care or ongoing monitoring.

Rationale for Current Score

Risk reviewed with CMO on 06/12/2023 - Avoidable 2222 data demonstrates special cause variation statistically significant reduction in trustwide avoidable 2222’s. Score remains at 3x5 as frequency of avoidable 2222 has reduced but not yet to such a point that likelihood can be reduced to 2 (Unlikely) from current likelihood of 3 (Possible).

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Delays in whole patient pathway from initial deterioration to patient receiving correct treatment in correct part of hospital. Investigating critical care reasons for delay in taking patient. Ongoing work with Care Group leads focusing on 'culture change'. CITO (digital critical care information) now available for all medical staff. Cardiac and peri – arrest proforma in process of being implemented onto EPR. ART team feeing back the trends with avoidable ART calls. Resolved Issues - Investigating delays in review by Surgeons not answering bleep (Pilot for Surgical Teams to attend Hospital @ Night huddle with ART to support response times out of hours, SOP updated to reflect this change to process and engagement will be fully effective from 1 March 2023with new rota in place to support) - resolved. A3 started regarding ALS and EPALS compliance, and arrangements for providing this training. Resus Service now attending doctors (in training) inductions to manually gather Resus certificates data for ESR. - Resolved	These are reviewed in weekly 'huddle' and remain under review until marked as complete. Training and funding for ALS/EPALS – funding confirmed and has been requested by Divisions as part of Business planning. Status paper drafted which will provide clear countermeasures to deal with known gaps.

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1a. Doctors not ALS/BLS Trained	1a. Improve ALS/BLS training compliance	22/05/2023	Overdue	Chief Medical Officer	**trained/attend training.** **06.05.2024 - Ongoing** 15.04.2024 - Divisional directors will work with Resus team to identify staffs who are non-cmpliant 11.03.24: Als 81% BLS - 73% YTD average only at 80%, target not yet achieved. Work ongoing with action plan. Service Managers working with respective areas on compliance.

2a. EPR system needs optimisation	2a. Cardiac and pre-arrest proforma on to EPR	24/04/2024	On Track/Not Yet Due	Tamara Stephens, Sherwin Sinocruz	**11.06.2024 - To be piloted in June** **06.05.2024 - still in pilot change and wants to ensure the functionality is correct. Pilot in progress – feedback by end of may** 11.03.24: going through testing Ongoing SIM testing referral tool for escalation. Re-design complete and awaiting electronic completion.
2b. EPR system needs optimisation	2b. Electronic SBAR referral tool for escalation	24/04/2024	On Track/Not Yet Due	Emma Coutts	**11.06.2024 Deferred to June** **06.05.2024 - updated its on HOLD for the time being bcos of delay in Order Comms launch. EC noted that it is a part of EPR project** 11.03.24 : Going through testing 20/03/2024 This has been moved through to testing which will take place 08/02/2024 and will then be taken back to the EPR Board for approval
2c. EPR system needs optimisation	2c. ABG/Point of Care Testing integration with EPR	22/04/2024	On Track/Not Yet Due	Tamara Stevens, Kerry O'Reilly, Dilip Pillai	**11.06.2024 Deferred to July** **06.05.2024 - This will be taken on following order comms and upgrade which will mean there is change freeze, discussion under way this will not take place until July. meet with SS mid July to re ignite.** Order Comms live is 16.04.2024 11.03.24: deferred to 20/04/2024 Awaiting Order Comms Switch on 04/2024
2d. EPR system needs optimisation	2d. Medicus ART clinical entry integration with EPR	31/03/2025	On Track/Not Yet Due	Dilip Pillai, Kerry O'Reilly, Emma Coutts, James Alegbeleye, Zohreen Amir	**11.06.2024 Ongoing** **06.05.2024 - This is a technically challenging project, and needs to be explored . We will be looking at the technically feasibility. To look into this update in a month time (May 22).** There will be an integration cost involved of £6000 which has been reduced by £3000 if the trust can complete this integration along with the update that MEDICUS will be completing for us . To be confirmed if this can be sought from the critical care budget in line with the ICU IT Medicus costing. Update due 21/02/2024. MAy go through Stategic Filter? corporate project
2e. EPR system needs optimisation	2e. **ReSPECT/DNACPR/TEP development + electronic integration with community ICS and Trust	01/09/2024	On Track/Not Yet Due	James Alegbeleye, Zohreen Amir, Dilip Pillai	**11.06.2024 TMB Group & pilot July** **06.05.2024 - ChP/ZA to update after cancer palliative care divisional meeting & TMB group to meet again on 5th June to finalise TEP** 15.04.2024 - Update: Going through Governance approval before piloting 11.03.24 going through consultation final version available soon Larger project, pending JaA work + recruiting next Darzi fellow. Discussions/review ongoing around content, electronic integration and whether there can be a single form across the community and Trust. Not yet complete, ongoing discussions. Pilot form to be tested. Update 13/03/2024
2f. EPR system needs optimisation	2f. Rewrite of TEP form	30/06/2023	Complete	James Alegbeleye	See action ref 2e. **This has been marked as complete despite ongoing work as it is now included in action 2e.**
3a. Failure to escalate/escalate/gap in clinical plan: Gap in knowledge of SOP/Standard	3a. Targeted NEWS/Alert training to be mandatory for all staff	15/11/2023	Complete	Emma Coutts	Complete
3b. Failure to escalate/escalate/gap in clinical plan: NEWS not captured as per standards	3b. A3 on timeline for NEWS	01/09/2024	On Track/Not Yet Due	Jamie Moore, Kate Holmes, Emma Coutts	**11.06.2024 Note to Comms to distrbute to clinical teams. DD asked to look into their business needs.** **06.05.2024 - Ongoing** 11.03.24 Bring back by end of march 2024 Three streams - i) Ensure Observations are undertaken as needed; ii) ward scores visible on whiteboards; iii) Streamline and automate processes for uploading results to EPR and acting upon these. Updates om all three by 06/03/2024
3c. Failure to escalate/escalate/gap in clinical plan: Lack of data, ownership, review delays	3c. Metavision critical care virtual ward for ITU outliers reintroduced - SOP to be written on referrals	08/11/2023	Complete	Rachel Krol	It has become clear that Metavision is not suitable for this and RaK is pursuing other options. Marked as complete as moved to BAU in critical care
3d. Failure to escalate/escalate/gap in clinical plan: Delay in prescribing meds, lack of monitoring of high NEWS list	3d. Tazocin PGD	08/11/2023	Complete	Emma Coutts, Rachel Krol, Godwin Simon	Upon review, this action is not required.
3e. Failure to escalate/escalate/gap in clinical plan: Delay in prescribing meds, lack of monitoring of high NEWS list	3e. Metraminol in ED, SOP to be implemented	08/11/2023	Complete	Emma Coutts, Godwin Simon	Marked as complete as moved to BAU

3f. Failure to escalate/escalate/gap in clinical plan: Board rounds and handover pilot	3f. Escalation on board rounds	08/11/2023	Complete	Jamie Moore, Kate Holmes, Dilip Pillai, Tracy Stocker	This is now BAU. Ongoing, trial on Harvey and Pembroke for ward handovers is now underway, using WOW's to share information amongst team.
3g. Patients leaving ICU/HDU do not always have an appropriate level; of consultant and other senior review, knowledge of patient, and escalation of care when transferred to a ward. Also concerns re admission handover and access to parent teams whilst on ICU	3g. Review of ICU pathway including admission, parent clinical team review whilst patient on ICU/HDU and medical and nursing handover arrangements when patient leaves ICU/HDU	13/03/2024	On Track/Not Yet Due	Chris Parokkaran, Rachel Krol, Howard Cottam	**11.06.2024 A3 still ongoing, develop SOP** **06.05.2024 - progress is slow, possible away day to complete work, work on SOP - due 05/06/2024** 15.04.2024 - Ongoing A3 11.03.24 - Ongoing discussions A3 Had initial meeting. Ongoing discussions
4a. Failure of appropriate delivery of care, monitoring and escalation by specialist team whilst awaiting transfer, lack of ownership of patient care	4a. SRO led session to establish full root cause and key tests of change and engagement with wider stake holder group	31/03/2025	On Track/Not Yet Due	Howard Cottam	**11.06.2024 To meet in July - ongoing** **06.05.2024 - SRO - led session to establish full root cause and key tests of change and engagement with wider stake holder group. - 03/07/2024** 11.03.24 Ongoing A3 completed. HoC workign with other DMD's re how to mitigate
5a. End of Life Decision being made at night rather than earlier in the day. End of Life decisions are often not prioritised and therefore, are not always completed by the end of the day.	5a. Discussed and agreed at QPSC that action is required but multi-disciplinary meeting needed and learning	24/04/2024	On Track/Not Yet Due	Emma Coutts	**11.06.2024 to be discussed 12.06.2024 - true north mortality a3 refresh** **06.05.24 - EC to provide weekly data - Multi-disciplinary meeting needed and learning to report back to Huddle. Discussed and agreed at Qpssc that action is required** 15.04.2024 - Expected data analysis 11.03.24 data collected ongoing Clincal fellow & Emma Weekly data to be provided. Audit presentation to be reviewed at quality huddle on 21/02/2024.
6a. Epilepsy following cardiac arrest - reduced awareness of time critical drugs	6a. Clarify status of non-avoidance of 2222 call - Review case of epileptic patient and clarify whether this was a non-avoidable 2222 call.	08/11/2023	Complete	Godwin Simon, Tamara Stephens, Emma Coutts, Rachel Krol	Missed dosage working group to look at report and identify ongoing actions to resolve issue. Drugs issues to be raised on risk register for both Divisions - JD to circulate list of time critical drugs to doctors for comment. Pharmacy students currently working on this list as a project supervised by Chief Pharmacist. **Action complete.**

Trust Risk Register Aligned to Board Assurance Framework	Risk 1433: Delayed recording of Observations on EPR	Current Risk Score: 20
	Risk 1539: Blood Gas results not recorded electronically on EPR	Current Risk Score: 12

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

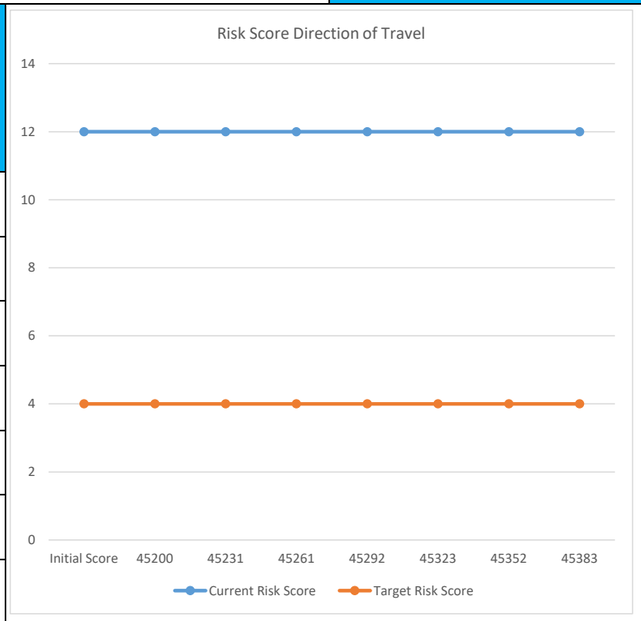
Investigations taken forward - new rota in place
Current status - Hospital at Night - working well

Date of Last Review:	11 June 2024
Date of Next Review:	11 July 2024

PEOPLE BOARD ASSURANCE FRAMEWORK

Risk ID:	3d	**Objective:**	To be the employer of choice and have the most highly engaged staff within the NHS
Executive Owner	Chief People Officer		
Operational Owner	Dominika Kimber, Deputy Chief People Officer	**Principal Risk Name & Description**	There is a risk the Trust is unable to retain sufficient levels of staff to ensure safe staffing levels, which results in higher turnover and in turn higher than expected levels of recruitment.
Primary Risk Grouping	People		
CQC Domain	Well-Led	**Relevant Group/Committee**	People Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	4	**12**	**N**
Risk Score at Last Review	3	4	**12**	**—**
Current Risk Score			**12**	
Target Risk Score	2	2	**4**	**—**
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Average**	**Comments:**
Agency Spend	3.7%	2.7%	2.0%	2.7%	1.2%	2.1%	2.4%	2.2%	
HR KPI - Time to Hire (days)	42.0	60.4	88.0	60.0	66.0	61.0	55.3	65.1	
Care Hours Per Patient Day (CHPPD)	9.5	9	9.1	9.2	9.05	9.81	9.96	9.4	
Voluntary Turnover First 2 Years of Employment (in month)	1.0%	0.9%	1.3%	0.6%	1.4%	0.8%	0.6%	0.9%	
Voluntary Turnover (Annual)	12.0%	10.6%	10.2%	9.7%	9.4%	9.0%	8.7%	9.6%	
Contractual Vacancy Rate (%)	9.0%	3.6%	4.2%	3.4%	2.9%	8.0%	7.7%	5.0%	
HR KPI - OH pre-employment checks reviewed within 2 working days.	90.0%	17.8%	76.2%	9.0%	37.9%	43.3%	28.4%	35.4%	

Context Summary
(Patient First problem statement, current situation)

The Trust's refreshed People Breakthrough Objective revealed much higher than expected level of voluntary turnover in the first two years of employment. The overall voluntary turnover rate also exceeds the set target, which indicates difficulties with our ability to retain staff. Countermeasures developed through the People BO include proactive measures such as Stay Conversations, re-launched as part of the Intention to Leave process. High turnover leads to increased recruitment activity, which results in extended time to hire, poor candidate experience and Trust losing applicants during the recruitment process. High number of new employees requiring OH clearance also impacts on the team's effectiveness and the overall time to hire. Recruitment efforts continue to deliver safe staffing levels and enable the Trust to maintain vacancy rates below the set targets.

Rationale for Current Score

The Trust's metrics indicate that there are no risks to its ability to staff clinical or corporate areas substantively. Ongoing Junior Doctors' dispute with the Government risks of industrial action by all staff groups can have a negative effect on the staffing levels however this would be temporary and safe staffing levels would be ensured. There is however an indication that the candidate experience during the recruitment process results in the process being inefficient due to the number of candidates withdrawing before their appointment (this KPI needs to be developed).

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)

1. NHS Long Term Workforce Plan and MFT People Strategy aligned to the Plan. 2. Retention programmes across Trust. 3. Attraction: Resourcing plans based on local, national and international recruitment. 4. Temporary staffing delivery: a. NHSE agency ceiling reporting in place; b. Monthly breach report to NHSE; c. Reporting to Board of substantive to temporary staffing paybill. 5. Workforce redesign: a. SDR review of hard to recruit posts and introduction of new roles; b. Reporting to People Committee apprenticeship levy and apprenticeships. 6. Operational: a. Operational KPIs for HR processes and teams reported monthly. 7. Care group nursing recruitment plan: Number of substantive nurses currently at highest point since 2015 and international nursing offers in place. 8. Bi-weekly CNO led meetings focussing on recruitment, retention, education and develepment of nursing and midwifery and CSW staff 9. People Breakthrough Objective focussed on staff turnover in the first 24 months of employment	1. HR&OD performance meeting monitoring the People Strategy and operational HR KPIs. 2. 'Our People' true north and breakthrough is monitored through the Trust Management Board SDR. 3. Monitoring of KSS benchmarking during elevated national turnover. 5. Monthly SDR including discussion on workforce, vacancies, recruitment plan and temporary staffing. 6. Regular reports to People Committee a. Resourcing Report b. Temporary staffing utilisation c. Safe staffing report 7. Vacancy Reporting: Bi-monthly reporting to Board demonstrating: a. Current contractual vacancy levels (workforce report) b. Sickness, turnover, starters leavers (Integrated Quality and Performance Report (IQPR)) 8. Monthly reporting to services or all HR metrics and KPIs via HR Business Partners. 9. Monitoring controls: a. Monthly reporting of vacancies and temporary staffing usage at PRMs; b. Daily temporary staffing reports to services and departments against establishment; c. Daily pressure report during winter periods for transparency of gaps.

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Safe staffing levels for the periods of industrial action.	1. Multi - disciplinary preparation for industrial action, open and transparent communications with staff and trade unions.	Ongoing	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	This is an ongoing action for the periods of strike action.
2. We need to improve our end to end recruitment and onboarding process. This includes time to hire (advert approval to unconditional offer) and candidate experience.	2a. We are exploring robotic automation of the elements of the recruitment process with a view of outsourcing this process from another NHS organisation	31/08/2024	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	Exploring procurement routes
	2b. We are supporting Trust's Medical Productivity Programme and an A3 methodology on Medical Recruitment.	Ongoing	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	Progressing well
	2c. Review of the end to end medical recruitment process.	Ongoing	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	This is aligned with Action 3 - A3 on medical recruitment
3. We need to understand how we might improve our retention by preventing resignations.	3a.Stay Conversations to be offered as an action as part of Staff Survey action planning (where staff indicated intention to leave the organisation)	30/04/2024	Overdue	Dominika Kimber, Deputy Chief People Officer	Action Plans are delayed due to the accessibility of staff survey results for care group levels
	3b. Develop Stay Conversations to be rolled out within the teams where turnover is higher than average.	30/03/2024	Complete	Lisa Webb, Associate Director OD	
	3c. Continue to embed Intention to Resign process within the divisions	Ongoing	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	HR BPs to address individual cases where resignation was not processed through the Intention to Resign process
4. We need to improve our understanding of the reasons why staff leave clinical areas difficut to recruit to.	4a.Intention to Resign process is going to be linked with the VCP process for vacant roles.	30/04/2024	Complete	Dominika Kimber, Deputy Chief People Officer	This approach is now in place and is being piloted, regular feedback from HR BPs is obtained
	4b. Continue to promote Intention to Resign process and Exit Interviews through team huddles and HR BPs.	Ongoing	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	
5. Consider implementation of recruitment and retention premia for difficult to recruit and retain roles, including medics	5. New approach to be explored with the system and new policy written.	30/04/2024	Overdue	Dominika Kimber, Deputy Chief People Officer	Development of an ESR report to identify difficult to recruit areas.
6. Improve performance of the Occupational Health team	6. Address staffing issues (FTEs and job roles) through the investment case	31/05/2024	On Track/Not Yet Due	Lisa Webb, Associate Director OD	Outcome of the business case is pending

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

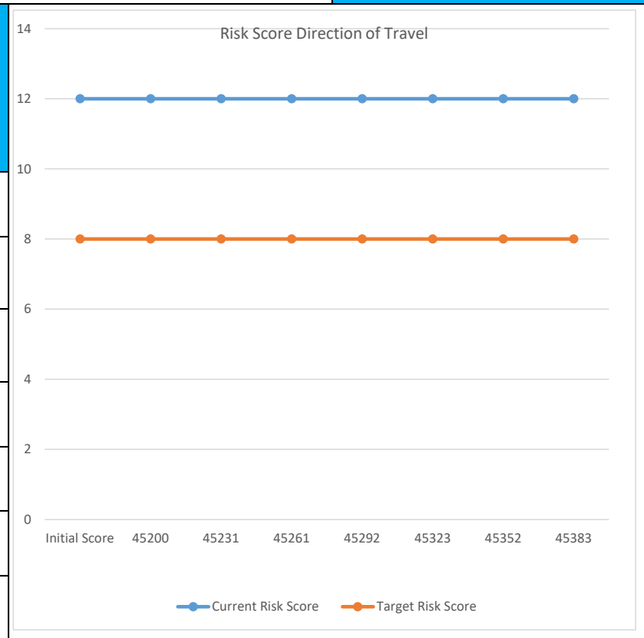
Additional Comments (Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)	
External labour market - addressed through annual skills demand profile through operational planning returns to ICB (education commissioning shortages) and continued international recruitment to address domestic skills shortage through ethical recruitment. Our ability to retain staff through competitive rewards packages is limited due to the Trust's financial position and a natonally agreed rates of pay, therefore we plan to develop and promote Trust's Employee Value Proposition through the refreshed Employer Brand.	
Date of Last Review:	15 May 2024
Date of Next Review:	15 June 2024

PEOPLE BOARD ASSURANCE FRAMEWORK

Risk ID:	3e
Executive Owner	Chief People Officer
Operational Owner	Dominika Kimber, Deputy Chief People Officer
Primary Risk Grouping	People
CQC Domain	Well-Led

Objective:	To be the employer of choice and have the most highly engaged staff within the NHS
Principal Risk Name & Description	There is a risk that staff will not feel confident to raise concerns and that their concerns will be dealt with by the organisation. This may lead to worsening engagement levels and quality of patient care.
Relevant Group/Committee	People Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	4	**12**	**N**
Risk Score at Last Review	3	4	**12**	**—**
Current Risk Score			**12**	
Target Risk Score	2	4	**8**	
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Average**	**Comments:**
Staff Survey Engagement Score	6.93	6.63	6.63	6.63	6.65	6.65	6.65	6.64	
Staff Survey Question: *If I spoke up about something that concerned me, I am confident my organisation would address my concern* (Q25F)	48.7%	42.0%	42.0%	42.0%	41.5%	41.5%	41.5%	41.7%	2021,22 and 23 survey results are between 39% and 41%. National average is 47-48%
Staff Survey Question: *My organisation respects individual differences.* (Q21)	70.0%	65.7%	65.7%	65.7%	67.9%	67.9%	67.9%	66.8%	2021 survey - 61.7%; 22 Survey - 65.7%, 23 Survey - 67%. National average 70%
Staff Appraisal Rate	90.0%	88.6%	89.0%	88.8%	89.3%	88.9%	87.9%	88.7%	
Uptake of Management Essentials Training	120ANN	14	9	14	9	16	15	77	
New metric on incidents reported once we have sufficient data from the Anti-Bullying and Harassment Group									

Context Summary
(Patient First problem statement, current situation)

Our staff engagement across the Trust has improved slightly for the last three years; however, remains in the lowest quartile which impacts on our ambition to have a better work culture, improved productivity, improving patient experience and outcomes. Analysis of Staff survey questions which have the highest correlation with staff engagement levels releaved two questions where the gap to the national average result is the highest (e.g. If I spoke up about something that concerned me, I am confident my organisation would address my concern and My organisation respects individual differences.). This indicates that, in order to improve staff engagement, we should address lack of confidence in the speak up process and perceived lack of respect of individual differences by the organisation.
The Trust has been in the lowest quartile for staff survey results (score 6.63, rank 94/126) for staff engagement for the last five years but has improvement in the last financial year to the threshold between quartile 3 and 4 having improved by 18 trust rank score.
National Staff Survey 2023 return rate shows decline in staff engagement with the Survey, from 40% in 2022 to 37% in 2023.
There appears to be an increase in staff raising concerns using formal channels, these relate to violence and aggression in ED and more general reports of bullying and harassment.
Current management essentials training does not link management / leadership behaviours with staff engagement levels.

Rationale for Current Score

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)

1. Strategy: People Strategy in place to address the underlying cultural issues within the Trust, to ensure freedom to speak up guardians are embedded and deliver the 'Best Culture' 2. Staff Health and Wellbeing strategy in place with nominated NED Wellbeing Guardian 3. Culture Intervention: The Trust has embedded the delivery of 'You are the difference' culture programme to instil tools for personal interventions to workplace culture and a parallel programme for managers to support individuals to own change which is embedded in induction. 4. The Trust is currently implementing the NHSEI Culture, Engagement and Leadership programme. 5. Communication routes well established in Trust 6. Freedom to speak up guardians are in place. 7. VBR in place Qualitative and quantitative values-based appraisal to continue to embed values into the Trust culture. 8. Culture Intervention: Principles of 'Just Learning Culture' are embedded in all HR processes and into training (e.g. management essentials, Trust Induction) delivered to staff. 9. New Starter Survey ICB led project is under way and the results are being analised. 10. Refreshed Strategic Leadeship Initiative (Leadership and Behaviours)	1. HR&OD performance meeting monitoring the People Strategy and operational HR KPIs. 2. JSC and JLNC in place. 3. 'Our People' programme reviewed through the Trust Improvement Board (including NHS People Plan) 4. Annual report to the Board on staff survey results 5. Regular reports to People Commitee: a. Freedom to Speak Up Guardian report b. Leadership Development programme c. Wellbeing Guardian quarterly assurance report d. Staff survey results annual report 6. New Starter Survey (ICB) will be analised and actions reported to the People Committee. 7. Welcome On-Board meetings have restarted and feedback is collated for repoirting to the People Commitee.

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. We need to ensure that Leadership and Management behaviours make a clear link with staff engagement levels. This is part of the People Startegic Initiative.	1. Staff Compact to be reviewed and updated to include new / additional leadership behaviours. This links with the NHSE Behaviours Framework which is being developed.	31/08/2024	On Track/Not Yet Due	Lisa Webb	Whilst awaiting the national Behaviours Framework, we are starting development of examples of negative behaviours through engagement with staff and network reps
2. Management essentials to be reviewed to identify gaps which deliver skills required to improve staff engagement levels. This is part of the People Strategic Initiative.	2. In conjunction with colleagues in East Kent, review our management essentials offer and identify modules for development / collaborative work. This links with the NHSE Behaviours Framework & Management training which is being developed.	31/08/2024	On Track/Not Yet Due	Lisa Webb	Head of Wellbeing and Staff Experience & Head of OD are liaising with East Kent to progress
3. Currently we have little data which could be used to improve staff retention e.g. reasons behind our high turnover of staff in the first two years of employment.	3. Design Stay Conversations which will be rolled out to the teams/departments as a proactive retention tool.	30/03/2024	Complete	Lisa Webb	
4.We need to understand the engagement of newly recruited employees to be able to address any factors which may affect their engagement levels and their retention in the first two years of their employment.	4. ICB New Starter Survey 2023 results need to be analised and actions assigned to the respective teams.	01/05/2024	On Track/Not Yet Due	Lisa Webb	In depth analysis of the data is underway. A dedicated T&F Group will be established to discuss actions.
4. We need to understand the engagement of newly recruited employees to be able to address any factors which may affect their engagement levels and their retention in the first two years of their employment.	5. MFT own New Starter Survey, replicating ICB survey is going to be launched.	01/05/2024	Overdue	Lisa Webb	New Head of Wellbeing and Employee Experience will be taking this action forward
5.We need to see an increase in appraisal completion and ensure that the level is sustained.	5. Identify areas where completion falls below 90% and raise in care group/team meetings.	Ongoing	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	Action to be progressed by HR BPs.
6. We need to improve perception of appraisals and their addedd value, to improve engagement levels.	6. QA process to be rolled out. Feedback to be provided to the HR and OD Performance Group.	31/03/2024	Complete	Lisa Webb	
7. Review Trust's Freedom to Speak Up Policy and process for comissioning investigations.	7. FTSU process has been reviewed. Policy needs to be updated and published.	31/01/2024	Complete	Katrina Ashton	
8. We need to provide staff with alternative ways of raising concerns with the organisation.	8. Launch and promote Dignity at Work Advisors.	31/01/2024	Complete	Dominika Kimber, Deputy Chief People Officer	
9. Improve staff confidence that the organisation listens to their concerns and implements improvements.	9. Communicate lessons and improvements implemented from staff feedback and concerns/grievances. Design a dedicated intranet page where these reports will be accesible.	30/06/2024	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	The design of this page is in progress, planned launch date in mid July

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

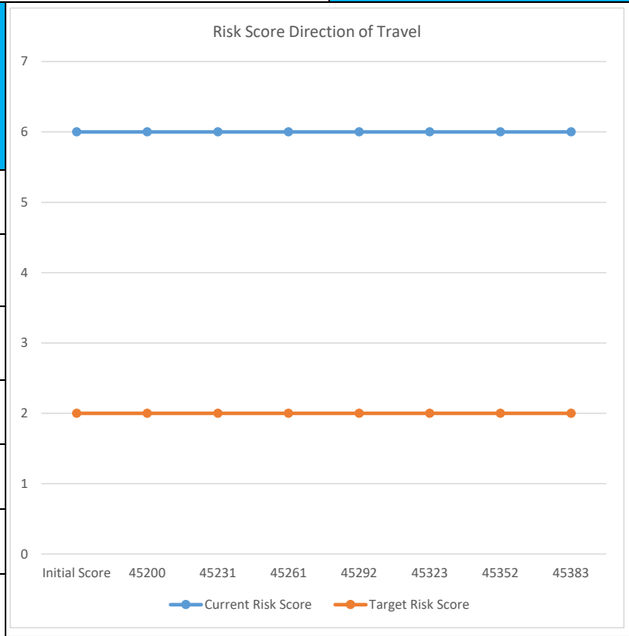
Factors which are external to the Trust and not in our control are likely to have a negative impact on staff engagement and morale (worstening financial situation, cost of living crisis, recession).

Date of Last Review:	15 May 2024
Date of Next Review:	15 June 2024

PEOPLE BOARD ASSURANCE FRAMEWORK

Risk ID:	3f	**Objective:**	To be the employer of choice and have the most highly engaged staff within the NHS
Executive Owner	Chief People Officer		
Operational Owner	Alister McClure, Head of Equality and Inclusion	**Principal Risk Name & Description**	Should the Trust fail to deliver its strategic objectives relating to EDI, there is a risk that our people will not be able to thrive at work and that the Trust will not meet its statutory obligations to its employees. This may lead to poor employee experience and negative impact on staff wellbeing, both at work and in general. IMPACT: Failure to meet the requirements of the Equality Act 2010; increase in staff turnover; increase recruitment and retention challenges; and therefore impact negatively on quality of patient care and experience.
Primary Risk Grouping	People		
CQC Domain	Well-Led	**Relevant Group/Committee**	People Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	2	**6**	**N**
Risk Score at Last Review	3	2	**6**	**—**
Current Risk Score			**6**	
Target Risk Score	1	2	**2**	
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Average**	**Comments:**
WRES 5 and 6	29% 20%	N/A	N/A	35.86% 25.4%	35.86% 25.4%	35.86% 25.4%	35.86% 25.4%		WRES 5 - % of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. WRES 6 - % of BAME staff experiencing
WRES 8	15.0%	N/A	N/A	18.1%	18.1%	18.1%	18.1%		% of BAME staff responding to say they had personally experienced discrimination at work from managers, team leaders, or other colleagues
WDES 4a I and 4a ii	33% 15%	N/A	N/A	34.5% 19.5%	34.5% 19.5%	34.5% 19.5%	34.5% 19.5%		% of staff with a lon term illness experiencing harassment, bullying or abuse from patients/ service users, their relatives or other members of the public in the last 12 months; and % of staff
WDES 4b	48.0%	N/A	N/A	47.9%	47.9%	47.9%	47.9%		% of staff with a long term illness saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months
WDES indicator 8 (Reasonable Adjustment)	75.0%	N/A	N/A	70%	70%	70%	70%		% of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.
% BAME Staff at Band 8a and above (AFC)		N/A							This will need to be new monthly data request to Workforce Intelligence, and will need to be a comparison between Band 8a and All bands. Workforce request has been submitted.
AfC staff Gender Pay Gap	0.0%	N/A	N/A	N/A					

Context Summary
(Patient First problem statement, current situation)

The measures of equality, diversity and inclusion, as expressed through the Workforce Race and Disability Equality Standards (WRES, WDES) and gender pay gap demonstrate areas of disproportionality lower than expected protected characteristics as a ratio of the Trust population. This in turn may have a direct impact on staff engagement from underrepresented groups, lower diversity of thought, lower motivation, which in turn can also affect staff performance, professional conduct, quality of patient care and retention.

Rationale for Current Score

WRES and WDES are currently only assessed annually; periodic calculations could be made only for the quantifiable measures such as pay gaps.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
1. Strategy: People Strategy in place to address the underlying cultural issues within the Trust, to ensure EDI elements are embedded and aligned to NHS Long Term Workforce Plan and People Promise 2. Action Plans are in place for the WRES, WDES and in development for the Gender Pay Gap 3. Key policies include Anti-bullying, Harassment and Conflict Resolution, and Reasonable Adjustment and Modified Duties. 4. Right skills: 30 Advisors and 60 investigators trained in Dignity at Work (bullying and harassment) complaints; EDI Mandatory Training and EDI element of Management Essentials 5. Culture Intervention: Culture and wellbeing programmes (including NHSEI Culture, Engagement and Leadership programme), wellbeing champions, staff equality networks 6. Non-Executive Wellbeing Champion; Executive Champions for some staff networks 7. Staff networks in place: LGBTQ, BAME, Disability and Wellbeing (DAWN), Womens'. Development of the Faiths and Beliefs (FaBs) Network 8. Revision and further communication of the Anti-Discrimination Statement	1. 2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting) 2. 'Our People' programme fortnightly review meeting which includes the NHS People Plan 3. Overall statutory and mandatory training compliance report to Board (bi-monthly) and internally weekly. 4. Regular reports to the People Committee and the Equality and Inclusion Steering Group, including: a. Freedom to Speak Up Guardian report b. Leadership Development programme c. Wellbeing Guardian quarterly assurance report d. Staff survey results e. IQPR data f. EDI Metrics (Pay Gap, WRES, WDES, and Action Plans) g. Staff survey results h. Statutory mandatory training update

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to engage and retain staff.	1a. Review of the People Startegic Initiative (Leadership and Behaviours) and implementation of the agreed actions.	Ongoing	On Track/Not Yet Due	Dominika Kimber	
	1b. Development of Behaviours Framework (aligned with Trust Values, incorporating all existing tools referencing behaviours e.g. Compact, Our Leadership Way, Nolan Principles)	31/08/2024	On Track/Not Yet Due	Esther Sodunke/Lisa Webb	NHSE plan to develop a similar Framework - we are liaising with them to check how this work may overlap
	1c. Development of examples of negative staff behaviours to be included in the Behaviours Framework	30/06/2024	On Track/Not Yet Due	Alister McClure / Esther Sodunke	Consultation with staff networks initially, using examples of negative/uncivil behaviours recorded to Datix
2. Executive team and Trust Board have committed to EDI Objectives as part of their personal objectives (HIA1); although now signed off, work is required over 2024/25 to support delivery of those objectives	2. Periodic meetings with Executive Team and whole board to support delivery of HIA1 Objectives that were agreed before 31 March 2024	31/07/2024	On Track/Not Yet Due	Alister McClure	HIAs now developed
3. All forms of discrimination (including bullying and harassment) must be managed effectively and we need to understand what preventative/proactve measures can be taken.	3a. Anti-bullying and harassment group to be reviewed and re-established.	31/01/2024	Complete	Dominika Kimber	Reviewed and meeting monthly
	3c. All Network Leads were offered regular informal meetings with Senior HR team to offer an opportunity to discuss issues in confidence and to agree what actions should be taken	30/04/2024	Complete	Dominika Kimber	Metings are now taking place monthly
	3b. Revised Bullying, Harassment, Discrimination and conflict resolution policy to be launched and communicated by the Exec (wider comms plan)	31/01/2024	Complete	Dominika Kimber	Published and communicated
	3d. New duty to protect staff from sexual harassment and actions relating to the Sexual Safety Charter will be embedded into Trust's policies and processes	31/07/2024	On Track/Not Yet Due	Dominika Kimber	
4. Advice and signposting regarding concerns around discrimination (bullying and harassment) must be easily accessible and volunteer advisors must be competent and trained in their roles.	4. Trained Dignity at Work Advisors will become available to advise staff. Ongoing support will be provided by the Head of EDI.	31/01/2024	Complete	Alister McClure	Programme launched in February

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

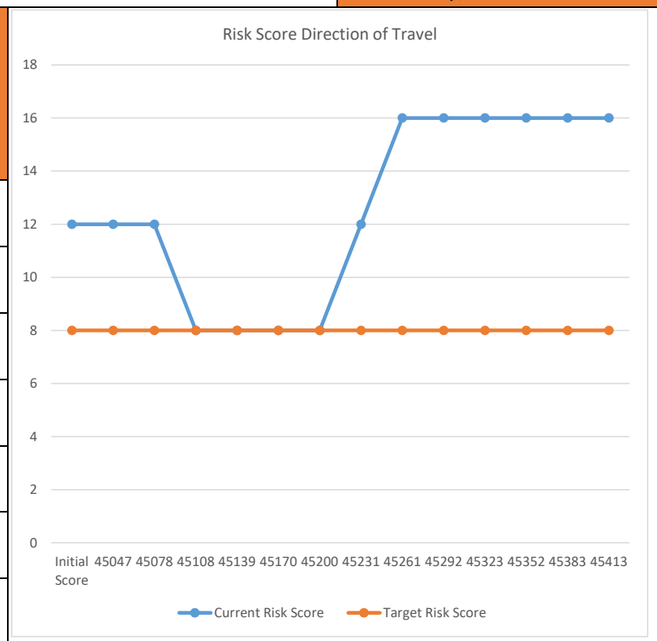
Poor adherance to the Trust values may lead to the worstening employee and patient experience with negative impacts on quality of care and patient safety and the Trust's reputation amongst the patients, their families, current and prospective employees.

Date of Last Review:	15 April 2024
Date of Next Review:	10 May 2024

SYSTEMS & PARTNERSHIPS BOARD ASSURANCE FRAMEWORK

Risk ID:	4b	**Objective:**	Delivering timely, appropriate access to acute care as part of a wider integrated care system.
Executive Owner	Chief Operating Officer		
Operational Owner	Nicola Cooper, Divisional Director of Operations	**Principal Risk Name & Description**	Not meeting the RTT standards brings a risk to the quality of care we are providing our patients as well as their overall experience.
Primary Risk Grouping	Systems & Partnerships		
CQC Domain	Safe	**Relevant Group/Committee**	Trust Management Board / Finance, Planning & Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	4	**12**	N
Risk Score at Last Review	4	4	**16**	▲
Current Risk Score	4	4	**16**	—
Target Risk Score	2	4	**8**	—
Trust Risk Appetite	Appetite: Very Low Range: 1-4 Score (trigger level): 4			
Assurance Strength	Low			
Adequacy of Controls	Inadequate			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Average**	**Comments:**
RTT Incomplete Performance	92.0%	52.2%	51.8%	51.4%	50.6%	51.2%	51.48%	51.4%	

Context Summary
(Patient First problem statement, current situation)

% of patients that have been treated within 18weeks from referral to treatment

Rationale for Current Score

Risk reviewed and still remains appropriate. RTT postion continues to decline. The total number of patients over 65 weeks has increased largely due to endoscopy. Mutual aid for Endoscopy continues with Dartford and outsourcing to PPG, both organisations now taking RTT patients. Ongoing Industrial action has also had a negative impact waiting times due to clinic cancellations

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
The trust had 28 x 78 week breaches majority of which relate to ENDO and all related to endoscopy capacity. 9 x ENT 4 have no TCI and due to national equipment issue 2 are patient choice others are not a concern. 1 patient choice in general surgery. Trust are now reporting 2 x 78 week breaches by end of March (both of which are patient choice) A request has come from exec to complete an affordability chart on elective WLI which will be done in the next few weeks.	Weekly RTT meeting including robust review of RTT process Reports direct to COO Monthly reporting to TMB Focus on clinical urgent and then long waits Patient P control in operation Use of ERF monies to support increased activity Breach validation plus clinical harm

Gaps in Controls
(What additional controls and assurances should we seek?)

Mitigating Actions to Address Gaps
(What more should we do to address the gaps?)

Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**

1. There is a risk associated with the junior doctor strike which has increased the PTL.	1 - Cancellations continue in line with IA in order to provide safe care on wards	Unknown	Complete	Trustwide	
2. Increase risks due to onging industrial action	2 - Cancellations continue in line with IA in order to provide safe care on wards	Unknown	Complete	Trustwide	
3 Lack of Endoscopy capacity in K&M	3-Ongoing work with ICB/NHSE to provide additional capacity	Unknown	Complete	Nicola Cooper	
4 Lack of RTT training programme for operational managers	4-Training programme design underway for non-clinical and clinical staff	01/07/2024	On Track/Not Yet Due	Nicola Cooper	

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

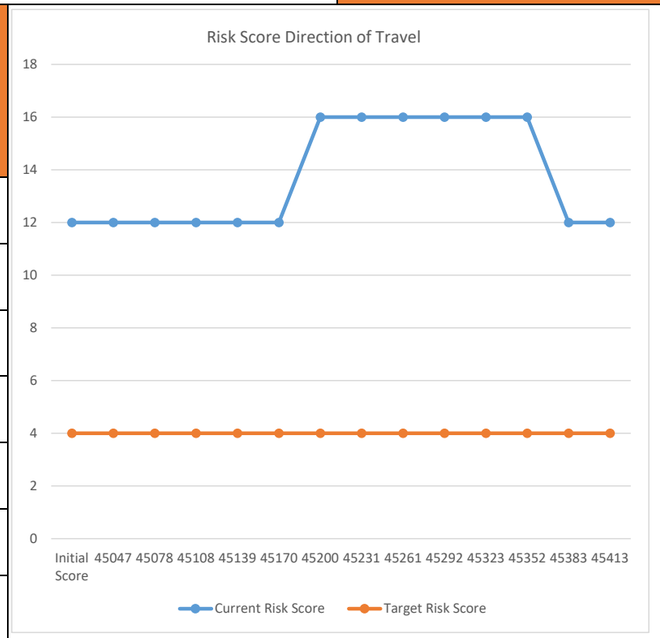
Trust has agreed to hit no 65 week breaches by September 2024.
Lack of ward and outpatient space currenlty. New Ward has been assigned which is due in August.
Increase in winter presentations may negatively impact RTT performance.
No sustainable long term solution for Endiscopy currently - continuing with mutual aid to support Cancer/RTT/DM01 performance. Trust have agreed a fund a mobile endoscopy unit to be situation at the acute site for the next 12 months to support with additional capacity whilst long term plan considered

Date of Last Review:	12 June 2024
Date of Next Review:	12 July 2024

SYSTEMS & PARTNERSHIPS BOARD ASSURANCE FRAMEWORK

Risk ID:	4c	**Objective:**	Delivering timely, appropriate access to acute care as part of a wider integrated care system.
Executive Owner	Chief Operating Officer		
Operational Owner	Holly Reid, Divisional Director of Operations	**Principal Risk Name & Description**	Lack of operational performance for example not meeting constitutional measures (new quality indicators)
Primary Risk Grouping	Systems & Partnerships		
CQC Domain	Safe	**Relevant Group/Committee**	Trust Management Board / Finance, Planning & Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	4	**12**	N
Risk Score at Last Review	3	4	**12**	▼
Current Risk Score	3	4	**12**	—
Target Risk Score	1	4	**4**	—
Trust Risk Appetite	Appetite: Very Low Range: 1-4 Score (trigger level): 4			
Assurance Strength	Low			
Adequacy of Controls	Inadequate			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Average**	**Comments:**
Average time in EC Dept (mins)	7	401.2	424.7	389.0	335.4	300.9	306.01	359.5	
Ambulance HO delays > 60mins	0	10	9	5	6	3	3	6	
ED 12 Hour Breaches	0	785	953	798	798	523	588	741	
IP Discharge Before Noon	40%	15.2%	14.1%	14.6%	12.9%	12.6%	14.0%	13.9%	
Total ED 4 Hour Performance	95%	65.6%	68.3%	70.4%	77.6%	81.1%	78.6%	73.6%	

Context Summary
(Patient First problem statement, current situation)

The Trust is currently not achieving national KPIs, the Breakthrough objective for flow and discharge is to achieve 95% performance for ED. Our ambition is to improve flow across the Trust and reduce patient waiting times. This will support our ED performance targets, avoid delays and contribute to smooth flow through the organisations.

Rationale for Current Score

The score reflects the continued challenge and deterioration with our MFFD position and the estate/evironment restrictions that impact on the ability to achieve escalation capacity. However these controls are strengthened by the current Flow and Discharge Programme under the Patient First Programme, and ongoing work to explore alternatives to ED, admission and delayed discharge.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Continuing to embed the Acute Medical Model Reviewing the Full capacity protocol, opel triggers and actions Embeding fit to sit/pulling next patients to wards Focused work through the HARIS group Reviewing existing protocols and processes to achieve improvements Improving relationships with SECAmb and working in partnership has mitigated high numbers of ambulance handover delays increace in Virtual beds to 155 by end of Q4 currently av. 75 virtual beds for early supported discharge and admission avoidance Single Point of Access pilot Rota of Senior Operational staff on the shop floor safeHaven 24 hour mental health provision	Ongoing review of current systems and processes Breakthrough huddles weekly SDR score card reflecting performance Safer staffing huddles to support safe flow Care group SDRs currently being implemented Dedicated daily support on the floor to prevent 4 hour breaches Live validation and review of 4 hour breaches

Gaps in Controls	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)

(What additional controls and assurances should we seek?)	Action	Due Date	Action RAG	Action Lead	Progress Notes / Action Completion Date
1. Need to consider benefit realisation for the Acute Medical Model and unintended consequences Standard work for Board Round Processes	1. Care Group to review and implement and bring to Divisional management Board.	31/03/2022	Complete	Linda Stevens, General Manager / Kathy Ward, Head of Nursing / Chris Parokkaran, Clinical Director	
2. Full utilisation of community capacity at all times to support flow	2. Exec escalation for ICB support.	01/04/2024	On Track/Not Yet Due	Linda Stevens, General Manager / Kathy Ward, Head of Nursing / Chris Parokkaran, Clinical Director	
3. Review In-reach support from Spec Med to ED	3. Review current in-reach with clinical leads	19/03/2024	Overdue	Chris Parokkaran/Tanya McKie	SOP drafted for expectations of in-reach. Next draft to include CSN
4	4				

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

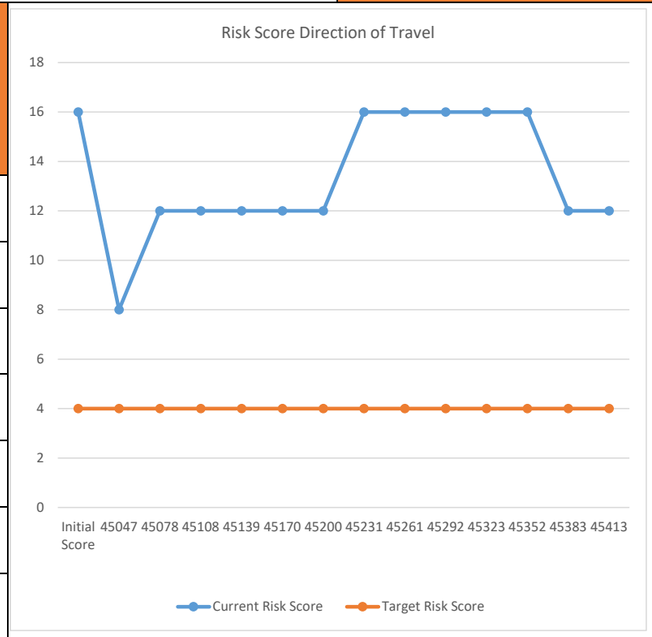
Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

Date of Last Review:	14 June 2024
Date of Next Review:	14 July 2024

SYSTEMS & PARTNERSHIPS BOARD ASSURANCE FRAMEWORK

Risk ID:	4d	**Objective:**	Delivering timely, appropriate access to acute care as part of a wider integrated care system.
Executive Owner	Chief Operating Officer		
Operational Owner	Holly Reid, Divisional Director of Operations	**Principal Risk Name & Description**	Shared quality of care and performance across the heath and Care Partnership may impact on the Trusts quality and safety through increased ambulance handovers, patient acuity, mortality and admissions.
Primary Risk Grouping	Systems & Partnerships		
CQC Domain	Safe	**Relevant Group/Committee**	Trust Management Board / Finance, Planning & Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	4	**16**	N
Risk Score at Last Review	4	3	**12**	—
Current Risk Score	4	3	**12**	▼
Target Risk Score	1	4	**4**	—
Trust Risk Appetite	Appetite: Very Low Range: 1-4 Score (trigger level): 4			
Assurance Strength	Low			
Adequacy of Controls	Inadequate			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Average**	**Comments:**
Total ED 12 Hour Breaches	0	785	953	798	798	523	588	741	
Total 4 hour performance	78%	65.6%	68.3%	78.4%	77.6%	81.1%	78.6%	74.9%	
>14 day LOS		403	424	380	375	397	382	394	Currently based on sum of 'Those discharged between 14 and 20 days' and 'Discharged 21 Days or Over'
#NCTR								#DIV/0!	Due to the TT deployment BI are not able to supply figures from October.
Average wait to 1st OPA (days)	60	94.43	99.37	104.18	103.42	106.82	105.26	102.2	

Context Summary
(Patient First problem statement, current situation)

There is a risk that conflicting priorities, fianancial pressures and/or ineffective governance results results in negative impacts to Medway Foundation Trust's ability to deliver timely, appropriate access to acute care. Examples of this could included but are not limited to: changes in ambulance attendances resulting in increased demand and poorer patient experience, increase in Medically Fit for Discharge (MFFD) patients 'blocking' access to Acute hospital beds, and increases in levels of risk held within the Acute setting.

Rationale for Current Score

Conflicting priorities, infancy of ICB and systems and processes supporting are not yet well established. Despite this, good working relationships exist with focus on key metrics for all providers, and established forums to capture and resolve unintended consequnces of any sytem-based decisions. Deterioration in performance of system partners (community, Medocc) contributing to increased risk in last quarter, additionally the sustained high number of NCTR patients in MFT beds.

Key Existing Controls
(What are we currently doing about the risk?)

- LAEDB - Oversight dashboard
- Kent and Medway Integrated Care Board
- Kent and Medway Intregrated Care Partnership Joint Committee
- Joint development of plans at ICS level
- Kent CEOs Meeting
- Alignment of Trust, Primary Care, Community and other system partner plans with ICS and ICP plans
- Trust-wide Flow and Discharge Corporate Project

Assurances on Control:
(What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)

- Dashboard capturing actions and unintended consequences on system partners
- Evidence attendance at ICS and ICP meetings
- Updated ICP and ICS risk register, reflecting input from system organisations
- Risk Report monthly
- Finance Committee report to Board
- Internal review and monitoring of access to care metrics with exec oversight

Gaps in Controls
(What additional controls and assurances should we seek?)

Mitigating Actions to Address Gaps
(What more should we do to address the gaps?)

Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**

1. LAEDB Refresh, pulling together renewed dahsboard to capture actions and impact across all agreed system KPIs	1. Review of LAEDB ToR, agenda and required reports	31/08/2023	Complete	Chief Operating Officer	Extended due to AL in July.
2. Trajectory for Medocc Performance	2. To work with MEDOCC to agree trajectory for sustained improvements	31/08/2023	Overdue	Chief Operating Officer	Some incremental improvement seen but not yet sustained
3	3				
4	4				

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

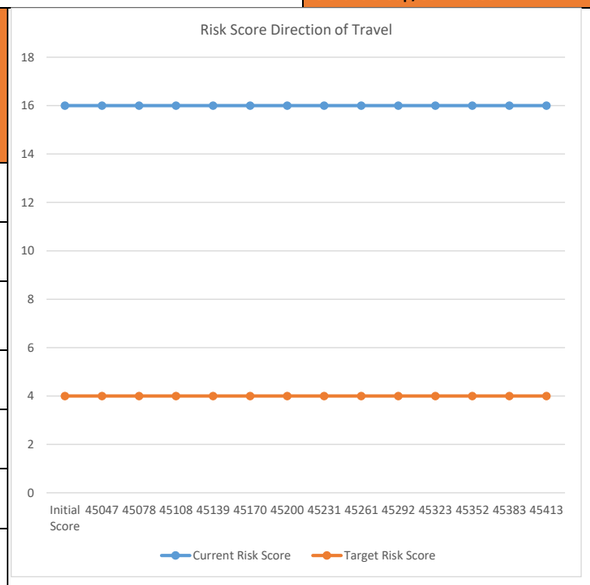
Date of Last Review:	14 June 2024
Date of Next Review:	14 July 2024

SYSTEMS & PARTNERSHIPS BOARD ASSURANCE FRAMEWORK

Risk ID:	4e
Executive Owner	Chief Operating Officer
Operational Owner	Tracy Stocker, Director of Operations for Flow & Integration
Primary Risk Grouping	Systems & Partnerships
CQC Domain	Safe

Objective:	Delivering timely, appropriate access to acute care as part of a wider integrated care system.
Principal Risk Name & Description	There is a risk of financial impact if we are unable to increase flow and close escalation areas.
Relevant Group/Committee	Trust Management Board / Finance, Planning & Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	4	**16**	N
Risk Score at Last Review	4	4	**16**	—
Current Risk Score	4	4	**16**	—
Target Risk Score	1	4	**4**	
Trust Risk Appetite	Appetite: Very Low Range: 1-4 Score (trigger level): 4			
Assurance Strength	Low			
Adequacy of Controls	Inadequate			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Average**	**Comments:**
Pre Noon Discharge - G&A Adult > 1 Day LoS (Including Transfer to ADL)	40%	15.2%	14.1%	14.6%	12.9%	12.6%	14.0%	13.9%	
Avg. Length of Stay - G&A Adult > 1 Day LoS	7	11.1	11.7	11.7	12.1	11.5	11.1	11.5	
Bed Occupancy - G&A Adult > 1 Day LoS	92%							#DIV/0!	Due to the TT deployment BI are not able to supply figures from October.
NCTR at Midnight (count) - Month Average	80	100	106	112	96	101	98	102.2	
IP Discharges - - G&A Adult > 1 Day LoS (Including Transfer to ADL)		1834	1789	1812	1920	1861	1861	1846	

Context Summary
(Patient First problem statement, current situation)

The Trust has a high number of escalation beds open due to high demand for beds and reduced care capacity which is impacting discharge numbers and flow. The functioning of these escalation area's puts added pressure on the financial position of the Trust, as well as placing pressure on the wellbeing of our clinical teams as staffing levels are spread over a wider demographic throughout the Trust. By focusing on reducing the length of stay of our inpatients will increaces the potential for the reduction of escalation beds and will have a posative impact on both financial and operational efficiencies.

Rationale for Current Score

The Trust is under increasing demand and is frequently operating in Opel 4 and Business Continuity our increase in patients without a criteria to reside (100 - 150) and the low discharge profile reduces flow and increases demand for bed capacity. The improvement activity taking place requires a cultural and transformational change as well as informed training to support best practice which will take some time to fully embed.
The availability of residential and home care capacity has been significantly impacted by many factors including cost of living, reduced funding and the impact of the covid pandemic. The impact of this has left MFT with very high numbers of patients across our bed base without a criteria to reside. These patients are at risk of functional deterioration and further complications from hospital acquired infections and disability, tissue damage and low mood. The combined impact of reduced care capacity and increased LoS in an acute bed is not only costly, more importantly it impacts the well being of our patients and staff. There are many things causing increased length of stay for patients without a criteria to reside that are not within our gift to improve, however efficiencies can be made in reducing LoS for patients not requiring care after discharge (PW 0), including standardised processes and discharge planning. in addition to this there is a risk relating to data quality regarding discharge date and time, this is currently being investigated to ascertain the extent of the issue and develop process to mitigate this.
There are increased delays to dscharging PW1 and PW3 patients dur to a change in comissioned services for Medway PW2, lack of availability for complex nursing PW3 placements. TS is working with partners to resolve these issues and new PW2 pathways being developed which will enable time monitoring. Ongoing system demand is continuing to impact flow and ED capacity. There are still delays in discharging ps via PW1 -3. MFT requires assurance from system partners on availability for on-ward ToC and pathway work to improve discharge opportunities.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
The Trust has alined the reducing LoS work into a corporate project within Patient First Flow and Discharge, this is focusing on systems and processes that will improve discharge planning and expedite the patients journey home. A training programme is being developed to ensure consistency and standardisation in Board Rounds to support actions for early discharge planning and avoid unneccesary delays to discharge. A National MADE requirement has enabeled us to review board round functions, attendance and processes; there is also a large amount of data from this event which will help us identify oportunities for improved flow and reduced delays. The wards should apply a full MDT conribution to the care and consequent discharge of our patients following SAFER princiles and the Red to Green concept. Integrated Duscharge Team (IDT) are SME's regarding discharge pathways and processes, they work with LA and and community partners and support ward teams across the Trust with discharge planning and management of PW 1-3 and complex patients. TeleTracking, Virtual Wards and the opening of Amhurst Court beds will support reducing bed occupancy and improve transfer of care timeescalse. these mitigations will require time to bed in (Amhurst Court to Open)	Regular management meetings to monitor and support progress on improving discharge processes throughout the Trust. This is monitored via; Flow and Discharge Corporate project, These workstreams review current position on a regular basis as well as seek further opportnities whilst following Patient First methodology, improving pre-noon discharge breakthrough objective hudles, HCP Discharge Group, Efficiencies Group and LAEDB. Data dashboards including the Flow dashboard (MFT) and the Discharge dashboard (HCP) to capture current performance and help create realistic trajectories for improvement moving forward.

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. An operational plan that supports the closure of escalations area's. Full collaboration with system partners in discharging patients that have no criteria to reside in an acute bed. Cultural change within clinical teams across the Trust. Training programme that emphasises golden standard discharge processes.	1. Both Divisions providing senior oversight of BR's to support discharge planning against EDD.	31/03/2023	Complete	Divisional Management Teams	New action to be agreed as part of the Corporate programme to improve flow and reduce LoS 16/02/24 Action complete, BR improvement within the new F&D corporate project. Asurance via 4th action below
2. Standardised LoS meetings with divisional care groups to challenge and escalate patients for MDT, Snr review	2. Each care group attends a LLoS meeting BiWeekly chared by6 DoOF&I	31/10/2023	Complete	Care Group Management Teams	update 20/11/23 these meeting are in diaries and LoS for all IP >14 days for CTR and NCTR
3. Review of discharge processes and pathways across the HaCP to reduce NCTR and NCTR LoS	3. HaCP discharge group reviewing pathways via an action plan following the Vital Hub audit	31/08/2024	On Track/Not Yet Due	Tracy Stocker, Director of Operations for Flow & Integration	action plan has been drawn up by the HCP discharge group, however, HCP have delayed the review of the pathways until Jan. TS has discussed this with the COO and is writing a PID for a solution to this. 16/02/24 HACP decideing on plan to review, MFT waiting for HaCP exec decision. All discharge related work through the HCP has been stopped pending HCP / ICB decisions on the Transfer of Care functions. this is due in Q2 of 24/25.
4 Board Round improvement as part of the reducing LoS CP.	4. Re-embed SAFER, red2green and operationalise electronic BR's as part of the Flow and Discharge Corporate Project6	31/08/2024	On Track/Not Yet Due	Tracy Stocker, Director of Operations for Flow & Integration	Work with the care groups has started. Work with Sapphire and with Planned care ward commenced in early november 16/02/2024 Five wards have been supported with BR and escalation improvement. Further wards to be planned.

Trust Risk Register Aligned to Board Assurance Framework		
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

The Trust regularly has 100+ patients bedded within the Trust that have no criteria to reside. Exploratory work needs to be constructed to understand what can be done to expedite the journey home for these patients. Initial focus should be on pathway 0 patients that require little intervention and are within the Trusts own ability to discharge.
The KPMG Audit on Discharge Data published in April along with the Vital Hub audit on LoS and discharge processes have a number of recommendations being reviewed at HaCP level alongside the Patient First Flow and Discharge project to make improvements. This will form basis for all future training materials as processes will be confirmed, creating a standardised approach to discharge throughout the Trust and allow Clinicians to embed the golden standard of discharge that our patients expect.

LoS efficiency work to support effective Board Rounds (sept '23), Virtual wards and the mobilisation of 41 beds at Amhurst Court in October will support the trust in reducing LoS across the acute wards. There is an element of concern with our partner organisations ability to meet the demand for PW 1-3 moving into winter and MFT are working with the wider HaCP to manage these pathways more efficiently and to mitigate additional risk of increased LoS and reduced flow across our beds.

All discharge work relating to the HCP has been paused pending ToC development and review. MFT have started a programme of work through the Flow and Discharge corporate project to improve discharge planning and EDD setting which will lead to improvements in LoS and bed occupancy. it is acknowledged that this needs to be a back to basics approach that is delivered to be fully embedded.

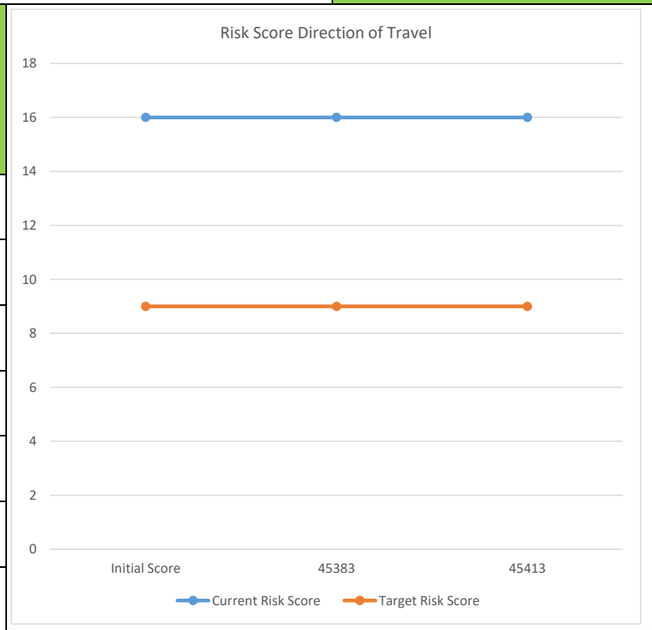
The Board Rounding project requires some PMO / Transformation resource to move forwards, this is a mission critical corporate project and this additional resource is recognised a fundamental success to re-educate and embed SAFER BR process. The HCP is still reviewing ToC services and no improvement work will be commenced regarding discharge, ToC Hub, reducing complex pathways until this review and remodel has been completed. MFT have commenced the Faculty Frontier AI project which will work on EDD accuracy and support discharge planning. run concurrently with the BR project we should be in a position to reduce this risk. there are no timescales set for this yet.

Date of Last Review:	13 June 2024
Date of Next Review:	13 July 2024

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

Risk ID:	5a	**Objective:**	Living within our means providing high quality services through optimising the use of our resources.
Executive Owner	Chief Financial Officer		
Operational Owner	Deputy Chief Financial Officer	**Principal Risk Name & Description**	Delivery of the in-year control total
Primary Risk Grouping	Sustainability		
CQC Domain	Well-Led	**Relevant Group/Committee**	Finance, Planning and Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	4	**16**	
Risk Score at Last Review	4	4	**16**	—
Current Risk Score	4	4	**16**	—
Target Risk Score	3	3	**9**	
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**YTD**	**Comments:**
Variance to control total	0.0	-1.7	-3.3	2.6	1.3	-0.2	0.2	0.0	YTD position is for 2024/25 only, i.e. from April 2024.

Context Summary
(Patient First problem statement, current situation)

The Trust agrees a plan at the start of the year with the ICB and NHSE – the deficit that has been agreed in recent years is known as the Trust's control total and equates to £29m in 2024/25.
Performance in recent years has been adverse to that control total (after "allowable misses").
Given the inherent risks within the plan (e.g. current position on unidentified/unapproved efficiencies) there is a risk that the Trust does not meet its control total.

Rationale for Current Score

The Trust is meetings its plan YTD but has not yet fully identified the efficiency schemes it requires to meet the plan. Further work is required to provide assurance over delivery of elective activity targets. Mitigating work is underway. The consequence is therefore currently considered to be "major / 4".
Until such time as there is greater assurance over these items the probability of variance is considered as 31-90% and hence is "likely / 4".

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
- Robust budget setting - Weekly executive-led check and challenge sessions re efficiencies/mitigations - Access operational group - Budget statements/budget holder meetings - Full staffing of PMO - NHSE Improvement Director support and NHS Intensive Support team - Application of "Grip and Control" checklists, and "Core/Level 2-3-4" NHSE controls - Self-assessment and implementation of HFMA sustainability checklist - VCP and enhanced non-pay controls	- Weekly Breakthrough Objective huddle - Finance, Planning and Performance reporting, coupled with Trust Board reporting - SDR's - Appraisals / objective setting - Oversight and RSP meetings

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Roster controls /demand templates	1a. Medical staffing project underway to deliver a roster solution.	31/03/2025	On Track/Not Yet	Chief Medical Officer	
	1b. Reconciliation of budgets to rosters	31/07/2024	On Track/Not Yet Due	Finance Business Partners & HR	

2. Budget sign-off 24/25		2. Budgets to be signed off by divisions	31/07/2024	On Track/Not Yet	Finance Business Partners	
Trust Risk Register Aligned to Board Assurance Framework	2057: Unfunded inflation		Current Risk Score: (4 x 3 = 12)			
	2056: ICB alignment of clinical income		Current Risk Score: (4 x 4 = 16)			
	2055: ERF / Elective recovery plans		Current Risk Score: (5 x 3 = 15)			
	2052: 24/25 efficiency programme		Current Risk Score: (5 x 4 = 20)			
	1861: Cash holdings depleting may result in Trust running out of cash		Current Risk Score: (4 x 2 = 8)			

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

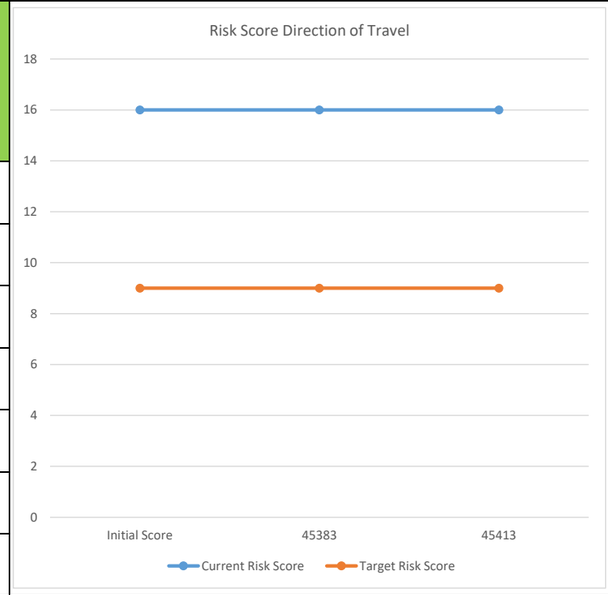
Operating plan resubmission delivered on Wednesday 12 June 2024.

Date of Last Review:	14 June 2024
Date of Next Review:	15 July 2024

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

Risk ID:	5b	**Objective:**	Living within our means providing high quality services through optimising the use of our resources.
Executive Owner	Chief Financial Officer		
Operational Owner	Deputy Chief Financial Officer	**Principal Risk Name & Description**	Delivery of the Trust's financial strategy
Primary Risk Grouping	Sustainability		
CQC Domain	Well-Led	**Relevant Group/Committee**	Finance, Planning and Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	4	**16**	
Risk Score at Last Review	4	4	**16**	—
Current Risk Score	4	4	**16**	—
Target Risk Score	3	3	**9**	
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**YTD**	**Comments:**
Number of open Oversight Framework 4 exit criteria for finance	0	6	6	6	6	6	6		

Context Summary
(Patient First problem statement, current situation)

The Trust strategy sets out a vision of underlying breakeven (transition out of deficit) by 2028/29. Without clear enablers, system and NHSE support and full alignment to the clinical strategy, this could be at risk.
The Trust currently remains in SOF4.

Rationale for Current Score

Until such time as the Integrated Improvement Plan (IIP) and/or updated Financial Recovery Plan (FRP) is in place there is an uncertain delivery of key objectives, hence the consequence is "major / 4".
Given the uncertainty mentioned, the likelihood is considered "likely / 4".

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
- Patient First True North and governance - Trust Board approved Finance Strategy - Working alongside NHSE Intensive Support director - Development and implementation of an IIP - ICS financial recovery work being undertaken (of which the Trust is engaged)	- Self-assessment against the exit criteria - Delivery/monitoring against IIP - Oversight and RSP meetings

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Findings from KPMG report remain open	1. Implementation of KPMG financial improvement recommendations	Various	On Track/Not Yet Due	Various	Monthly update reporting to Trust Executive group. Closed/open/overdue - TBC
2. Exit from Oversight Framework level 4	2a. Implementation of IIP	Various	On Track/Not Yet Due	Various	IIP drafted and going through governance processes
	2a. Tracking of IIP	TBC	On Track/Not Yet Due	Chief Delivery Officer	

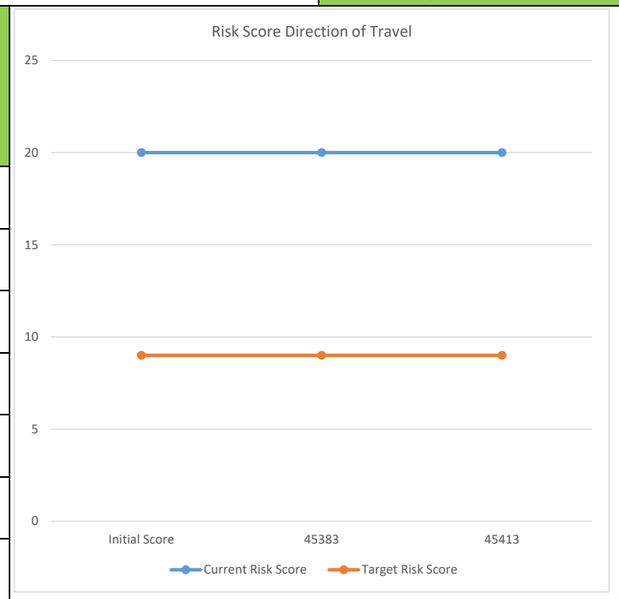
	2058: Unchecked staff growth	Current Risk Score: (5 x 3 = 15)
	2056: ICB alignment of clinical income	Current Risk Score: (4 x 4 = 16)
	2060: Capital allocation vs requirements	Current Risk Score: (5 x 5 = 25)

Trust Risk Register Aligned to Board Assurance Framework	2057: Unfunded inflation	Current Risk Score: (4 x 3 = 12)
	2056: ICB alignment of clinical income	Current Risk Score: (4 x 4 = 16)
	2055: ERF / Elective recovery plans	Current Risk Score: (5 x 3 = 15)
	2052: 24/25 efficiency programme	Current Risk Score: (5 x 4 = 20)
	1861: Cash holdings depleting may result in Trust running out of cash	Current Risk Score: (4 x 2 = 8)
Additional Comments (Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)		
Date of Last Review:	14 June 2024	
Date of Next Review:	15 July 2024	

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

Risk ID:	5c	**Objective:**	Living within our means providing high quality services through optimising the use of our resources.
Executive Owner	Chief Financial Officer		
Operational Owner	Deputy Chief Financial Officer	**Principal Risk Name & Description**	Unfunded services
Primary Risk Grouping	Sustainability		
CQC Domain	Well-Led	**Relevant Group/Committee**	Finance, Planning and Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	4	**16**	
Risk Score at Last Review	4	4	**16**	—
Current Risk Score	4	4	**16**	—
Target Risk Score	3	3	**9**	
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Low			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**YTD**	**Comments:**
Identified annualised value of under-/un-funded services provided	-	10,050	10,050					n/a	All items flagged to the Commissioner for decision in 24/25 planning and contracting.

Context Summary
(Patient First problem statement, current situation)

The Trust has experienced significant growth, e.g. in its workforce, with no correlating growth in activity, i.e. it has become less productive. This has been coupled over the years with the provision of services that have not been commissioned/funded. These factors contribute towards the adverse/deficit financial performance.

Rationale for Current Score

A number of the services referred to have been run for some time and relate to activity undertaken each week. In extremis, the Trust could choose to cease service provision, although no quality impact assessment has been completed to outline what that would mean for staff and patients. The likelihood is therefore classified as "likely / 4".
Given the funding is not assumed in operating plans, there is no financial impact under the status quo. However, should these services be funded then income could significantly increase (albeit in practice there would be a likely offset against the top-up income received). Given the variability, the consequence is considered as "major / 4".

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
- Business planning / contract negotiations - Correspondence and meetings between provider and commissioner outlining issues and actions - Seek support from operational/clinical colleagues at the commissioner.	- Business planning / operating plan sign off (e.g. by Executive, Finance Planning and Performance Committee, Trust Board) - SLA

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Consensus between Trust and commissioner in respecet of commissioned services / de-scoping.	1. Contract review meetings to reach proposals for presentation to Boards	30/09/2024	On Track/Not Yet Due	Chief Financial Officer	

Trust Risk Register Aligned to Board Assurance Framework	2058: Unchecked staff growth	Current Risk Score: (5 x 3 = 15)
	2056: ICB alignment of clinical income	Current Risk Score: (4 x 4 = 16)

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

System affordability is a clear issue.

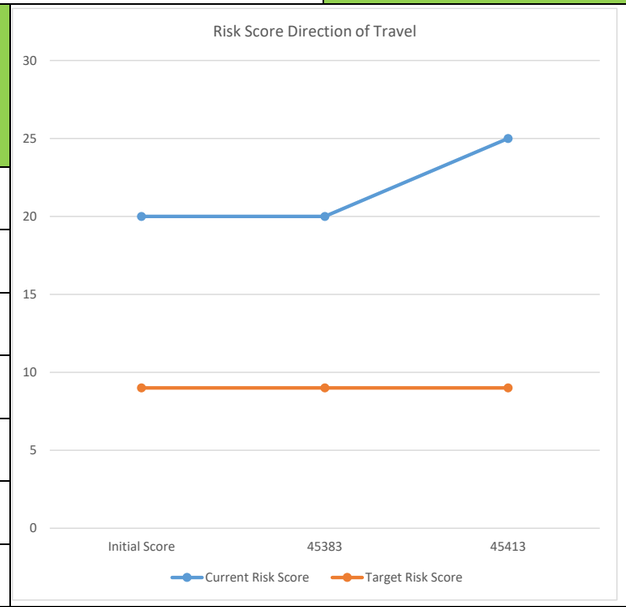
Date of Last Review:	14 June 2024
Date of Next Review:	15 July 2024

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

Risk ID:	5d
Executive Owner	Chief Financial Officer
Operational Owner	Deputy Chief Financial Officer
Primary Risk Grouping	Sustainability
CQC Domain	Well-Led

Objective:	Living within our means providing high quality services through optimising the use of our resources.
Principal Risk Name & Description	Capital allocation / funding
Relevant Group/Committee	Finance, Planning and Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	5	**20**	
Risk Score at Last Review	4	5	**20**	—
Current Risk Score	5	5	**25**	▲
Target Risk Score	3	3	**9**	
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Low			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**YTD**	**Comments:**
In-year capital allocation from system (Target is the planned depreciation and amortisation value for the Trust in-year.)	20.3	12.8	15.5					n/a	System operating capital allocation is £12.8m; additional £0.7m awarded to support CDC overruns and £2m for 23/24 ED performance.
In-year additional capital funding (no min/max target set)	n/a	1.9	9.7						Key items include: PDC funding of CDC (£2.5m); PDC frontline digitisation/EPR (£1.9m); Decarbonisation grant (£5.3m).
5-year capital programme - in-year request (no target)	n/a	63.3	63.3						Excluding decarbonisation plans and 6-facet survey findings.

Context Summary
(Patient First problem statement, current situation)

Capital allocations from the system have been below the Trust's depreciation level, and there are no guarantees of receipt of additional capital funds. Without sufficient investment the Trust may not realise its strategic aims and/or could compromise quality and safety, particularly in light of backlog maintenance reports.

Rationale for Current Score

The latest backlog maintenance report for the Trust indicates critical works that far exceed the in-year and even a multi-year allocation from system operational capital.
Given the value and the classification of these works, this is scored as 5 x 5.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
- Completion of Trust prioritisation matrix, including risk register entries - Programme review and approval by Trust Executive each financial year - Proposal paper drafted setting out options to address findings of the 6-Facet survey - Submission of capital plans and requests via the system to secure minimum fair share of operating capital allocation - Application for additional capital funds where available, e.g. PDC, charity, grants, etc.	- Internal audit core financial controls audit - External audit opinion on accounts and VFM - Risk register entries - Trust Investment Group and Investment Delivery Group governance and reporting, e.g. to Finance, Planning and Performance Committee

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Consideration of strategic capital funding applications	1a. Risk based proposals on a preferred way forward in respect of 6-Facet survey risks (investment proposal will subsequently be required to be prepared)	30/06/2024	On Track/Not Yet Due	Director of Esatetss and Facilities	Initial paper presented to Trust Executive on 11 June 2024 - further information requeted.
	1b. Explore strategic capital finance options with ICS and NHSE.	31/07/2024	On Track/Not Yet	Chief Financial Officer	
	1c. Report findings of the 6-facet survey to ICS/NHSE	30/06/2024	On Track/Not Yet	Chief Financial Officer	

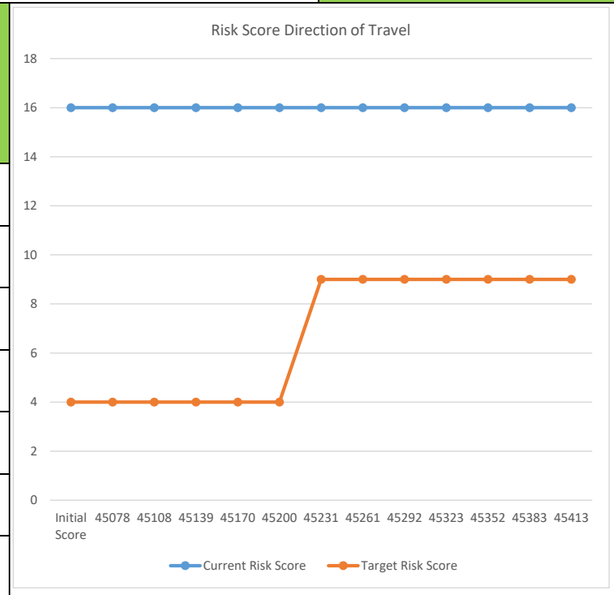
Trust Risk Register Aligned to Board Assurance Framework	2060: Capital allocation vs requirements	Current Risk Score: (5 x 5 = 25)

Additional Comments (Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)	
The Trust has secured a grant totalling c£25m over two years (with the Trust required to contribute £3.5m) for the purpose of supporting site decarbonisation.	
Date of Last Review:	14 June 2024
Date of Next Review:	15 July 2024

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

Risk ID:	5e	**Objective:**	Living within our means providing high quality services through optimising the use of our resources.
Executive Owner	Chief Financial Officer		
Operational Owner	Deputy Chief Financial Officer	**Principal Risk Name & Description**	Financial culture
Primary Risk Grouping	Sustainability		
CQC Domain	Well-Led	**Relevant Group/Committee**	Finance, Planning and Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	4	**16**	N
Risk Score at Last Review	4	4	**16**	—
Current Risk Score	4	4	**16**	—
Target Risk Score	3	3	**9**	—
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Low			
Adequacy of Controls	Inadequate			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**YTD**	**Comments:**
Number of lapsed budget holder training (no.)	0	79	74	75	75	TBC	TBC		
Number of lapsed budget holder training (%)	0%	39%	36%	36%	36%	TBC	TBC		

Context Summary
(Patient First problem statement, current situation)

A number of independent reports into the drivers of deficit at the Trust have identified the financial culture of the organisation as a contributory factor in the performance. Without addressing the culture the Trust may struggle to deliver its financial plans.
Failure to address this as an issue could impact the Trust's exit from SOF4.

Rationale for Current Score

Consequence: staffing and competence - moderate error(s) due to levels of competency (individual or team). Finance including claims: before utilisation of reserves the Trust is adverse by >1% of budget in clinical divisions. Statutory duty: low performance rating.
Likelihood: expected to occur at least weekly.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Budget holder meetings Budget holder training (statman) Finance Training Policy Mandatory objective in appraisal form Sustainability workstream within Patient First Communication via senior managers meetings and Trust Management Board Compliance reporting to FPPC (as part of payables update) and to the Audit and Risk Committee. Better Business Case trained staff.	Previously performance review meetings - now Strategic Deployment Reviews. Care group and divisional board meetings. Budget holder meetings Efficiency Delivery Group / Check and Challenge sessions Finance, Planning and Performance Committee Trust Board Oversight meetings Internal audit

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Budget holder training is not yet part of statman.	1. Take proposal for inclusion as statman through TMB.	31/07/2024	On Track/Not Yet	Deputy Chief Financial Officer	

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:

Additional Comments (Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)	
A wider leadership training programme is being explored at the Trust, which would require individuals to complete specified elements of financial training. The Trust Investment Group has approved expansion of the Financial Management team to support divisions in their finance needs/obligations. This includes anticipated funding from the NHSE Intensive Support Team/RSP funding in 24/25.	
Date of Last Review:	14 June 2024
Date of Next Review:	15 July 2024